West Dunbartonshire Council

NHS Greater Glasgow and Clyde

West Dunbartonshire Health & Social Care Partnership

Health and Social Care Partnership Strategic Commissioning Plan 2019 – 2022

Welcome

Today:

- Describe the Health and Social Care Strategic Plan for West Dunbartonshire
- Describe the Programme to transform health and social care services across Greater Glasgow and Clyde: Moving Forward Together
- We will explain why we think we need to make changes to services
  - Describe what this might look like through our Vision to deliver Tiered Models of Care
- Hear what people think about the plans and Programme and start conversations about **what matters most** to people
- Let you know where you can get more information and stay involved

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NHS Greater Glasgow and Clyde

West Dunbartonshire Health & Social Care Partnership

Moving **Forward** Together.

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Our vision:

Improving lives with the People of West Dunbartonshire

Our Strategic Commissioning Priorities

- Early Intervention
- Access
- Resilience
- Assets
- Inequalities

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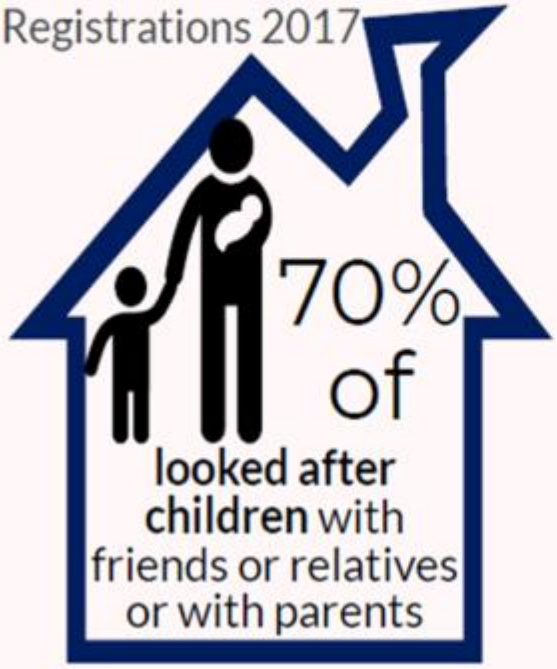
SAFE

3rd Highest rate of Child Protection Registrations 2017

40 % of Domestic abuse incidents **children under 5**



70% of **looked after children** with friends or relatives or with parents

Highest rate of unintentional injuries under 5s

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1 in 5

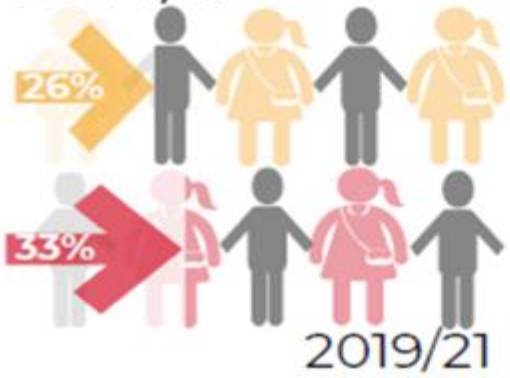
UK families live in POVERTY

Over half are working families

4128

Lone parent households

Child Poverty 2016/17

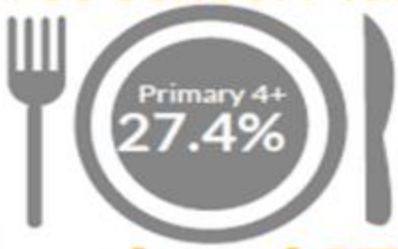


2019/21

50%

Lone parents are not in employment

Free School Meal



Scotland 17%

Largest projected reduction in welfare spending per adult

West Dunbartonshire £323

Scotland £250

INCLUDED

Burden of Disease

- **Cancer** is ranked as the top burden of disease nationally and ranked top within the burden of disease estimates for West Dunbartonshire with a projected 10% increase by 2026. Top 3 types of cancer prevalent in West Dunbartonshire are breast, colorectal and prostate. The incidence (new cases) of all cancers by age is projected to increase nationally by 33.5% by 2027.
- The rate of **Depression** in West Dunbartonshire (82.9 per 1000) is higher than the Scottish rate (73 per 1000). There are locality differences with Clydebank having a higher rate than Alexandria/Dumbarton (difference of 5.9).
- **Coronary Heart Disease**, also known as Ischaemic Heart Disease, is a preventable disease which kills over 8,000 people in Scotland every year. CHD is a priority in Scotland where prevalence of the associated risk factors such as smoking, diet and physical inactivity is high
- The snapshot extract from GP registers shows that the prevalence of **Stroke** in Clydebank (27.8 per 1000) is higher than the Alexandria/Dumbarton rate (22.8 per 1000), (a difference of 5 per 1000). Hypertension prevalence in West Dunbartonshire is higher in Dumbarton/Alexandria locality than Clydebank.
- **Alcohol related hospital stays** for West Dunbartonshire are higher than the Scottish average and increasing which is in contrast to the Scottish position. Alcohol liver disease is increasing and alcohol related death rates are slowly decreasing however this masks an increase in deaths in the 45 plus age group.
- **Smoking** prevalence rates are the highest in Scotland (25.5%).
- Percentage of households of 75+yrs will increase from 12 % in 2014 to 20% in 2039.

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Strategic Commissioning Plan Case for Change

- Christie Commission
- Health and Social Care Delivery Plan
- National Clinical Strategy
- Social Care (Self-directed Support) (Scotland) Act 2013
- Carers (Scotland) Act 2016
- Community Empowerment (Scotland) Act 2015
- National Eligibility Criteria Framework
- Regional Planning framework
- Moving Forward Together

Moving Forward Together.

Moving Forward Together

Programme Overview

Welcome

Today:

- Describe the Programme to transform **health and social care** services across **Greater Glasgow and Clyde**: **Moving Forward Together**
- We will explain why we think we need to make changes to services
  - Describe what this might look like through our Vision to deliver Tiered Models of Care
  - Describe what is work is already underway or planned locally that fits with the Vision
- Hear what people think about the Programme and start conversations about **what matters most to people**
- Let you know where you can get more information and stay involved

Introduction to Moving Forward Together

What is Moving Forward Together

- Moving Forward Together is a **Vision** to transform **healthcare** and **social care** services across **Greater Glasgow and Clyde**
  - It was developed by a **cross-system team** with clinicians, frontline staff and the six Health and Social Care Partnerships
  - It describes **new ways of working** that provide safe, effective, person centred care to:
- Aims to deliver improvements in care and outcomes for all patients service users and carers by:
  - **Maximising available resources**
  - **Making best use of innovation and technology**
- It has been approved by NHSGGC Health Board and noted by the six Integration Joint Boards
  - Sets a **strategic direction** of travel for the next **3 to 5 years** and beyond to meet future needs of the **whole population**
  - It is aligned with **Scottish Government** strategy and plans

Why we need to transform services

There is increasing demand across the whole system

Advances in medicine and effective public health interventions are helping us all to live longer

As more of us live longer the demands on health and social care services are also increasing

Nature of illness has changed, people are now living with diseases and conditions that previously would have been fatal

Health and social care system is struggling to keep pace with extra demands

What this means

Our **current models** of care are facing a number of challenges

The current **'fix and treat' approach** to healthcare doesn't focus on prevention, self-management and reablement

Increasing reliance on hospital care is simply not in the best interests of people

The **increasing demand** will simply **not be met** unless we change how services are accessed and used

There is a **limited** budget to spend on health and social care, and we need to use our resources to provide services that are **realistic, affordable and sustainable**

What we want to do

To meet the challenges we face we aim to deliver an integrated and seamless **tiered system** of person centred care across the whole system that:

1. Maximises Primary, Community and Virtual Care Opportunities
2. Aligns with West of Scotland Regional Plans
3. Optimises our Hospital Based Services

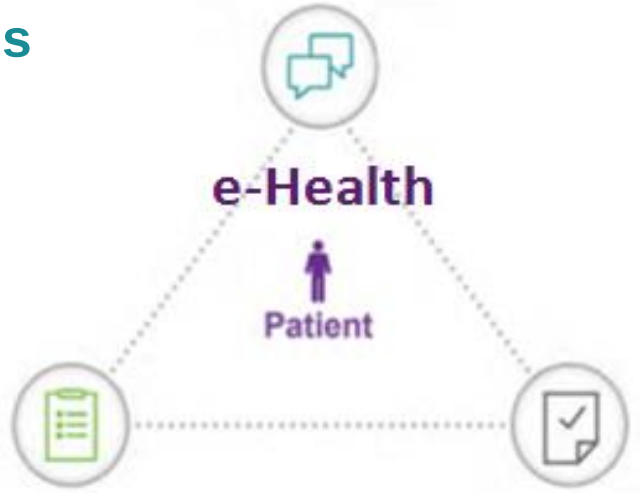
Local tiers are provided across the whole of GGC at / close to people's homes to promote independence and self management

As treatment or care becomes increasingly more complex with severity of illness, it is provided in fewer and more specialist centres that serve an area or even a region

Innovation and Technology

Central to developing **new ways of working is** better use of **eHealth**, **information** and **technology**

- **Integrated systems, records** and **care plans** that **improve communication, decision making** and **safety**
- Give the right '**people'** access to information to enable them to make confident **informed decisions**
- **Technology enabled care** to provide real-time information that supports people and services



It's not just services that need to change...

- To help reduce pressure on the system people need to access the **right care**, in the **right place** at **right time**?
- We all need to **think**, **work** and **act differently** to:
  - Promote greater self care and health improvement with the community networks to support this
  - Support people to access and use services differently with knowledge of and trust in new models and alternatives
  - Work more collaboratively with the Third Sector, community planning partners

Importantly...

We will need to work alongside **people** on concepts to **hear what matters most to them** to develop more detailed plans

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HSCP agreed activities and priorities

- Commitment to Adverse Childhood Experiences
- Delivery of the Pledge linked to the Domestic Abuse Summit
- Housing Contribution Statement linked to Local Housing Strategy/Strategic Commissioning Plan
- New bespoke housing for those with additional housing needs
- New Focused Intervention Team with Community Care and Health
- Continued commitment to recovery model of care within addictions service and with partners
- Continued commitment to shifting the balance of care
- Community assets development with CVS across all adult services
- Commitment to work with carers and Carers of West Dunbartonshire to meet requirements
- Review of respite, charging policy and short breaks
- Refreshed approach to commissioning and procurement

Feedback and Questions

What are your thoughts so far?

- Do you recognise the challenges we face and the need to change?
- Do agree with our direction of travel
- Other thoughts or questions?

The Tiered Model of Care

- Puts the Person at the Centre
- Supports people to live longer healthier lives at home or in a homely setting
- Provides more care in or close to people's homes in their community
- Provides more specialist care in a community setting
- Provides world-class specialist hospital care for our whole population

Person Centred

Moving Forward Together recognises The absolute need to put the person at the centre of all care

We need a system that:

- Is fair and built upon values of dignity, equality, freedom, autonomy and respect,
- Also recognises the needs of carers and ensures everyone is treated as an individual
- Empowers people to be more involved in and make better informed decisions their care
- Improves experience and outcomes

Level 1: At home

Moving Forward Together aims to:

Help people to live independently at home or in a homely setting within their community by:

- Promoting healthier lifestyles and supporting people to maximise their own health and wellbeing
- Supporting self management of long-term conditions and improving anticipatory care planning
- Using technology to monitor health, provide real-time information to improve decision making and prevent hospital admission
- Providing end of life care and supporting people to live how they want until death

Level 2: In communities

Moving Forward Together aims to:

Provide a network of community based services that can:

- Offer advice, support or treatment to improve, maintain or support a return to health
- Rapidly escalate through the other levels care when required to meet individual needs

The GP practice is at the core of the network coordinating care:

- The practice team will be tied into a wider network providing easy access to a range of services that share information and care planning
  - These might be organised in clusters to share resources more effectively or aligned to a community hub
- In the wider community network there will be other teams and community assets delivering an extensive range health, social care and wellbeing services

Level 3

Local hospital & special community care

Moving Forward Together aims to:

Provide access to hospital and other specialist care as an extension to the care delivered in a person's home and community

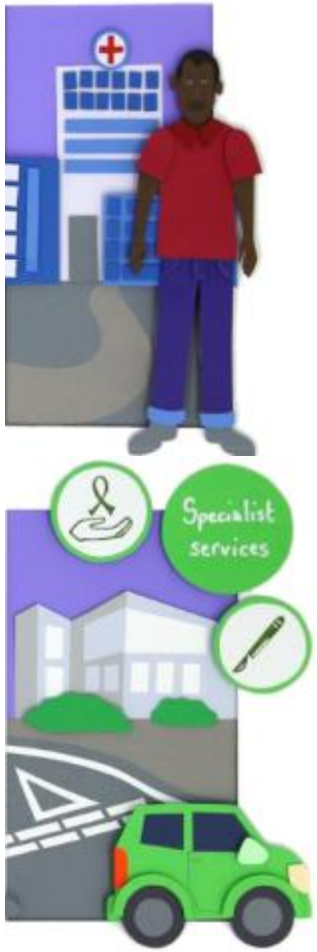
- Wherever possible hospital care should be anticipated as part of a process of care and a system that:
  - Access to a wide range of day case and short stay treatments available within their local geographical sector
  - Provides highly specialist community care for some conditions with some services only having one team for the whole population
  - Enables a and supports a person to return to independent living as soon as practicable and safe to do so
  - Meets the needs of people and living with a single condition or those with a complex array or multiple needs

Level 4: Specialist Hospital Care

Moving Forward Together aims to:

Provide world class specialist hospital care to the whole population of Greater Glasgow and Clyde and beyond

- Some care will require access to specialist equipment or highly trained specialist staff
  - These services might have to be delivered by a single team or from a single location
  - By working this way we are able to deliver better outcomes whilst effectively using our resources
- Provide more day case and short stay procedures to minimise the time people are in hospital
- Where safe to do so we will use ‘hub and spoke’ models and hospital outreach to deliver some elements of care as locally as possible



What this might look like: Specialist Hospital Care

Our current model of care for people who need chemotherapy to treat cancer

70% of all patient treatments are given at the Beatson West of Scotland Cancer Centre

25% at the New Victoria Infirmary

5 % at Inverclyde Royal and the Vale of Leven hospitals

The Beatson opened in 2007 with a capacity to provide a **maximum of 30,000 treatments per year.** It currently delivers almost **38,000** with this projected to reach **53,000 by 2025**

What this might look like: Specialist Hospital Care

How we ant to deliver chemotherapy to treat cancer in the future

50% of all patient treatments are given at the Beatson West of Scotland Cancer Centre

50% in 3* cancer treatment units and in 5 cancer outreach centres

Some treatments eventually given in community setting including pharmacies

A **tiered model** with **Beatson outreach** to other settings will ensure we meet capacity and deliver more services closer to where people live

How we currently provide services

For people who need chemotherapy to treat cancer

Mr Smith lives in Greenock and he has been diagnosed with prostate cancer. For this, he is prescribed a medication called Abiraterone, which is available in oral tablet form.

In the current clinical model, he attends the Beatson West of Scotland Cancer Centre every 4-8 weeks for an outpatient appointment with a consultant oncologist.

His oncologist gives him a prescription to take to the hospital pharmacy. All his appointments are at the West of Scotland Cancer Centre.

How we want to deliver services

For people who need chemotherapy to treat cancer

In the proposed new model, Mr Smith will attend the Royal Alexandra Hospital for his initial assessment and the start of his treatment.

If his first treatment goes well, he will then go to Inverclyde Royal Hospital every 4-8 weeks for an outpatient appointment with either a specialist nurse or a pharmacist from the Beatson

He will be given the choice of getting his prescription from the hospital pharmacy or his local high street pharmacy.

Feedback and Questions

What are your thoughts on the Tiered Model of Care?

Other thoughts or questions?

Find out more and stay involved

For further information

Visit: **www.movingforwardtogetherggc.org**

Call: **0300 123 9987 (free phone)**

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Group discussion

We would like to know:

- **What matters most to people**
  - Help us develop new models of health and social care that are person centred

- What do you think the HSCP should prioritise to deliver?
- What do you think we should be asking the independent sector to support?
- What do you think we could asking the 3rd sector to support?
- How do we share the benefits of self care with our citizens?

Moving **Forward** Together.