Whole System MFT Event - 30 January 2018
Banqueting Hall, City Chambers, George Square GLASGOW

Moving Forward Together

SUMMARY OF TABLE TOP DISCUSSIONS

TABLE TOP DISCUSSION ONE: QUESTIONS

In terms of transformational opportunities; what opportunities do advances in e-health and technology offer? What are the three top priority changes which we should be securing?

KEY POINTS FROM THE TABLES

E-HEALTH TOP 3

Comprehensive shared patient record across primary community and acute care including pharmacy and other prescribers Robust communications mechanism between primary and acute care to support decision making on admissions or alternatives Patient access to records and information to support self-management and prevention
Everyone appropriately connected to the same systems and using equipment/agile access; need guidance/protocols and training; governance systems in place Better understanding of pathways All tackle the same three things across the system could make a big impact at scale
A single electronic record accessible to all who are involved in a person's health and social care via a card or phone app carried by the individual would be ideal for accurate up to date information sharing. An example of a working model is the My Health Record system in Australia. In the absence of single electronic records our three top priority changes are: Make anticipatory care plans accessible to social work, community teams, mental health teams, ambulance service and patients and carers as well as general practice and acute care. Use ehealth and technology to advance safety further, for example by developing further the use of technologies to keep people safe in their own homes and by improving safety of medicines by ensuring that changes made to medicines in acute care are visible to general practice and community pharmacy. Ensure that e-health systems take people's communication needs into account at the design stage (in terms of literacy, learning disability, non-English speakers, British Sign Language users and people with sensory impairments). For example, address accessibility issues such as making translation possible within Trakcare for people who do not speak English.
Joined up systems to support team communication and workflow Single patient record with patient at the centre Remote monitoring, e.g. for diabetic care could transform patient care in this area

Still bit of dissonance between what available and what can access- get the basics correct Implementing systems- need to speak to each other and access issues need to be resolved. GPS and managing the associated risks.
Liberalisation of access to systems to let you do your job. Especially applies to the areas like mental health / social care and health boundaries. Make the best use of what we have and sharing learning.. less working in silos, separate bids for small things– make sure that what we do can scale Organisational risk: need corporate support to take risks of new ways of working. Without that no point putting in place new things.
Very helpful for clinicians anywhere in the system to see activity anywhere in the system (e.g. GP and secondary care appointments). New data sharing agreements between primary and secondary care should be very helpful.
Get the current systems working well so that services/specialities can communicate effectively Integration of systems – lots of systems in NHS which do not connect Easy access to information for patients about how to manage their conditions.
Supporting the wide scale use of Virtual Clinics to allow patients to participate in consultations without travelling to hospital. The “Attend Anywhere” initiative within Dermatology at the Royal Alexandra Hospital, which is part of the Modernising Outpatient programme”, was noted as an example of good practice allowing more patients to me seen whilst minimising travel. The group discussed the applicability of Attend Anywhere to other clinical specialties e.g. fracture clinics and orthopaedics. Promoting and testing the use of wearable’s in supporting anticipatory care. An example was shared where an individual can wear a wrist band which monitors changes in joints over time and helps ensure targeted Physiotherapy intervention to improve readiness for treatment or rehabilitation Maximising the use of the Clinical Portal on a West of Scotland basis and in working with Social services in providing shared information access. The group discussed risks in relation to emerging data protection legislation and the importance of governance to underpin shared access
Automated and integrated discharge summaries and systems in general that allow easy communication between Acute and PC teams. Time spent correcting mistakes and miscommunication is excessive and saving this time through robust systems could in itself be transformational. GGC need to develop a true electronic patient record system to support transformational change – learn from other health boards who have already succeeded in developing this. Can an app be developed which can support patients in holding their own record e.g. trial in maternity services, albeit this may not be appropriate for the older generation. Make full use of telemedicine opportunities. Remote Boards currently make full use of this given the geographical challenges. Referrals accompanied by photographs e.g. in dermatology, could remove the need for clinic visits and save time and resources.

Use of improved technologies could help in many ways – table agreed that video conferencing was a slow and complex system, and we should be working with technology that we already have (e.g. Facetime, Skype etc). This includes working with phones/laptops/iPad already owned (mention of system in some firms where employees get a grant every 5 years to assist with technology buying, and it the staff are then able to use their own devices within the organisation). This could also be helpful in rural areas where the patient could show physical symptoms via Facetime etc.
Key theme: The biggest challenges of optimising current – let alone future – e-health/e-care opportunities are behavioural rather than technological.

E-HEALTH OPPORTUNITIES

Diabetes and renal services are champions of e-health supported working with databases and good methods of sharing information. Diabetes are ready and need to fully implement this way of working which could act as an exemplar. There are many opportunities if community pharmacy and other healthcare providers can be linked into the mainstream records and systems. Permission to share data and see record across sectors is likely to be a challenge but is one we must overcome. Data sharing is at the core of patient centred care.
Enhance portal and other IT approaches to access/share information/data/patient notes/results etc. and move this beyond GG&C and across other Boards and services ; particularly patient access Maximise technology to book appointments, self-management etc. Need to ensure communication is cascaded throughout the system (patients and staff) Internet access is problematic in some areas (rural) which could be challenging for tile-health etc.
ehealth can transform administrative processes Resilient and reliant IT equipment Need to reduce duplication but recognise transitioning to full electronic records Directories and contact details need to be kept up to date Primary Care payments still on paper and leading to inefficiency Recognise that this may add to workload whilst in transitional phase. Job plans and clinic templates need to be modernised Having user input into the design and procurement pf systems is essential Operational hours between social care and NHS differ, e.g. Xmas Still issues with data sharing, e.g. Between medicine and mental health services and primary care, social care although some progress is being made. National direction needed

Shared digital record across all health & social care? Not platform specific Issues? Data security/permissions What are we trying to achieve …. What's the question? Regionalisation/Nationalisation of systems…. Examples of what works? Change perception of first point of access - digital first rather than traditional front door to service
Huge opportunity – need to get away from silo working and work across the different sectors E health in clinical services – risk is lack of the technical infrastructure – funding for licences etc not always there and becomes a rate limiting step Remote monitoring and use of devices happens in pockets – Dietetics – SG funded project on management of celiac disease – real push from lead to embrace technology to support people with the disease – challenges all associated with funding and who pays? Funding for tech based funded care in pockets in the HSCP Primary care – GP IT pretty good – need to share – also need to share with wider teams within HSCPs etc. Need to consider the patients – using tech to book appointment, cancel appointments etc – patients making appointments on line – remind and cancel by text message. Be mindful of how co-ordinated Prescriptions – can order on line but still need to print off bit of paper to take to the pharmacy – should be technology enabled. IT and ideas – need to consider population and who can be applied to. Some patients deteriorate and need to be managed – GPS – alarms – works up to a point. GPS trackers for dementia patients key as will take patients out of hospital – need to consider and use spend to save. Open discussion of risk and risk mitigation – families will need to sign up to these. – need to have conversations early enough and not wait until patient is in crisis and attending the hospital. Basic issue with technology that need to be addressed - fundamental – how share access to records – historically could access written notes but no permission to allow access. Lot elderly people with long term conditions – want to take the control – not enabling the people who could manage own health better – how pull in to deliver the balance. Doing work in London with the mental health teams around young people where suicide search happens get automatic pop up to allow on line chat. From staff perspective – sometimes rate limiting fact is that staff not aware of what they can signpost patients to. Lot health apps available – how do we enable staff to consider those with evidence base and use appropriately.
Lack of visibility of what's available: sense people don't know what's out there: some of what was presented was new, no-one had heard of Attend Anywhere for example We haven't been strategic in what we have done – local bids to solve problems in a particular way that can't scale. Infrastructure – iPads now used to support patient self-care but can't download the app via poor hospital Wi-Fi. (need to follow up with where this was) Frustration around information sharing.. even within one social care organisation – double recording (legislative stuff on DIS and then replicated on EMIS). Can't access mental health letters information – (MH summary said to be not fit for purpose for this reason). Also we have made things more difficult to get access to systems (example cited of social workers

unable to accessing mental health system in Paisley now sorted but took months). Opportunity around advice support - disease self-management – health and wellbeing hubs (falls prevention, exercise… diabetes cited as good examples Recognise that patients will use whatever apps they find – they may need help to find the right ones (this is coming with the QA approach in Scotland) A lot of praise for idea behind patient portal to manage appointments and virtual clinics (like the idea of pictures /video) – some are doing this already but again need advice to scale and deploy. Sense of frustration that we don't use technology to max potential
Useful to use ehealth to promote dialogue between clinicians and patients Good to move away from doing everything face to face Recognise that not everyone has access to relevant tech and need not to leave them behind A shared patient record very helpful for pharmacy; important to include community pharmacy in that data sharing (including ECS; new GP contract should facilitate that). Need to move from writing paper notes and scanning in so that we can type right into EPR – that facility not yet available everywhere in Acute, delaying communication and adding to admin time. Need to allow full access to MH patient information (using "break glass" system as in place for gynaecology)
Communication between services and specialities is very difficult. It is not easy to identify colleagues from the email system. Portal information can be out of date Why can't West of Scotland systems be connected up? The higher tiers need rapid information from the community services on patients. Community pharmacy cannot access Portal as there are bureaucratic barriers to setting this up. Move to cloud-based system will create data protection issues. Forms of communication are still old fashioned in some areas – e.g. telephone calls between medical staff rather than using digital methods. Staff behaviour in relation to new technology can be a barrier e.g. GPs who still dictate letters which then need to be typed up. However, emails cannot be used as part of patient record. If range of practitioners are accessing and using results of scans/tests etc. who holds overall responsibility for the information? Technological links between primary and secondary seen as a particular weakness. Data protection concerns need to be resolved. Integration of systems, especially those between primary and secondary, seen as a priority. Need to empower patients to manage their conditions using new technology. Easy to access information for patients about how to manage their conditions, e.g. patient management systems.
We require uniformity and transparency of digital patient information with the relevant protections built in. This should be GGC-wide/WOS-wide/Scotland-wide. Our information systems need to be more responsive and more intuitive to help clinicians see relevant patient information more easily. This needs to be combined with education of staff in how to make best use of the technology. We need to get to a position where all the IT hardware used by our staff is more up to date and regularly updated.

Could/should we be aiming for a patient held record that patients bring to appointments? (as an addition to the NHS record)
Good example in Edinburgh renal hospital Remove structural barriers to giving everyone access to acute/HSCP systems patients having access to their own clinical information – clinical information along the cancer pathway and ability to interact with the scheduling process and have visibility of clinical decisions being made on the pathway Give patient more control of decision to interact with clinic scheduling – e.g. patient who doesn't need to attend all their return appointments should have autonomy to make that decision. Nuka, Alaska example – principle is that patient owns the health care set up as they have been integral to what services are required and how they have been set up Need standardisation of leaflets and documentation across the board – potentially available on patient portal. Electronic critical decision pathways would support consistent front door pathways Live chat opportunity for patients when the patient is booking an appointment / or seeking further information Keeping apace of services developments e.g. acute knowing what services HSCP / GPs/ community assets offer locally Single HSCP partnership – currently duplicating effort between systems MDT cancer systems – currently wasting resources and money Ward rounds are slow – PACS and clinical portal slow response – older equipment on the ward Improving existing technology!! Sharing ambulance information electronically into the clinical portal Scottish ambulance access to acute patient information Queen Elizabeth Hospital, Australia – hand held patient records
Cross system ability to access all medical records – caveat at security To include services with no e-records – dental, pharmacy and community planning Automation of virtual clinics and consultations Advice referrals – underpinning phlebotomy and diagnostic access Secondary care results management Improve E-Systems to include automatic alerts when particular drugs are prescribed Different approach to clinics are necessary – virtual and face to face – enable diagnostic tests in community – more access for GP's Relationships for GPs – acute different how overcome lack of knowledge in the system
Need to ensure that IT systems are easier to use and more integrated: this should involve the employment of experienced app developers to ensure technology is fit for purpose. The cost of lost time due to slow and non-integrated systems should be realised. Need to engage with IT colleagues and perhaps invest more in IT staff – good examples of forward thinking IT use is BadgerNet. Need to ensure there is selectivity about where to invest. Challenges for these areas include: 1) having the capacity to invest in IT, 2) how to govern and manage data volumes, 3) information governance and security (perhaps need to encourage risk taking in terms of organisational governance). 4) Ensuring remote access for software and technologies.

Ensuring interoperability of systems
Aim of IT is to improve efficiency and save time. It needs to be joined up and patient centred. Frustration around the scale and pace of IT change, not keeping up with organisational change and planned in silos rather than strategically. Particular issues in sharing mental health information and in sharing health and social care information. For acute, different HSCP systems are an issue. Need to review the planning mechanisms and governance structures around planning IT – not just the systems themselves. Recognised progress with Trakcare and clinical portal, and AD dashboard seen as positive progress. Noted difficulty in getting useful information out of systems after data has been input. Need to be thinking about IT to support our future vision, and not just to support our current jobs. Discussion about patient holding and controlling own records. Discussion about how to incentivise codes to ensure information is accurate.
Single client record system for both health and social care data (to replace myriad of current systems, albeit interfaced by Portal). Broaden staff groups/disciplines who can add to the electronic Key Information Summary (e-KIS). Develop a cloud-based electronic Anticipatory Care Plan (ACP) that is patient-owned and shared, which can be view and updated not just by a full range of staff but also the service user themselves and their carers. It would be ideal to think more comprehensively in terms of an overall Care and Support Plan (in which the ACP was integral); and similarly, provide for the requirements of Carers Support Plans. Move (quickly) from written to electronic referrals (both within hospital and between hospitals and NHS external contractors) – with an emphasis on keeping it simple. Greater development of digital treatments (e.g. dental robotics). Greater adoption of telephone consultation and virtual clinics – both by Acute Services and by GPs/general practice. GPs to commit to smoother and more consistent data sharing with wider health and social care system (as per the aims of the national digital strategy). Improve electronic access to data by Scottish Ambulance Service (e-KIS is already available for them to view – linking to point above). Technology can be an enabled to augment skills of staff already working to top of their licence across professional groups – thus allowing greater and more complex care provision to be moved “down” tiered models.
Whole system context is important. What about information overload? Richness of coding in both primary care and secondary care. How do we widen understanding of what exists in the 'other' sector to advance this? Each sector has a limited understanding of information availability and flows in the sector in which they do not work. Should we have one clinical store for Scotland? It was felt that we single clinical portal that covers primary and secondary care. Patient safety and cost are two important drivers. The information commissioner/DPA may prove to be a barrier. We would extend this further to allow region wide access as patient movement between health boards is not uncommon. We acknowledge information governance may be an issue bit not one that couldn't be overcome. We thought that there should be ease of access at point of need e.g. paramedic emergency care. Ehealth in Primary Care should let different services add to a single clinical record (physio. +

DN's + podiatry etc.). This will let all services see what services are being delivered to which patients and what treatments are being undertaken. This should be shared with Secondary Care and vice versa.

Sharing of information between social care and health services allows greater knowledge to make better decisions for patients. I am clear that doctors and nurses and physios etc. and social workers are all working as HSCP workers and not health or social care.

Signposting by reception staff will be important, directing towards the most effective care which will almost certainly be better than seeing their GP (Optometrists for eyes, podiatry for foot issues and physio. for MSK problems being x3 obvious examples). This will require a lot of buy in from GP Receptionists and we have to accept that there will be a very gradual change in patient behaviour.

Technologies:

Patient centred booking was considered necessary to minimise non-attenders in clinic and thus make the outpatient setting more efficient. Patient portal opportunities should be extended if the pilot is successful to allow patients to have ownership of elements of care and as technology progresses this could perhaps be delivered via an APP with the functionality to allow patient notification.

There should be greater sharing of records across all parts of the system, rather than separate primary and secondary care casenotes within silos

Even within sectors, some records are not available to the rest of the team (separate records between health and social care, and even separate records between professions within health)

Community nursing records are not integrated into acute records at all

Scottish Ambulance Service when responding to 999 calls have no access to patient records beyond ECS and no access to details of community or other non-hospital services which might be in place to support patients, therefore patients default to hospital admission

Respiratory symptoms were the third biggest reason for 999 ambulances being called (1 was inter-hospital transfer and 2 was chest pain)

The majority of calls from patients are in the morning, not out of hours, therefore redirection to other non-ED services are eminently possible

Nurses and Respiratory Physios could play a much larger role in the management of respiratory patients and the avoidance of emergency admissions if the pathways from SAS to existing services were established

In England, OOHs services, including ambulance services, have access to a single care record which specifically has flags for end of life care and patients with long term conditions who have care plans in place

Ambulance Services could avoid emergency admissions if they had access to alternatives to admission, esp knowledge of other services which could be brought into the patient's home setting to support them

Better linking between NHS24, OOHs services and 24hr community teams would allow much better support for care homes and their residents

Variation in service provision and access protocols between HSCPs make it complex to manage across so many relationships

GGC manages significant numbers of non-GGC residents, and sharing records across NHS Board boundaries is very poor indeed

Only clinicians with dual contracts across NHS Boards (e.g. oncology consultants) have access to multiple systems, but they are not integrated, and the patient's local NHS Board records does not communicate with the GGC record

Tech has moved on so much in recent years, big opportunities to engage better with patients. Patient portal / self management has big potential

People having more control over own health via the portal is great. Patients often have issues managing appointments, lots of wasted appointments because people didn't know, didn't remember, just didn't bother attending - can sometimes lead to an emergency admission

Ability to communicate virtually with patients could help manage / mitigate 'referrals by protocol' where the person doesn't really need to be seen.

Application in community - web based tool which runs an algorithm which identifies what people need to do / who to see. What if there was some sort of live webchat / advice service to screen things, may help avoid referrals. Who is the decision maker in these cases? Consultants wouldn't necessarily have time to do this, but what about eg typing your symptom into system and it generates a factsheet - governance of this important so it's accurate reliable advice. Ideal if over time this became more sophisticated so information was personalised to the patient to some extent.

Must be wary that these are great ideas, but relies on investment not only in the tech but also in promoting it. Also significant reliance on reducing (or at least aligning) the number of ICT systems used across the whole system.

Also need to bear in mind that the things that are making a difference in use of technology are internally delivered - outsourcing ICT rarely (never?) works out as it was intended to.

TABLE TOP DISCUSSION ONE: QUESTIONS

In terms of transformational opportunities; what opportunities does the integration of health and social care offer? Are we realising these opportunities?

KEY POINTS FROM THE TABLES - INTEGRATION

Better communication between services and shared knowledge of what is available and how to access those services. SPOA has helped but there is work to be done. Inreach and outreach models are both applicable and integration is a two way process. Integration amongst health care services is still required as is integration amongst the 7 different branches of social care as well as integrating wider healthcare with wider social care. Building trust and relationships is essential to success. Integration is about all services and not focussed on discharge and delays. MDT approaches and a multi-disciplinary team approach whether virtual or physical are key. Managing risk needs to be central to service design and delivery. Alternatives to acute care need to be robust high quality and sustainable so that they can be successfully marketed to and trusted by our population. Integration starts with being joined up and a different approach to commissioning.
Require accurate and consistent messages to public regarding their expectations about service provision. Changing attitude to risk – stop being risk averse and instead 'testing change' and enabling risk Clear messages from/to politicians about redirection and difficult decisions e.g. hospital closures Workforce predictions are crucial Need to move to generalist rather than specialist approaches Lots of good work happening in HSCP joint assessment and delivery
Integration offers opportunities for agencies to build relationships and work together better in caring for people. For example people with complex and recurrent requirements can remain in their own homes for longer, therefore reducing the need for hospital and nursing home care, by involving the full range of agencies in their care. A model of weekly multi-agency meetings in a shared space to facilitate this is developing in some parts of NHSGGC (Glasgow City was our example) and could be expanded. Sometimes simple solutions such as 'good morning' calls or visits to relieve social isolation and loneliness can make the difference between people coping at home or not, making properly resourced inputs from the third sector central to caring for the whole person (could lottery funding be sought?).
Integration of teams and resources not just systems (more social care staff working in the hospitals) Better transition arrangements between acute and community care has not improved enough Needs to include opportunities across the region to maximise benefits
Intuitively, more holistic care of the patient/client. Lack of connectivity works against needs of individual Statements: Time to think, Changing attitudes to risk, institutional parameters are different

(health/social care) think differently to families/carers. Space to allow acceptance of differences not obligatory to solve. Concept of Primary Carer? May change as individual's needs change - digital record provides equality of access more transportable. Current problem is unidirectional data flows… e.g. care plans developed in hospital. When patient moves out to home, plan moves with them but hospital team do not see whether the plan worked? Can this be overcome (heart failure example given by Karen Hogg) - transferrable knowledge assets.
Variation a significant theme. Experience in different HSCPs; delayed discharges seem to be much more improved in HSCPs with long-standing health and social care integration. Local variation can be so significant that some aspects of care are not available everywhere. Even where it is available, it may be difficult for everyone to know what's available where because it changes to rapidly. General sense of integration working well once it's in place, and that process may be easier for smaller HSCPs. Experience of having social work as part of Acute MDTs was very positive. Recognition that improved integration may facilitate earlier discharge, and that has consequences for the workload in primary care.
Need for real time communication. Acute is struggling with the unscheduled care problems and this acts as a barrier to partnership working on less immediately urgent/longer term issues. However, flow of patients through the system has improved as a result of improved joint working between acute and community services. Key area is to prevent patients needing acute care as far as possible and when the most effective care can be provided in the community
The integration of health and social care provides opportunity for progressing realistic medicine. Linked to this an example was provided from orthopaedics (north Glasgow) describing the 'workbench' referral process which is delivering better referrals into the service.
Efficiency of systems – View stated that means nothing if the staff across the different teams are not working together. Social work need to be in the hospitals? Disputed by others at table as not happening everywhere and some debate as to what is the appropriate model – different across the different HSCPs and different models in place. This model works well in the Clyde sector but different model in Glasgow that equally works. Investment and efficiency of mental health legislation needs considered – guardianships, involving local sheriff courts.
Education to overcome fears from public about how information shared. Gaps in services – still no electronic record e.g., oral health We need to develop regular forums that allow us to come together, e.g. MCNs or groups across primary, secondary and social care at local level coming together to solve problems and improve service design We need to identify ways to make this happen quickly, we will need to take risks and have challenging conversations when required. Implementation of small tests of change and willingness to stop and adapt things that are not working quickly will be crucial. The current hierarchical structure in GGC acts as a barrier to decision making and the ability to move quickly therefore to drive this forward we need to devolve decision making powers to the teams, which in turn encourages ownership. One of the biggest challenges in working towards admission avoidance is the availability

of safe housing stock in GGC. GPs often have no choice but to send an elderly patient to hospital because of the type of house they are living in. Challenges with accessing out of hours Social Work support and onwards transfer to safe housing will result in elderly 'patients' being transferred to an Acute bed when it is not necessary. We need a truly 24 hour, 7 day a week social care service We need to develop a mechanism for sharing 'what really happens' in Acute and Primary Care – is there lack of awareness of the challenges in the respective areas e.g. the QEUH had 120 medical 'boarders' throughout the hospital putting significant pressure on clinical teams. Equally community teams experience challenges on a similar scale. Can we find a way to raise awareness amongst all parties? Is there a need to review job plans – given the recent winter experience? Should we be looking at seasonal job plans that push elective activity during the summer, leaving the winter period to focus on trauma and acute medical patients, working closely with community colleagues?
Transparency and flexibility around budgets Quicker decision making Wider range of services offered in local areas Better understanding by elected council members to help ensure communities understand the wider context and the challenges the HSCP/NHS faces (e.g. helping to get support for ward closures etc).
Patient centred booking was considered necessary to minimise non-attenders in clinic and thus make the outpatient setting more efficient. Patient portal opportunities should be extended if the pilot is successful to allow patients to have ownership of elements of care and as technology progresses this could perhaps be delivered via an APP with the functionality to allow patient notification.
The language is important - not NHS or Council but HSC beds. Prevention agenda in homecare. Supporting prevention and re-enablement agenda across a wider workforce such as homecare. What does acceptable risk taking look like? Barriers: Allowing patients and families to take risk Difficult conversations about risk and also end of life care Ideological positions and assumptions. Understanding governance and accountabilities in a changing system - we still need governance. Despite the Community Respiratory Team being rather doctor light, the service is still reaching saturation. If we provide such services they may act like roads and become full up. Unfortunately this may require funding. This may have to come from Secondary Care as this type of service is set up to reduce admissions.
Consultants should make themselves available to speak to GPs more frequently Many consultants were resistant to this, citing pressure of time, but cardiologists who had trialled this found that the time commitment was around 5mins per day GPs and non-medical staff should have direct access to more diagnostic support without requiring a referral to acute consultant Protocols and pathways would be key to ensuring appropriate requesting Virtual clinics had a place in hospital care, especially for follow-up Job plans and clinic profiles should be updated to allow slots for review of care by consultant (with wider team, if appropriate to the specialty) without need for the patient to

attend Updated management plans could be communicated directly to patient and GP Dumfries had a visiting consultant service whereby the patients attended their local hospital (Dumfries/Stranraer) and the consultant was based in Lothian Although this had very high patient satisfaction (over 95%), the service was discontinued because the consultants in Lothian did not like the remote nature of the consultation Clinical leadership and Champions of Change are key to success Just do it! Proof of concept is hard to dispute There needs to be acceptance that all tests of change require some element of double running
There's more open-ness now than there was before, but not sure we're quite there in terms of trusting each other and 'giving things up'. Frustrations are not necessarily about the transformation of services themselves, but of the journey. Shift in mindset needed still. Disconnects still exist, particularly between GPs and acute. Don't think about 'losing' people eg DNs going to work in GP practices, but accept that we're all part of the whole system and people moving about it is good for sharing learning and experiences etc. Tiered model - a lot of people haven't seen this before. Consultation / communication not been carried out to a significant degree. Lack of constructive dialogue leads to risk of new models not being accepted.

TABLE TOP DISCUSSION TWO: QUESTIONS

In terms of transformational opportunities; what do the possible new models of Primary Care enable in supporting the transformation of services?

What lessons can we learn from the experience in mental health and how could the approach taken in Mental Health apply across other services?

KEY POINTS FROM THE TABLE – PRIMARY CARE

Changes to contract encourage team working and empowerment of ANP AHP Pharmacists Optoms as a team.
Some new roles or enhance roles have up to 7 year lead time so will need investment for many years before a benefit is realised however there is opportunity for interim benefits
Change champions are essential to lead transformation
Retention of staff and supersession planning needs to be built into the investment proposals
A long term vision for workforce is required not just counting heads
Empowering staff to operate at the top of their licence.
Making full use of staff experience and skill set.
Identifying quick wins – pharmacy input to medicines reconciliation
This requires a change in culture and an investment in our staff
We must seize the opportunity to change embedded constraints and attitudes
We should celebrate success and roll out what works across the system
If we are to be transformational we need to change the population's attitude to accessing healthcare – use of MIU and other alternatives to A&E, alternatives to GP visits, use of facilities in retail and other high footfall areas.
Patient expectations need to be changed through education and honest conversations
There needs to be a long term view to transformation and a realisation that change will not be delivered quickly but there will be some quick wins
Out with diabetes services there would be a case for developing community based health and wellbeing hubs. These could be used to undertake a lot of chronic disease surveillance namely phlebotomy, monitoring of weight etc. In relation to diabetes this could also include retinal, foot and microalbumin screening.
These hubs would therefore provide the 'Processes of Care' and could be provided by band 2 or 3 staff. The results of these investigations could then be shared via portals such as My Diabetes My Way.
This would support person centred care with joint goal setting etc. and then review by an appropriately trained HCP could then focus on the 'caring process' and disease management rather than the monitoring part.
This would ensure highly skilled staff could devote their efforts and attention into improving outcomes rather than data gathering etc. This would also allow the development of care models along the lines of the National Clinical Strategy with a move to moving services out of GP surgeries etc. and to utilise a wider multi-disciplinary team.
Broadening of 'touch points' for patients. Shift to open access to broader range of professionals.
Doctor no longer gatekeeper but becomes specialist.
Issues for change:
Bridging finance to allow introduction of new models
Cultural change - shift of emphasis from the doctor
Advanced Nurse Practitioners - Glasgow is behind the curve.

Beatson critical care is nurse led. Availability of people? Money from SG. But can't recruit to current vacancies (all professionals) Huge impact on training requirements Risk of losing core staff to more specialist positions - churn Advanced Nurse Practitioners must be trained along holistic lines not to become… "Heart Failure specialist" MDT membership - all part of it - risk of models breaking this? Timescales (SG) for implementation of new contract not realistic? Nothing will change from 1st April. Concern that tide of GP retirals will leave big gap. What is the gain from shift out of Hospital (MSK examples; LTC if surveillance is conducted out of hospital)
Some concerns around workforce planning – fishing in same pool already – have fragile pool in some areas already. ANPs good example of where shortages are an issue. Robust workforce planning required if we are to make the 'whole system' work well Pharmacists less of a worry and Paramedics models also being explored/piloted Planning process are flagging that the biggest issues are related to availability of appropriately qualified and/or trained staff. Some discussion at the table around the requirement to deliver a cultural shift both from the teams and the user – some individuals less open and will take the time to change. There is a clear need to win over the general public as to who best placed to deliver the different tiers of care and recognised that user experience will start to win over if the benefits can be seen/realised. Glasgow ahead of the game – focus on encouraging the population on the Primary care building to get healthcare rather than the ED departments. – Take lessons from where there are-co located centres and use the evidence that is being collated – e.g. alcohol advisors, money advice etc – lot of evidence that working for the patients. However needs to be acknowledged that a significant proportion of practices are not part of a 'big' centre where this model could be replicated. Need to take time to consider how this type of model could work in practice where there is no obvious 'building'. Community hubs key theme coming out of the consultations processes and reliance on nurses. Challenge to make sure that resources are used to free up the GP to do complex care and that the resource is used appropriately. Key that we think about how to engage with the communities that are high users of the GP and other health services? Primary care have done some work on multi morbidity already – could be built on as part of the transformational work. Hospitals seeing lot of old people. Also need to recognise that we have a huge deprived population who will get the diseases 15 years earlier so need to consider that also – Recognised that life expectancy in this group is lower but that these populations will live longer with disease.
Many excited by the new contract and opportunities Could see easy replication for many chronic LTCs. Seek to link acute specialist clinicians more closely to clusters or localities. There is an appetite to work in the same way once an evidence based approach tried and tested- we discussed if having 6 IJBs was a help or hindrance and felt that if approach

was evidence-based then it would be adopted across the Board Note that a lot of this transformation is already happening in areas– e.g. addictions working closely with primary care. There remains disparities: why is there a road map for cardiac rehab but not vascular rehab? A key problem is not facilitating onward sharing across the organisation. Overall need more leadership and governance to promote change. There's no point having a new contract if we don't know what to change and lack tools to effect the changes.
More community-based services; ensure appropriate use of services and agile working. Strengthening community-based teams is important. Skills of staff in the community need to be supported so that they can manage more complex care as people leave hospital earlier. Need to invest in staff development to ensure that people can be recruited to these new roles. People value some of the new ways of working, but we are years away from having enough pharmacists, DNs, physio etc. available to do that work. Would be useful to enhance primary care capacity to deal with urgent/unscheduled care – not clear whether that best delivered in the practice or in a more central (hospital) location. Many urgent care cases could wait a few hours to attend conventional cases – but how to influence that behaviour? Not clear if these are lifestyle or attitudinal issues… do we try to change that, or just respond to what people are doing already? NHS could do a better job (e.g. via social media) in trying to change attitudes (though people tend not to pay attention until they need a service, when it can be too late). Triage is effective in reducing face-to-face visits, but it also requires a significant investment of time.
There is a concern that the investment in ANPs/other practitioners in primary care may have an impact on other parts of the NHS by attracting skilled staff. Gaps in the workforce may appear in the hospitals, such as outpatient clinics. There is a need for a comprehensive and strategic workforce plan which covers both the acute and primary care to respond to these potential consequences. Concern that there are already long waits for physio services and not sure how the proposals will address this. Where will GPs focus their new role? Will it be on preventing A&E attendances/reducing demand for unscheduled care? May need to manage patients' expectations of what they will receive. Important that patients with complex conditions get to see the right practitioners. GPs and Practice Nurses – many are in the older age bands and likely to retire in the near future which will create gaps in the workforce. Need to plan jointly with the universities to ensure sufficient and appropriate training courses are in place. It is hoped that the multi-disciplinary approach will free up GP time to improve aspects of patient care (e.g. having good quality anticipatory care plans in place).
Greater opportunities for cluster working and access to wider sharing of resources in terms of staffing numbers and skills Potential for more focus on quality improvement and service development with a range of services being delivered in GP practices locally for patients instead of hospital outpatient departments

Future service models must be based on consistent use of all staff working at the top of their licence.

There needs to be respect for new roles, e.g. secondary care should not refuse a referral on the basis of it coming from an ANP rather than a GP.

Investing in time for education and communication will be essential to helping clinicians understand changes to services and new models of care.

We need to increase investment in training staff for these new roles (new and existing staff) to support the future workforce models. It's not apparent this is happening in sufficient numbers at present; e.g. ANPs, specialist AHPs. A lack of investment in this area inevitably will mean staff retention only becomes more challenging as all services compete for a limited pool of staff with advanced skills.

Primary Care supported by Hot Clinics in secondary care is the way forward.

One of the biggest opportunities comes through the establishment of rehabilitation services. A service that is run jointly between Acute and Primary Care thus reducing the need to compete for the 'same' staff e.g. physio and OT.

Rehabilitation should be looked at through the tiered approach as it cuts across all specialties and models of care. The large majority of the rehab care should be provided in the community but we need to be clear about which patients need which level of care and where this needs to be provided.

There will be many demands on the finite pool of AHPs including the development of MDTs to support GPs. A shared model of a rehabilitation hub should be developed that could be used by primary care and secondary care.

Can we use the ACHs in a different way? Can they serve as the community rehabilitation hubs where Acute and Primary Care MDTs treat all rehab patients?

We need to identify 'what good looks like' and develop robust tests of change. Is it about productivity and output or quality and outcomes?

Can we identify services that can be switched off but again this relies on the robust test of change and identifying and agreeing 'what good looks like'.

Can we develop a process whereby GPs can talk to the consultants regarding a patient with the aim of reducing the need for referrals (telemedicine?) – can Sky Gateway be used more fully to facilitate this?

Social carers and others visiting people at home should be able to take on a wider range of tasks to improve efficiency

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Opportunities to create solidified pathways for screening services (e.g. orthopaedic/physio), opportunities for early assessment will help to stop further referrals and use of services.

Importance of signposting using reception/admin staff/ e-health (apps etc).

Should focus on developing systems which require GPs to carry out less administrative work

Supporting staff in Primary Care should be working to top of licence – take administrative duties off them where appropriate to free up their time.

Challenges include the need to ensure there are impact assessments on workforce issues on the back of the GMS contract. Concerns regarding where to get new personnel from.

Strong support for tiered approach and working to the top of your licence but:

- How do we transition from where we are at the moment?
- Key staff shortages, and we need to get better at workforce planning.
- Money/funding/budget: little mention of this when thinking about future innovative models.

Recognition that we can learn from Inverclyde and from rheumatology models making better use of pharmacists, ANPs and AHPs. We need to get better at learning from these tests of change and applying them at scale to the whole system.

Discussion about changing population culture and expectations to make people want to take responsibility for their own health and to seek advice and support only as required. Also recognition that we need to put realistic medicine into practice through ACPs and education.

Because of the current service model, demands and workload, GPs are reactive to demand. We discussed models in other countries and other parts of Scotland where GPs are given the opportunity to be more proactive and control their day. For example, a meeting at the start of the day which prioritises work and focuses on known patients and hospital discharges.

Concern that we don't focus on education and training. This will give us a more skilled workforce and show staff that we value them.

Tricky in preparing the public for different expectations of not seeing a GP and seeing another professional. Perhaps we should see this as an enabler for resetting public expectations across the entire system. It is about changing culture.

Back to the governance between medics and non-medics. We need clarity around roles and accountabilities. Medics and non-medics need to work as a team rather than being competing processes.

We need clarity around delegation of activity and derogation of accountability (GMC guidance). We need clearer professional guidance accountability in the future.

We need to think about resourcing.

We need to avoid two primary care systems working in tandem: GP led and outreach secondary care led.

Shared priorities for staff managed by HSCPs but working in practice teams. We need to create shared and not two-tier priorities.

A lot of the things done in MH have been done in other places - sorting out pathways, clarity on who does what etc.

For restructuring to work, must be properly resourced.

Important to educate people to take responsibility for their own health and care. Do we have enough best practice examples around that do that?

Escalation must be available when it's needed, people can manage themselves as much as possible but has to be somewhere to go when that's not possible.

Culture shift is a great example. Shows moving from institution to community, which is the way we need to go. Question is how do we encourage people to recognise that community isn't 'lesser' service than inpatient. Not necessarily the service change which takes time, it's the culture change.

Challenge will be people in more affluent areas accessing the services most, which could lead to resource being shifted there rather than focussed on where it's actually needed more. How do we enable the people who really need our services to access them more? Socio-economic status is a consideration, but more importantly (particularly where we're talking about technology etc) is age demographic - who can comfortably use technology?

Danger of robbing Peter to pay Paul - shifting resources from elsewhere to put in to a particular service, to the detriment of the service they leave behind.

Reduction in beds was significant, but doesn't appear to have created patient experience issues which is an important and positive point to note.

KEY POINTS FROM THE TABLE – MENTAL HEALTH

Mental Health Strategy now has provenance Clear vision from the start moving from a bed based model to community model - Think big and what was possible Resource transfer negotiations between NHS and Social Care at beginning, this was vital in securing buy-in Learn from the messages to the public - Taking the public and staff along "buy-in" Risk-enabling. Whole system changes Stopped admissions and found alternatives Needs the involvement of all public sector and other sectors Pick one thing i.e. A&E, have a big picture vision, apply similar approach **Top priority** Changing attitude, behaviours and expectations of the public
The experience in mental health proves that shift is possible from hospital to community. Some factors in this success are: Transfer of resource from acute to community teams and supported living. Single system for assessing mental health and 'easy in, easy out' approach seems to work (but variable experience for GPs referring in to the service). The mental health approach could apply to other services through: Moving services from hospital to community with full resource transfer. For services transferring be clear about new services, roles and contacts. Making it easy for people to self-manage and self-refer. Use outpatient resource differently by cutting review appointments and instead monitor as required and make it easy for people to self-refer to a specialist when they are struggling. Encouraging people to develop resilience as part of managing their condition(s), for example through sports and other activities.
Anxiety in mental health service about further bed reductions Impact on prison and homeless populations, also acute hospitals and General Practice Big advances in pharmacology over the years which has helped Needs to be a balanced approach Likely to be more focus on crisis teams Agree with points about recovery within mental health services and is applicable across all chronic disease categories Loneliness is having significant impact on wellbeing and therefore need for care Need for focus on early years education and lifestyle. Generational issues Application of this model in other chronic disease services, e.g. diabetes including relevant support staff within the community services. Need to develop the workforce and fund appropriately. Currently vacancies in these teams are not being filled in some areas. Barriers relating to existing hierarchies exist. Mental health leading the way by reducing the number of entry points into the service. Much uncaptured work in services MDT approach could be exploited as a model and need for overarching view of team approach
Concern about using the 'shifting balance of care' and realism that will still need to cohort patients and deal with in secondary care – all conditions can't all be dealt with in the

community. Real differences across hospitals in lengths of stay even in same partnership. Clinical view is not necessary at point of admission – more about how intervene and get out as soon as can – are clinical interventions impacting on the outcomes? Given demographics and future projections for demands on the service question was raised as to whether we should 'stand still' with beds to test if the community infrastructure works before taking lots of beds out of the system. Should be looking at occupancy levels – demonstrate that should be running wards at 85% over prolonged period before starting to reduce beds – keep where are and test then safely cut the beds. How do we assure ourselves as to where there is a balance? Starting to work on physical health of mental health patients Significant focus in recovery colleges around wellbeing – England in front of us?? GPs would say that the services have been decimated in NHS in England. Need to be thoughtful of how work through the levels and where build in resilience to allow the work to progress without destabilising the systems
Key challenge of prioritising early intervention / pool of staff and ANPs Leadership of psychiatry was brought out of hospital – can we encourage that shift? Patient evaluated outcomes seem very attractive and even better the idea of tracking these to provide stepped and appropriate care. A concern that some services (e.g. Older People's MH) can 'fall through the cracks' of a big redesign especially if it is managed in different ways in different HSCPs or the service redesign focuses just on one large part of the service (in this case Adult mental Health).
One door access to mental health services is the preferred option. Huge pressures on primary care mental health and concern that funding is tipped in the favour of Community Mental Health Services. Concern expressed about variations in funding and staffing for CAMHS Because of waiting times for services, GPs are dealing with the problems of patients who have not yet received their treatment and care. Community pharmacy – extend range of over the counter medicines GP pharmacy – optimise use of medicines – advise on realistic medicine
The focus on ACES (Adverse Childhood Experiences) will help plan and deliver anticipatory care for Children's services across health and social care The Mental Health example illustrates that to plan for the future there will need to be collective decisions with regard to disinvestment in areas i.e. beds and reinvestment in community services; this point is relevant to the debate in shifting the balance of care from Acute to Health and Social Care Partnerships Self-care can be facilitated by community groups and networks of people can provide support to peers There was some caution in using NHS England as a show case for best practice given current concerns in relation to mental health provision in England
Reducing number of mental health beds and reaching out to community services and early intervention supported by public health initiatives, e.g. minimum alcohol pricing. Clear vision of what services they wanted to deliver in the community. Having confidence and long term vision to close beds. Having the right staff available at the right time. Changing the culture.

Mental health hosted by Glasgow but excellent buy in from all other HSCP. Requirement to build in bridging funding to flip the service over investing in prevention. Implementation of core-net and giving the patient ownership of tracking outcomes. Giving patients responsibility and trusting them. Importance of managing risk.
Identify what/who can be supported at home – being efficient? How do you balance your resource to support your change in practice – e.g., develop ANPs, Rehab Teams (Community) Developing community support to create change Remember not to over complicate what is being presented Change behaviours Consider moving some provision to a more local basis Hospital at home Hospital in Nursing home Intermediate care – need more beds
Aspects of the PCMHT/CMHT arrangement mirrored other similar arrangements that have been or are developed – e.g. MIUs/A&Es. An important lesson was felt to be the importance of close working between how both operated and the staff working within both. Saw echoes across a range of service proposals in the challenges that mental health faced in moving from predominantly institutional model of care to an increasingly community-oriented one. A key lesson was the need for political support and bravery – and (arguably) consensus and vocal leadership from clinicians alongside advocacy from within communities. Expressed frustrations that Mental Health being described as being separate from Physical Health – e.g. dementia "fits" within both Mental Health model presented and the Older Peoples model. Similarly felt that there was a missed opportunity in not explicitly acknowledging the interface between physical health conditions and psychological health. Psychological distress can be a significant issue for people who are struggling to manage their long term conditions, and often these patients use high levels of resources. There is still a tendency to think of 'mental health' in terms of ICD 10 mental health conditions – issues relating to mental health, in its widest sense, are prevalent across all conditions and co-morbidities. Linked to the point above, unclear how the Mental Health model presented fitted with the challenges presented by multi-morbidities more generally. The Mental Health model seemed to focus on dedicated mental health services and staff in the main, so unclear of engagement/input of other staff/services who will be supporting service users/patients with mental health conditions. The element of the presentation re: children's psychological wellbeing was welcomed, but unclear why no mention/inclusion of children and young people's mental health services (e.g. CAHMS) or role of other sectors (e.g. education) - and so unclear about engagement/input from those staff/areas in development of model and strategy.
The keys to success both within GGC and similar MH redesign in England were: There was a very clear vision to move from a hospital-based model to a community model with inreach to hospital only based on complexity and patient need Policy-led change with political buy-in Pump priming funding was available to establish community models while still maintaining hospital services (albeit diminishing)

The changes were clinically led, with strong medical leadership calling for the change

The wholescale closure of mental health inpatient facilities released both short-term funding from building and land sales, and also recurring funding (staffing, etc)

Mental health services were in chaos prior to the change, and the service acknowledged that a breaking point had been reached

Acute clinicians to do not yet have the same level of recognition that their service models need to change

Clinicians need to accept that ‘more of the same’ is not the answer to both current and future problems

Without pump priming or double running costs being made widely available, it was not clear how the necessary community services could be established while there was no prospect of acute hospital closures

Politicians in Scotland needed to get behind their own policies for the NHS

Realistic Medicine and care as close to the patient’s home as possible would necessitate the closure or downgrading of current facilities, but the experience over Vale of Leven and Lightburn Hospitals was that there was no political support for structural change

A change in government (eg Labour, Conservative or new coalition) was not expected to make any difference to the political resistance

TABLE TOP DISCUSSION THREE: QUESTIONS

What lessons can we learn from the experience in respiratory medicine and how could the approach taken in other services?

KEY POINTS FROM THE TABLE

Low level of consultant supervision and input required allows autonomy but how is this organised in terms of processes and delegation? Prehabilitation is an opportunity for improving patient care is done properly. Ideally as part of pre-operative assessment process for suitable patients
The "patient" was in charge and achieved through good access. "Quality of service" is improved Pathway was becoming more multi-disciplinary Very clinical need to consider wider support through other services/sectors. Self-management is more than just clinical.
The respiratory approach could be taken in other services through: Thinking through what is possible in each specialty Developing pathways Developing teams to provide specialist support at home Transferring resource
Applicable to other areas of chronic disease management MCNs have already described a number of the models discussed today. Leadership and linkage with the MCNs is important to break down barriers. Point of care ultrasound imaging and diagnostic investment would prove more efficient Diagnostic ordering and ownership of the result is an issue. Addressing this would prove more efficient. Thoughts on why younger generation would pick a clinical career Need a different model in order to address recruitment. Better use of radiographers and sonographers
Specialist services can lead to duplication when patient is admitted to hospital. Where already managed in community team need to be thoughtful of what non-medical interventions – recognise what done, already known and will have a plan of care – plan of care should continue – Working well in terms of interaction with patients – feel been cast adrift a bit. Integration in the out of hours period that causes problems for GP and at ED. Concept good but coverage key More and more specialist teams mean can lose out where have multi morbidity Think about developing workforce and resource that can use for multi morbidity. Outstanding issues remain in the out of hours periods – think about cross over – what would the specialist team look like in the future. ?? How using technology to support people to manage/self-care. ACPs key – do we have robust ACPs – is lesson that we can take self-management issues, use ehealth well, provision of baseline sats to reduce admissions. Role of consultant is to make diagnosis and then pass care onto the appropriate services but most common reason for admission. What do we do when the patient is in hospital to help prevent.

Community pharmacists doing some work - 6 month test with potential roll out. Initiative also to save money in care homes.

Managing patients at front door where very breathless and how can ease fear and anxiety. Some cases only option is to admit to hospital.

SAS looking at next layer – when see and person known then what are the interventions. Issue is how long the ambulance is spending at houses is a bit worrying to the GPs (given ability to access at times)

How provide interface and double running required where developing community services but can't resource release from Acute. Clear evidence on the return on investment where do invest in the service.

Interesting that lot of focus is on physio. As GP useful person is the pharmacist. How provide cost effective prescribing but also using to stop smoking etc. Recommendations made from acute with no awareness of costs of drugs.

Pharmacists been keen to get involved and have some good ideas. Looking at some of the output retrospectively. Are as a group keen to be engaged and do things differently.

Discussion from vascular /amputees group – need AHP led services to help keep at home – can we build a generic exercise class?

Independent and active living and 'pre-hab' – recognise that AHPs are preventative and are keen to work out of hospital as well

Elephant in the room is 7-day working - other gaps identified e.g. the 5-8pm gap in GGC and 6-8 pm gap in Renfrewshire

Support for interventions in local settings, but aftercare is crucial.

Our discussion about risk is not sophisticated. Are we saying that we need to improve our ability to stratify risk and mitigate effectively, or that there is a level of risk which we find tolerable? The issue may not be the actual level of risk to patients, but instead the extent to which staff worry about being held culpable for adverse incidents.

We should try to be clearer: are we changing the overall level of risk? Or just the accountability for those risks in redesigned systems?

Agreed that not all tasks need to be medical.

Will we have any general nurses left, once the ANPs and SNPs have all been developed? Note that there is an appetite for clinical posts beyond Band 6 (i.e. not to need to be a manager to progress)

Multi-disciplinary and multi-agency working in Respiratory medicine also requires the involvement of service users and patients in designing pathways for services

Skill mix and team should be reviewed to ensure that care is delivered by the appropriate professional and that all members of the team work up to the "top of their licence".

Mixed views of the respiratory model:

- Appears to show savings, but are the savings realizable?
- Specialist secondary care teams or skilling up primary care generalists.

Need to make "generalist" jobs more attractive.

Discussion about supporting GPs and clusters better by e.g. geriatricians working in community settings.

There seems to be relatively little consultant time required for this model. The model is physio predominant.

Are there other conditions which might be suitable? Volume and evidence. Purdy's evidence of absence was considered important. Incontinence could be a possibility? (gyn and urology). Admission prevention activity - how can we transfer this into the OOH review? We agreed there needs to be a condition with appropriate volume/prevalence for

this to work.
Could we agree some key principles that all services work to? e.g. common documentation between similar services in different areas, common referral pathways. The Community Respiratory Team model was felt to provide a good example for future service models applicable to a broad range of services. We need to move away from consultant led services and cultivate multi-disciplinary team working across primary, community and secondary care. We need to do more to promote/encourage realistic medicine, placing the choice back on to the patient. Examples from current practice were given – Orthopaedic 'opt-in' referral process at GRI, Lung cancer pathway with scanning before an appointment. National targets need to support future approaches. Some current targets can drive behaviours that are not always in the patients' best interest. Data quality improvements are required to ensure services have access to high quality real-time data to support services to monitor their own performance more easily and drive service change/improvement programmes. We need to ensure that the Scottish Ambulance Service is moving with us on this transformational programme – timely patient transfers are critical to the efficient running of so many services. Good day to day clinician to clinician conversations across the whole multidisciplinary team need to be supported. New technologies can have a role to play in this e.g. webinars, online Q&A sessions.
Inconsistencies with referral process Build a team to support symptoms – in order to maintain living at home Over imaging of patients Blended approach and scaling up highly specialist clinics for patient with multiple complexities Cluster s&l Develop chronic frailty teams – to support range of chronic conditions Patient responsibilities to self care Do care home liaison nurses impact on successful care Vast number of different job titles – ANP / CNP / surgical nurse practitioner – needs standardisation Workforce Development - up skilling all staff and in Public Health and Health Improvement e.g. every health care contact is a health improvement opportunity Improve communication with patients and staff Improved technology to support the clinician record activity against the COPD patient journey Anticipatory care plan is buried in the KIS and therefore difficult to extract information. Visibility of COPD patients when they appear at the front door to reduce any unnecessary clinical interventions. Need to consider how multimorbidity will be managed – inefficient to have multiple teams visiting the same patient and managing their conditions independently.
Enable more staff to work in different ways and Skill up for more specific areas to allow for wider delivery Skilling up of good staff enables staff to move elsewhere, other boards, more money Create an organisation and structure - that makes careers more attractive Change perceptions about what can be done and by whom – ask the public to consider

where they could go and when Engage public health and communications to get a clearer message about things have changed Deliver through public health messages campaign Patient advocates to spread the message Influence GPs to free up premises to help people access services differently Co-locate some GP provision next to acute (already happens) Remove the 4 hours target and its contribution to over provision Roll out respiratory approach across the system Collaborative sharing and learning More AHPs trained and developed Ensure the specialists can operate well, supported by generic roles which cover the need for more local access.
Huge challenge in identifying specific groups of patients before they reach the acute hospital setting. We must work closely with community colleagues to identify patients and get them 'into the system' and started on treatment prior to an admission. Can we utilise Discovery software? As previously mentioned the issue of what we measure and how we demonstrate value needs to be agreed – is it quality or productivity? We need a robust test of change process that will prevent us from 'throwing it out' when the process is actually working. Critical element of all of these new ways of working is to ensure that we can adapt and extend over time. Development of peri-operative support by geriatricians would have value in reducing length of stay but insufficient resource to provide this at present We need to understand how a more complex patient would fit into this system as a "test". Our patients are becoming more complex, so our services need to be designed around that, rather than signposting complex patients through a system designed around single pathologies.
Multidiscipline team approach is good for replication across other services. Increased use of technology (link in more patients with use of iPads etc) is good for replication across other services Personal monitoring pilots should be replicated to enable self-care Can apply this model to any chronic condition – we should be looking again at services to check if the teams work and check if there is an effective way of using resources. Discussed the danger of 'diluting' the workforce – if consultants solely look at complex conditions, they will not be able to establish an idea of what 'normal' is. Again there was concern over how to train up junior doctors and junior members of staff if keep taking away their basic roles.
Having an experienced consultant stand up and state that other members of the MDT that he worked with had a greater level of expertise in some areas than him and provided many aspects of care better than him was powerful and refreshing. For all the potential opportunities of new roles for other professional staff (e.g. ANPs, Advanced AHPs), it seems to be all too frequently motivated or expressed in the language of "off-loading" the parts of the job that one group of staff would rather not do so they can focus on the elements that are more exciting for them. The language and framing of the GP contract is a case in point. Given this, it is no wonder that communities often feel or perceive that if they don't see a doctor that somehow they are getting second-best. The recognition of the expert contribution of different members of the MDT illustrated within the respiratory case study indicated a fairer and more productive approach – not least as it felt likely to

motivate the team as a whole more if all individual components felt valued professionally as peers.

It was very insightful to see lowest levels of vacancies within AHPs. Suggests this is a group of staff we should be harnessing and utilising better to their 'full scope' of practice.

We were thoughtful how the approach set out fitted with the management of multi-morbidities, and whether value in development of teams like this within a wider, more team sharing more generic skills in respect of reablement and case management.

Respiratory services in Possilpark were put forward as a model which could support other long term conditions

- There was a virtual ward round of patients within the community (15 case reviews per week)
- Three separate tests of change had been trialled, and virtual ward round had been the most successful, and the favoured choice of both clinicians and patients
- Consultant has a large caseload, but not all patients are reviewed each week, and the actual treatment is carried out by community teams without the need for the patients to be admitted to hospital
- Glasgow city wide, but not currently available in other HSCPs

Long-term follow-up could be significantly reduced by giving patients quick access to self-refer back into Acute services

Cardiology had been discharging patients and giving them quick access, but very few patients every called. Previously, all would have been kept on annual surveillance

More teams should be present within A&E, not just Emergency Medicine clinicians

- For example, COPD services could be provided in ED
- This would require extension of current service operating hours from Mon-Fri 0800-1600, but would allow patients to be treated and discharged, rather than admitted to hospital

Pharmacists within the Possil virtual ward model already carried out domiciliary visits, and it was felt that their skills could be extended to other patient groups

Services were still organised around specialties, rather than symptoms, A single breathlessness clinic, with access to both cardiology and respiratory teams, would significantly reduce the pathway for patients, many of whom were sent to both services and had long (consecutive) waits

- Initial triage could be carried out by AHP/Specialist nurse, as was current pathway at GRI

There was concern that the increasing medicalisation had deskilled community staff, including community AHPs, District Nurses and Practice Nurses

There was also a recognition that patients should be encouraged to take more personal responsibility for their own care, and that not all symptoms required a clinical response

What would it take to deliver these approaches on a system-wide basis?

Delegation with support and the use of protocols is key to success

Protocols can link primary and acute care and increase team working and mutual understanding

ACP is a key document and supports patient centred care and patient choice and responsibility

Patient and family expectations need to be managed consistently throughout the care pathway

Transformation requires a fundamental change to the way people see healthcare

Realistic care needs to explained to and discussed with our population along with the concept of risk management and saying no sometimes Transformation should focus on the lower tiers first How do we change the point of contact for health and social care delivery? Care needs to be demedicalised and the population encouraged and supported to self care and self manage.
Robust systems established in advance of implementation Would need to have the correct workforce at the right level of skills and capacity. Challenges with recruiting from same pool Opportunities for GP clusters
To deliver these approaches on a system-wide basis would require: Providing resource for community teams Developing multi-morbidity pathways - building care and services around individuals. Freeing up GP time to work with complex patients so that the 'general specialist' team can provide best care except for during specialist episodes. Specialists having links to community teams and involvement as needed while maintaining connection to their peers and the specialist service.
More resource required but not doctors, need ANPs and AHP Need more good admin support that take administrative duties away from clinical staff (estimate that 2 days of admin time could save 50 days of clinical time in 1 particular service) Consultant capacity gap in Urology Enthusiasm for a "sessional" approach rather than resources focussed on a particular site Investment should be targeted in the next model of care, not in existing broken models Leadership is critical within each clinical team
We weren't sure how the CRT team came together.. So how would you replicate it? This needs to move to implementation. It's not felt there is much support for business planning and these skills aren't prevalent.. but some examples of bids getting through fairly easily (which is easier if new money is announced for a specific area). Needs bridging funding.. – opportunity has come and gone. The actual process of implementation remains too complex with multiple system of sub-groups and action, PIDs and complexity – it's a 'bit of an industry'. And often done multiple times over. Agreed clinical leadership and commitment clear Seek common themes to apply the same approach
Improved workforce planning process which looks at the health and social care workforce as an organic entity rather than disparate groups Early identification of skills development and training to prepare staff for new roles and ways of working Engaging communities and patients to understand new models of care
Possibly non-recurring small amounts of funding to get programmes of work up and running. Working across specialties given the amount of overlap between specialties in particular groups of patients. Size of the team is critical.

We need to utilise the full MDT in Acute and Community including home care teams who see service users every day and are an excellent resource in terms of knowing the patients well etc. Robust triage will ensure that patients are treated in the right tier/level. Again the appropriate test of change is important. Would suggest establishment of an 'innovative' group to develop this. Greater understanding of all the barriers to change. Support staff in devoting working time to innovation and change.
Training staff up to do more than one thing/ do more than their speciality. Having a clear workforce plan on where additional staff will come from, and impact assessments if staff move from other regions/services within the NHS.
There was enthusiasm for the repeated emphasis through the afternoon of MDTs – although not clear why the tier 4 of USC solely specified GP/GP-led out of hours (for example), when MDT out of hours service would be more joined up and consistent with the key themes of the day. We were very thoughtful about the financial and cultural challenges of moving to a genuinely MDT model of care, and particularly the likely call for bridging funding for what would essentially be new services in the community to replace other arrangements in the short-term. However, we were also unsure if many of the innovative models presented through the afternoon were envisioned as being instead of more established services or if they were predicated on being in addition to – if the latter, then there would be a call for additional recurrent funding, not all of which could reasonably be expected to be released by absorbing demand from other services (particularly if those services are over-budget, and so the consequence would "just" be to bring them into budget). Given the opportunity to embed the MDT as the key element of a community model for care going forward (in which primary care is included within as opposed to being presented as parallel) and in which the patient/service user is at the centre (rather than any one professional group or discipline), an important question is what its focus should be as we move from defining needs in a specialist (e.g. respiratory) or group of conditions (e.g. Mental Health) manner to more holistic and segmented needs (e.g. Frailty and Co-morbidity).
Infrastructure for hot-clinics to manage unscheduled care in a large number of specialties. This will increase the emphasis of unscheduled care in consultant job plans. . Timely access to urgent investigations where required to prevent admission with senior staff able to review patients and make decisions in an equally timely manner. It may be possible to train specialist staff to carry out specific investigations e.g. USS/Cystoscopy where this is seen as a barrier to access. We need a spectrum of options across PC and SC to avoid unscheduled care whenever safe.
Timing of how you plan training for new roles etc is critical. If it takes years, need to start now Increasing numbers of nurse-led services, some see this is a challenge. Some things work well, but we never seem able to carry them on or roll out wider. Need to try some things on a system-wide basis. Challenge in that a lot of young students (in egphysio) are from abroad and don't / can't stay long term Patients feel empowered in being able to look after themselves at home / in own community. Need to move away from entrenched view that we need to get people in constantly.

When we do things that make 'savings', do we actually make a saving? When we've remodelled and work flows away from consultants to ANPs, do we then not replace the next consultant who retires and recruit more ANPs instead? If we don't, these are additional pressures rather than improvements.

How do we balance the increasing sub specialist nature of complex surgery with local access?

Travelling for specialist care needs to be the norm and an understood limitation of our system
Messages to public about not receiving services on the doorstop and that a tiered approaches would be required.
Make the population aware of the clear message regarding best evidence, best care in relation to sub specialisation of complex surgery.
Use a network to balance the sub specialisation within surgery. Opportunity in the West of Scotland to lead the way. Need to start a regional discussion about how we address this.
We didn't get on to discuss this but noted the surgical presentations showed solid strategic planning and a desire to continue change practice.
Need more IPD nurses but also ensure that the tasks they undertake utilise their skills and knowledge. Gastroenterology teams are based on 3 sites and this is inefficient. Phlebotomy services – could be based in the community to enable access from both primary and secondary care. Whatever models chose investment will be required to ensure sustainability. Need for sufficient workforce capacity. Endoscopy ANPs – need to have a variety of tasks to prevent burn out. Clinics in many specialities could be based in local areas but currently are structured in a rigid way. Key criteria for patients is to have access to expertise and receive continuity of care. Need to avoid patients feeling that they are moved around merely to meet waiting time targets.
Raising awareness of current examples of where specialist services are delivered from key centres and the benefits of specialisation in terms of outcomes and use of precious staffing resources Timely, local and supportive follow up provision delivered closer to home Encouraging greater awareness and understanding of population based approaches to healthcare and the Regional planning agenda.
We need to robustly implement – Realistic medicine Informed consent Joint decision making Easy access to specialist advice across specialties
Opportunities to get specialists to discuss issues with patients/ articulate problems that probably do not need further investigation may prevent further help-seeking and use of services on the part of the patients

There must be communication put in place with the public on the safety issues and patient outcomes associated with local access. Should include clinical arguments and evidence.
Staff working across specialised and local units consistent with the needs at each level. Centralisation limited to the activities which need specialisation, e.g. pre-op and postop are managed locally with workup but surgery alone is centralised, so that surgery is performed in the 'centre' but all pre and post-op care with surveillance is performed locally.