Moving Forward Together

3 TOP TRANSFORMATIONAL CHANGES SUMMARY OF COMMENTS

Before attending the event participants were asked to help frame the discussion by letting us know what three top transformational changes they would wish to see taken forward by the programme. Comments received were:-

	3 Top Transformational Changes
1.	Increased involvement of AHPs in services including AHP led services where appropriate and where evidence supports
2.	Change in working patterns to ensure AHPs are available for extended hours and weekends – with associated tackling of barriers that currently prevent this
3.	Increase in AHP resources to support the above
1.	Universal healthcare professional access to universal core record
2.	Patient access to core record and better utilisation of teleheath/ technology
3.	Unified health and social care systems
1.	Strengthen unscheduled care facilities and resources in the community, not at the front door of hospital.
2.	Ensure sharing of the electronic patient record across the entire health system: community practitioners: GPs, AHPs , opticians, pharmacists, dentists, social care, and acute.
3.	Ensure that we walk-the-talk and actually 'do' whole system planning, rather than talking about it and then planning in our silos.
1.	Ensuring we have the right people leading by example - Authentic and accessible leadership
2.	Moving away from hierarchical cultures
3.	Extending collaborative leadership models and shared ownership
1.	Critical importance that whatever comes from this plan has explicit financial plan from April 18 onwards and also political cover to allow us to progress/deliver the changes. We cannot publish a plan that does not political support otherwise it will fail when we come to close/move/reduce things
2.	Critical importance that in the plan we are clear what are the must do prevention programmes we promote/deliver – need to change the dynamic so we are clear how people use services and for what. Clear that we change expectations about what people can get. Also prevention must be clear about patient responsibility

3.	Importance that this plan really does deliver consistent with the NCS and the H&SC Delivery Plan and this needs to be an explicit commitment up front in words but also in financial planning from April 18 onwards.....– therefore shifting balance of budget and spend towards community and away from acute. Recognises the vital importance of protecting and investing in community based services throughout the period of the plan.
1.	Re-location of cardiac surgery and cardiac services from GJNH to QEUH site to provide a world class integrated adult and paediatric cardiology service
2.	Routine cardiac imaging service (CT coronary angiography and cardiac MR)
3.	Routine availability of real time direct communication between primary care and secondary care to discuss potential clinic patients and ad
1.	Use of technology within clinical practice
2.	Widening the role of Dietitians and specialist nurses in gastroenterology (IBS, coeliac disease and IBD).
3.	Cancer care delivered by AHP is in reach.
1.	Dedicated paediatric GA sessions for dental extractions
2.	Reduction in waiting times for dental GA extractions for children- currently unacceptable
3.	Full review of SCI gateway as a referral portal for dentistry- currently unfit for purpose. Electronic information and reports to be mandatory for secondary care back to primary care GDS
1.	GP (or primary care) phlebotomy
2.	Significantly increased GP access to diagnostic tests and advice only referrals
3.	Reduce or remove clinical variation across the whole system
1.	A clear approach to engaging the wider population with the ‘Realistic Medicine’ issues
2.	Equality of service and resource for all patients, regardless of postcode
3.	More consistent access to community services to support patients in their own homes with the ability to provide robust rehabilitation within an appropriate time-frame
1.	An absolute focus on prevention.
2.	An absolute fair and even distribution of resources recognising the key and critical contribution of parenting and the early years.
3.	A commitment to better transitions between children's and adults around mental health and again prevention.
1.	More events like these to allow senior thinking time and planning instead of concentration on the here and now – better split strategic v operational.

2.	Slicker investment in IM&T to allow more use of artificial intelligence and precision medicine.
3.	Better workforce planning for 7/7 working if we really intend to do this – and plan now for what new roles are required to tie in with 2. above
1.	Finance to Support move of services to community.
2	Clear lines of responsibility for community services
3.	Community phlebotomy to Support acute clinicians with results back to secondary care.
1.	Use of the National ACP across community and hospital settings with all staff obliged to ask the question "Do you have a Anticipatory Care Plan?"
2.	Greater use of hospital Consultant expertise in non-hospital settings either by delivering community clinics or by e-links to generalist staff to provide advice and guidance, minimising travel time and maximising care episodes.
3.	Reduce Consultant and GP demand pressures by creating more Nursing & AHP led services with advanced/extended scope practitioners that are able to assess, order diagnostic tests, treat and discharge, hence.
1.	Ensure we have enough secondary care beds to respond at times of peak demand and get real about demographic projections.
2.	Use bridging finance to set up the community infrastructure that we are told will reduce unscheduled admissions and demonstrate that it can provide a safe credible, affordable alternative to hospital admission before any more secondary care beds are cut.
3.	Invest in care home liason services, not just in mental health but in acute and geriatric medicine so that when a patient can be safely investigated and treated in the care home then that is exactly what happens. Overall, keep calm and demand evidence.
1.	Investment in Advanced Nursing Practice- More nurse led services will free up Core Trainee Medical staff to do the job they are supposed to do. We as a board are way behind the smaller Health Boards across Scotland who have established patient pathways that can be safely led and managed by Advanced Nurse Practitioners.
2.	Turn off the clock- The 4 hour waiting time is actively affecting patient safety and producing inequalities in health care. Patients who attend A&E take priority over those who follow the correct pathway of G.P referral. Sick patients are lying (and dying) in corridors. While fitter patients are admitted to beds in order to beat the clock.
3.	7 day service- I would like to see full services available 7 days a week.
1.	Move towards better integration of Primary and Secondary care. All health care providers need to contribute/decide what is best for the patient and where that care should be delivered.
2.	Provision of a 7 day service (inpatient and outpatient service) Currently specialist nurses/dieticians work Mon-Fri only. This service would need to be resourced appropriately

3.	A dynamic inpatient service and the implementation of an "inpatient Team"
1.	Reduce length of stay in acute surgical beds, reduce overall length of stay for slow stream rehabilitation patients and improve rehabilitation outcomes by using **inpatient amputee rehabilitation beds** available for all GG&C lower limb amputees with rehabilitation potential, with or without a prosthesis.
2.	Reduce projected 12% increase in Vascular Surgery activity by intervening with **education and referral to exercise scheme** at diagnosis of intermittent claudication.
3.	Support prompt discharge from hospital, reduce re-admisssions, enhance activity and independence at home with **specialist community vascular AHP staff** acting as link between acute vascular unit, rehabilitation beds, Westmarc and community teams.
1.	People responsible for keeping themselves healthy and supported at all stages of life – culture change led by health and social care.
2.	Community models for those with recurrent needs including supported rehabilitation/ health improvement and rapid response when required.
3.	One stop rapid diagnosis units including multidisciplinary centres for diagnosing non-specific symptoms.
1.	1 Using IT for virtual care
2.	2 Prevention & Education as part of the tiered approach
1.	Embed Nuka principles in any transformational change. In papers and activity so far there is heavy weighting on service redesign. Our customer users are the only constant through the health care we offer and we seem to be shying away from investing in them. Nuka's evidence shows that this investment is critical and needs to start at the beginning of the journey.
2.	Conservative renal management: change in mindset of end stage renal management, this will provide opportunity for patients similar to current Edinburgh Renal Unit: fits in with Realistic Medicine
3.	Person centred care activity: Patients need to be equal participants in their care. Prepared patients will have much better
1.	the need for increasing investment in prevenative interventions to reduce burden of disease, demand on acute services and costs on managing long term conditions; optimising healthcare for all through application of realsitic medicine prinicples especially focusing on reducing unnecessary variation, harm and waste and improved shared decision making; finally improving health and provision of healthcare for those in vulnerable groups, thereby reducing inequalities.
1.	Establishment of a community based elderly medicine triage model reducing the need for acute hospital presentation.
2.	Clear community based assessment processes and management plans for long term conditions.
3.	Extended opening of GP practices and practitioner services (late evening/weekend and PHs) to reduce the need for ED presentation.

1.	Embedding House of Care philosophy in the development of ongoing services. This would ensure well informed well engaged patients could take a lead on their health. This will only work if there is a supporting infrastructure that supports this development. This could include the creation of community based Health and Wellbeing Hubs These wouldn't just be specific to one specific disease area but could be used to undertake a lot of chronic (and indeed acute) disease surveillance namely phlebotomy (a common theme), monitoring of weight etc. In relation to diabetes this could also include retinal, foot and microalbumin screening. These hubs would therefore offer a 'House of Care' type model providing 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 via eHealth 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. In addition the Health & Wellbeing hubs could be co-located with pharmacy services for medicines advice, smoking cessation services, financial inclusion advice, third sector etc therefore providing a genuine societal approach to health and wellbeing so we utilise all the assets within the community. It's also worth noting that these could be in more accessible locations such as shopping centres etc and out with the transitional health service based accommodation which may help with engagement particularly in areas of deprivation etc where historically disengagement rates have been high.
2.	Breaking down 'barriers' between primary and secondary care. Current models are often disease specific which leads to siloed thinking. This is reflected in the development of services and fails to take into account some of our major challenges including multi-morbidity. Service redesign should consider where specialist services 'add value'. There should be clarity about where specialist services can support generalist services and vice versa. This should include the development of a more dynamic interface between services and also consider how these developments can be provided in a community based setting. This may include the development of community based specialist services who then in-reach with their expertise into acute. A more specific example of this may be community based type 1 diabetes specialist services. This specialist resource would also link into type 2 diabetes care delivered predominately by generalists. In addition this specialist resource would in-reach into hospital to support in-patient care. These developments should also utilise 'big data' to risk stratify cohorts/individuals to ensure resources are being used most appropriately. There may also be the change to develop a societal approach to health and wellbeing by exploring the opportunity to deliver services within a 'non-health' care setting working in partnership with Glasgow Life etc.
3.	Take a long term approach to service development and healthcare: this is an excellent opportunity to challenge existing models of care and we should be utilising expertise and technology to genuinely transform care and avoid a 'short termist' approach. While this may relief some immediate pressures unless it factors in long term determinants of health it will fail to impact upon healthcare outcomes in the longer term.
1.	True seven day service for Occupational Therapy and Physiotherapy

2.	Improved communication between acute and community rehab teams, compatible IT systems.
3.	Increased number of Advanced Practice AHP's transforming what is seen as the traditional doctors role.
1.	Shared information system; Single client record; Hardware systems & and training. Examples in Estonia and Finland where they have a single patient/ client record- we could adopt such with CHI number being the unique identifier.
1.	Focus on a realistic public message regarding access to Health Services, with further focus on anticipatory approaches and self management
2.	A focus on What provides best outcomes for people as opposed to Who will do this
3.	A focus on communication and alignment of workstreams to reduce duplication and provide a consistent message
1.	7 day working for AHP's - appropriately staffed so that every day has an equtable number of AHP staff at work
2.	Purpose built rehab facility for Amputees - appropriately staffed and equipped
3.	More social housing which is equipped for wheelchair access and disability friendly - reduce the number of patients we send home to upper level, single room living
1.	Help nursing homes to avoid sending in the frail and demented to hospital
2.	Better access to secondary care for assessments and investigations
3.	Get the population to take more care of their own health
1.	Geriatricians being affiliated to neighbours hood team and having an ability to review patient in own homes
2.	Faster access to investigation/tests in community without having to attend a major hospital e.g x rays /diagnostics tests
3.	More step up beds city wide
1.	Development of advanced practice specialist non medical services leading to reduced consultant wait time.
2.	Longer and more flexible hours for access to services eg GPs, clinics, level 4 services.
3.	Improved use of existing highly trained staff to full extent of scope of practice.
1.	Investment in Advanced Practitioner AHPs to deliver services - appropriate for those with LTC and admission avoidance
2.	Provision of more services within primary care – with MDT focus with links through virtual clinics to acute sector
3.	Clearer pathways for unscheduled care
1	Implementation of the Board Wide Sexual Health Review
2.	Implementation of the Board Wide 5 Year Mental Health Strategy

3.	Closer working with community services and in particular the cluster arrangements across Primary Care
1.	Start changing services now to better support patients in the community, with appropriate allocation of resource.
2.	Move services out of our acute hospitals that do not require to be there, thus creating capacity to support our sickest patients who do need to be there. Avoid developing multiple sites for patients with very complex needs.
3.	Focus on what the Transformation means for staff, what resources and support do they need. How do we give staff time to plan, implement, engage with large teams and continue to deliver?
1.	Virtual outpatient work Administrative and clinical teams need to work collaboratively with IT to develop solutions for governing and measuring the introduction of "virtual clinical work", moving away from decisions being made in outpatient clinics in 10-15 minute slots. This work is very valuable - is taking place - but is discouraged by not being formally recognised in job plans. Lack of "admin DCC" will restrict adoption of this part of the transformative plan unless clinicians are allowed to reduce more traditional DCC work in parallel.
2.	Workforce management - GIM/specialty The pool of WOS trainees/ ggc employees need to be used more imaginatively if we are to provide quality training while also covering all sites - particularly in out of hours periods some rotas are unmanageable until service redesign takes place. E.g. Hub and spoke work patterns, more rapid rotation of junior (and consultant?) staff and an expectation that time will be divided between tertiary and dgh sites over each attachment. There are disparities between OOH rotas across sites (consultant and junior) - rota commitments should be reviewed critically when new posts are created on tertiary sites to consider if OOH session is required at that site - alternatively reduced frequency rotas in larger sites need to consider offering added value e.g. if an extended geographical area could be covered by a virtual specialty advice service. Locum staffing is insecure, inefficient and expensive - substantive posts are not filled while locum opportunities exist widely in gcc. An internal ggc alternative to locum agencies would be valuable - posts would need to be more flexible than current training rotational posts if they are to appeal to trainees. If consultants are expected to take responsibility for clinical work undertaken by extended role staff then they need to be involved in the hiring and training of these staff and have recognised time for this and for their clinical supervision (similar to medical education time allowances).
3.	Prioritising limited specialty resource Agree vetting guidelines for specialties to prioritise work/ improve communication with primary care and secondary care colleagues - also for wider role influencing patient and carer expectations in GGC. Currently resource in each consultant team determines how this is done - dedicated time for vetting reduces the number of patients waiting for a clinic visit to have their issue resolved and takes pressure off primary care - there are inefficiencies when larger groups of staff do not take personal responsibility to vet effectively. There is no feedback on vetting quality. There is less formal training for STs related to vetting now this is electronic.
4.	Role of MFTE - From an organisational perspective - wider issues include whether MFTE services need redefined now the majority of inpatients are frail. Also a review of arbitrary age thresholds that restrict access for the small number of younger adults having long admissions in their 50s and early 60s to the MDT rehabilitation resources close to their families e.g. adults with multiple comorbidities,

	adults with brain injury. These patients are poorly served in busy GIM wards currently - opportunities for rehabilitation and protection of independent living are missed.
1.	That transport options for patients are considered at the earliest stages of change, either by Scottish Ambulance Service or other transport providers.
2.	That the transformation takes account of incoming patients from other boards. i.e. Argyll and the transport option for those patients.
3.	There are no assumptions made, even small changes in patient flow to different sites cannot always be easily accommodated by other Health Boards.
1.	Difficult to frame 3 priorities but from initial discussions of MFT there seems little doubt that improving communication channels between primary, secondary and tertiary care and electronic record acessibility across regions will be crucial. The present system of phone / page / personal e-mail not ideal, and generic drop-box e-mails for monitoring by teams would seem one solution, though IT experts with a better grasp of the options may come up with something better. Getting the current electronic record systems to communicate better or become more uniform also seems necessary.
2.	Also, if there is a plan to shift much of the emphasis to services other than consultant / physician led, then developing a plan to push training and recruitment into allied specialities (nursing, OT, PT, dietetics, psychology etc etc) early is going to be crucial to ensuring ther is a pool of appropriately trained people to fill posts as needed, and not have different specialities competing for a limited number. This will have to go hand-in-hand with an education / information campaign to make people understand the drive to train more as there is not only an expectation, but pretty much a guarantee that there will be a considerable expansion in employment opportunities.