Moving Forward Together.

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#movingforwardtogetherggc

Moving **Forward** Together.

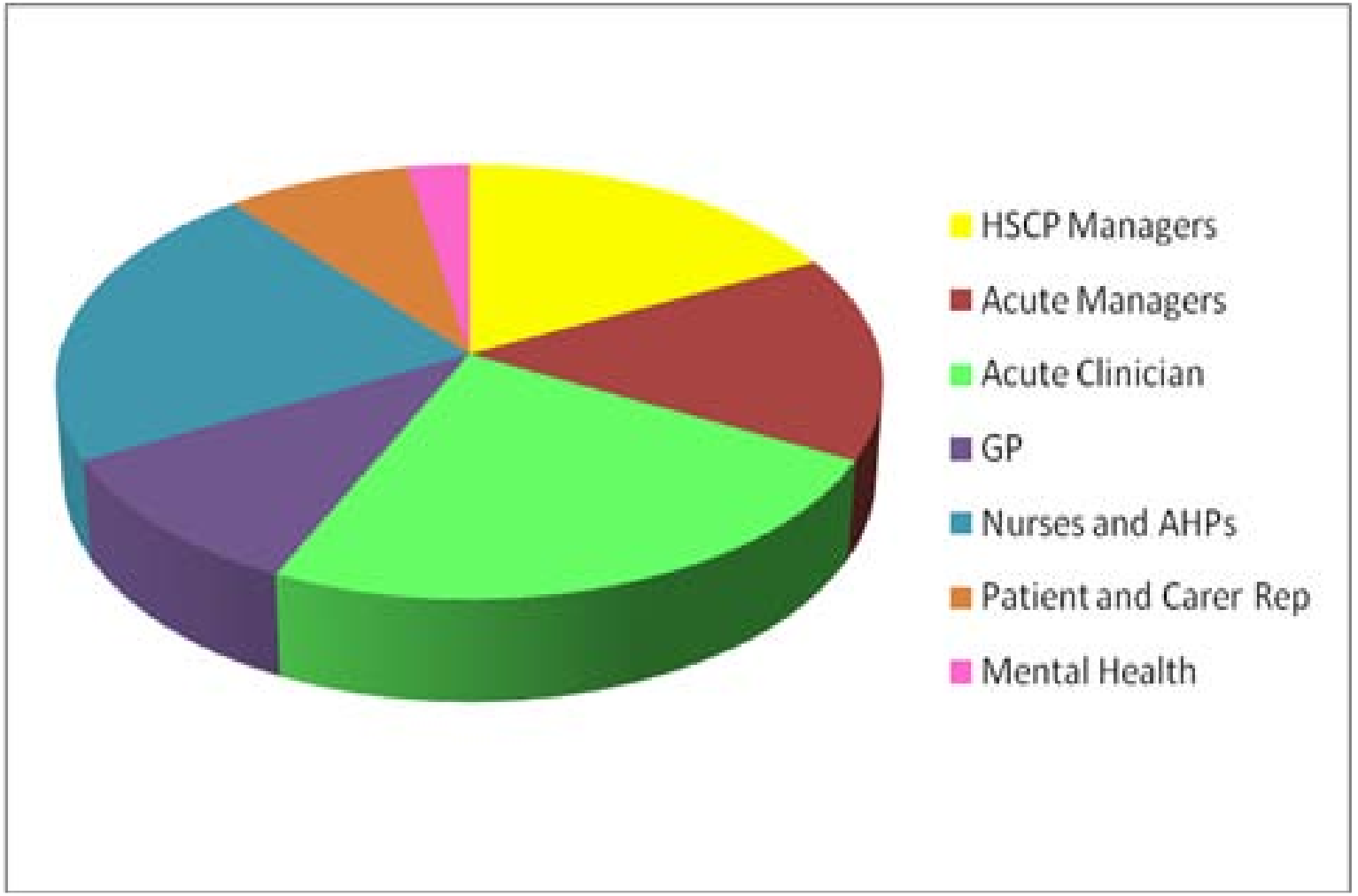
Introduction and Welcome

Jennifer Armstrong
NHSGGC Medical Director

The Three Horizons: Developing a sustainable and high quality NHS

Adapted from McKinsey and Co

Whole System



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GGC Health and Social Care Transformation Programme

30th January Programme Update

David Stewart

Moving Forward Together Progress Update

- Our Approach
- Our Phases
- The Tiered Framework
- Service Modelling Progress Report
- Emerging Themes
- Next steps

Our MFT Approach

- Aligned to National Strategic Direction
- Concordant and complementary to WOS Programme
- A whole system programme across health and social care
- Using the knowledge and experience of our wide network of expert service delivery and management teams
- Engaging with and listening to our staff and working in partnership
- Involving our services users patients and carers as early as possible
- Embracing technology and the opportunities of e-health
- Looking beyond today's constraints for tomorrow's solutions

WOS Programme Key Messages

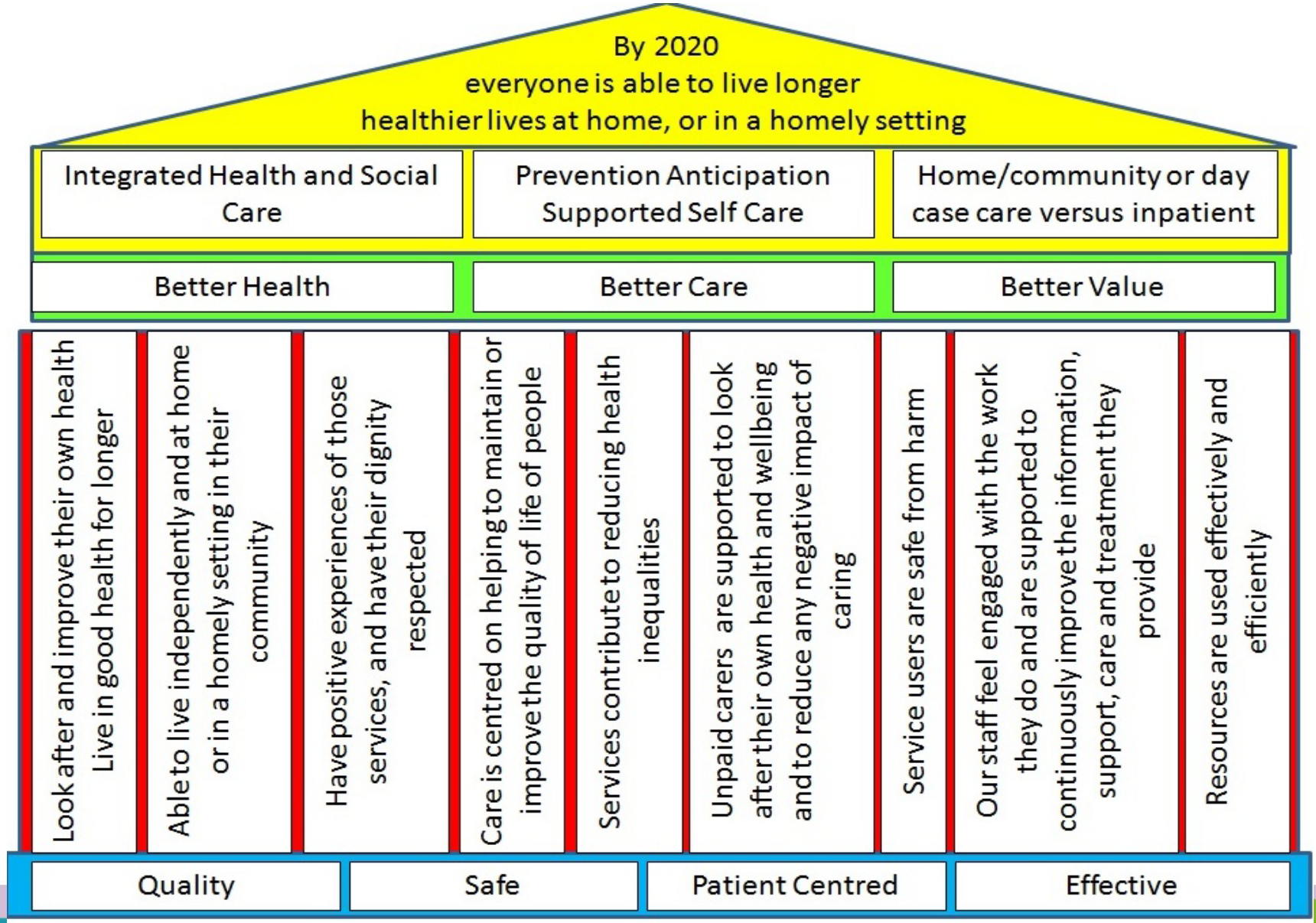
- This is a unique opportunity to **come together** across the organisational boundaries of 15 IJBs, 16 Local Authorities, 5 Territorials Boards, 3 National Boards
- There has been **lots of individual organisation progress** but there is a compelling case for **change in the region**
- We are united as a region in a common purpose to address this case for change, with **different levels of planning and delivery** to meet this purpose at national, regional and local levels
- We are **exploring a stratified model for local and acute care** in order to implement evidence-based care and make best use of **existing** workforce, estates and financial resources
- Submit draft WOS Report on **1 March 2018**

MFT: Programme Road Map

PHASE ONE – October to November 2017 COMPLETE

- Review the current range of relevant **National and Regional Strategic** Documents;
- Review the outputs of the **GGC Clinical Services Strategy** for comparison with National and Regional Guidance to create and amalgamated set of **principles** on which Transformation Strategy will be based
- Obtain mandate via **NHSGGC Board Approval** and IJB endorsement via a comprehensive **Transformation Programme Paper**
- Update the predictions on population changes to develop a **demand picture** up to **2025**
- Review and quantify the impact of the delivery of the **IJB strategic plans** and commissioning intentions
- Carry out a **stakeholder analysis** and develop **engagement plan**

Moving Forward Together : Cathedral of Care



MFT: Programme Road Map

PHASE TWO December 2017 to February 2018 ONGOING

- Prepare the Phase 1 principles framework, case for change, **care stratification model and evidence base** to enable a **structured discussion** with small clinical groups from and then across primary community secondary and tertiary care

- Commission **specialty groups** to review Phase 1 predicted service demand and produce **proposals for future service requirements**, the impact of which can be modelled.

- With clinical groups produce a **matrix of stratified clinical interdependencies** for each service which will inform **options development** and a plan for enabling changes and/or supporting services which are required to sustain the **new service models**

Tiered Service Population Approach

- To develop and agree a **tiered level of service delivery** and supporting infrastructure which is characterised by:
  - In the upper tiers; the need for **complexity and higher acuity** services with relatively low incidence to be **provided for a population** at the minimum number of locations commensurate with the size of population served
  - In the lower tiers; the need for **low complexity and lower acuity** services to be provided **at home or as close to home** as possible

- Carrying this approach **through the entire health and social care system** across primary, community and social care into acute scheduled and unscheduled care.

GGC Working Unscheduled Care Tiers (V3)

- **Tier 1**
  - Major Trauma Centre
  - Population base: 2-3M
  - Service Model: 24/7 Access to major trauma services
- **Tier 2**
  - Trauma Unit
  - Population Base: 400-600K
  - Service Model: 24/7 access to the full range of emergency services below that only provided in the MTC
- **Tier 3**
  - Local Emergency Hospital
  - Population Base: 100-200K
  - Service Model: Consultant led A&E with access to a range of emergency services and transfer arrangements to MTU and MTC
- **Tier 4**
  - Emergency Care Centre
  - Population Base: 50-100K
  - Service Model: GP led emergency care centre with access to a range of assessment and treatment services and transfer arrangements to MTU and MTC
- **Tier 5**: Community Based Services

TIER 1
24/7 access consultant delivered A&E, Neurosciences, Cardiothoracic , Hyper Acute Stroke, Vascular Full range of emergency surgery and acute Medicine Full range of support services, ITU/HDU etc

TIER 2
24/7 access
Moving towards 24x7 consultant delivered A&E,
Full range of emergency surgery and acute medicine,
Full range of support services, ITU /HDU, CGA and assessment beds
Access to intermediate care network

TIER 3
Front door services with Acute medicine
No onsite emergency surgery, Access to critical care/HDU and surgical opinion via network,
Outpatients and diagnostics

TIER 4
18/7 Access GP-led urgent care incorporating OOH GP and community based services
Access to community based step up/step down beds possibly with 48 hour assessment unit
Outpatients and diagnostics

Tiered Service Population Approach Methodology

- **Step One - Top down approach**
  - With wide clinical engagement
    - Sharing **tiered approach** with service modelling groups
- **Step Two - Bottom up approach**
  - Working tiers used as a basis for primary care, community service, social work and acute **specialty level engagement** to develop tier **stratified services**
- **Step Three - Joined up approach**
    - Infrastructure allocated to tiers and services aligned into infrastructure
    - Population access to tiered services correlated for each HSCP locality
    - Revision of allocated infrastructure where identification of gaps in infrastructure as required

Phase Two Process

- **Establish a series of cross system specialty based groups**
  - Virtual groups brought together for a single physical meeting in this Phase
    - Acute clinicians nurses and AHPs
    - GPs
    - Community nurses and AHPs
    - HSCP Heads of Service
    - Acute and HSCP Planning
    - Public Health
    - E-health
- **Issue preparation materials ahead of the meeting**
  - Results of global literature search on new or alternative models
  - Activity projection using synthetic estimates based on demographic change
  - Briefing on the tiered approach to service planning
  - Survey issued to all group members based on preparation material

- **HSCP Locality Level Meetings in each area**

Phase Two Service Modelling Groups

Already met

- Cardiology
- Endocrine/Diabetes
- ENT
- Gastroenterology
- General Surgery
- Geriatrics
- Respiratory
- Rheumatology
- Orthopaedics
- Urology
- Haemato-oncology
- Breast Cancer
- Dermatology
- Glasgow HSCP
- Vascular
- Diagnostics
- Urological Cancer
- Gynaecological Cancer
- Upper GI Cancer
- West Dun HSCP
- Renfrewshire HSCP
- ACH OOH Model Group

Scheduled

- East Dun HSCP
- East Renfrewshire HSCP
- Inverclyde HSCP
- Colorectal Cancer
- Lung Cancer
- Head and Neck Cancer
- Critical Care
- Palliative Care
- Infectious Diseases
- Tier 3/4 Unscheduled Care

Phase 2 so far; emerging themes

- **Tier 4/D services**
  - All specialty groups have identified service provision that could be moved from the hospital base to local or community delivery models
  - Each specialty groups have identified a need for more and better supported specialist nurses and AHPs to deliver this transformation
  - Models could be based on physical community or local assets or virtual teams with no fixed infrastructure
  - Support links into the acute consultant body and also into GP clusters enhance this model and are enabled by e-health solutions

- **Access to Comprehensive Records and Improved Cross Sector Communication**
  - This has long been a desire but now there are e-health solutions that can make this a reality

Phase 2 so far; emerging themes

- **Working to the top of a licence**
  - All specialty groups have identified service provision that could be done by more appropriately qualified staff which would allow each practitioner to spend more time doing only the work that they can do
- **Cross System Team Working**
  - Many of the specialty groups have already shown areas of good cross system working but there is a real enthusiasm that this could be expanded and rolled out to be universal practice

Phase 2 so far; emerging themes

- **The opportunities of integration**
  - Most of the specialty groups felt that the gap between primary community and acute service delivery had closed and that the transformational programme was an opportunity to bring about a much more integrated health and social care system

- **Developing‘generalism’**
  - Multi-morbidity and frailty driving a recognition of the need to support and develop generalist approaches both in hospital and in community, and to have clear structures and governance for how generalist and specialist services interact.

MFT: Programme Road Map Next Steps

PHASE THREE March to April 2018

- Review current **WOS planning and other Health Board** strategic intentions and assess the impact on GGC options
- Review all the work of Phase 1 and 2 and adjacent relevant workstreams to **develop a description of new service models** or options across Health and Social Care
- Describe the required changes, supporting and enabling work to support **future outline delivery plans** with options where relevant
- Use this basis to prepare an **outline of the strategic plan** with options to be discussed during the **wider clinical and public engagement** programme through an **open and transparent effective dialogue** process supported by a series of wide ranging conversations

Moving Forward Together.

Transforming Care with E-Health and Technology

William Edwards, Director of eHealth

Dr Andy Winter, eHealth joint Clinical Lead

Vision

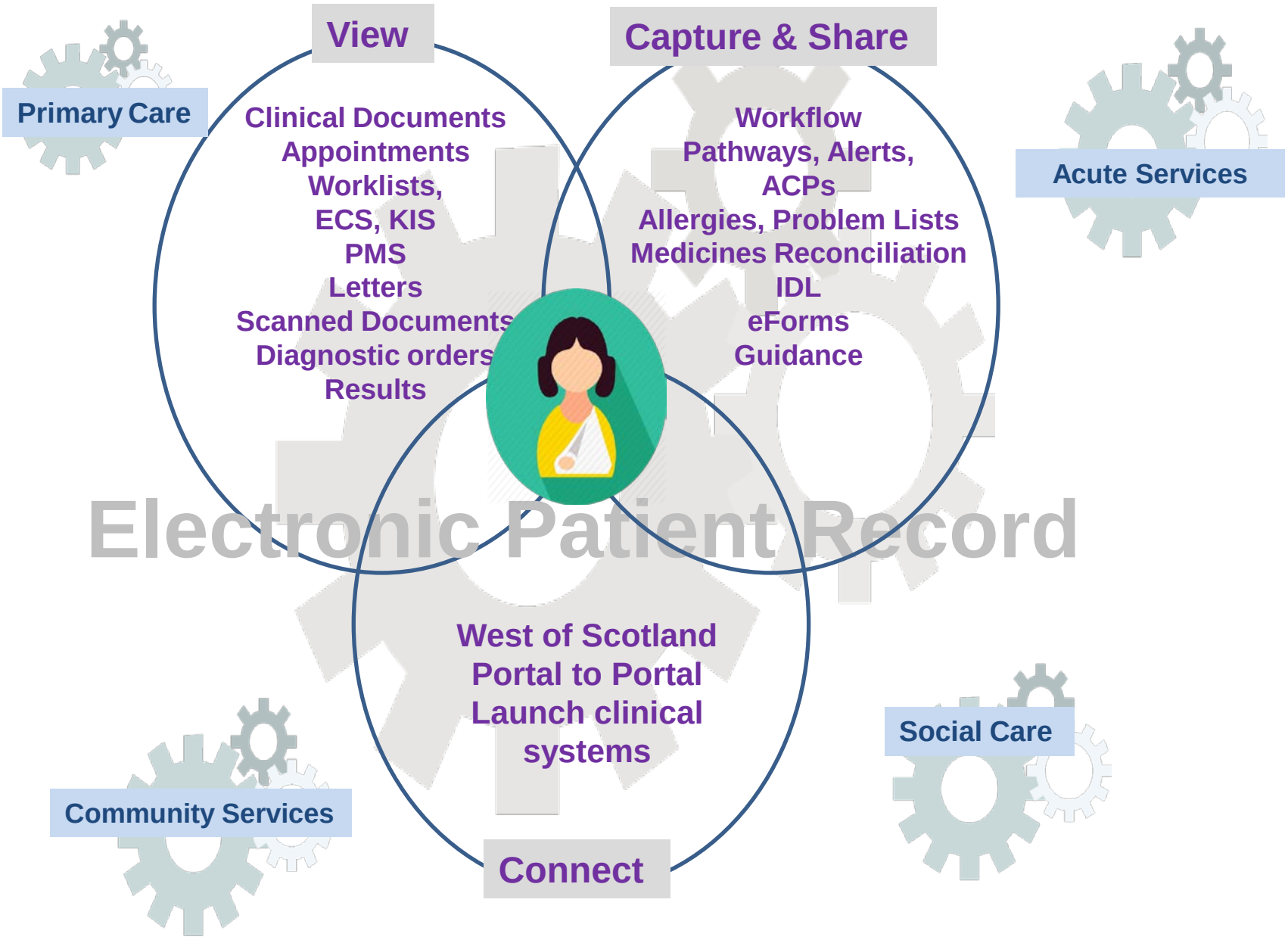
- **Technology as an enabler** for transformational change
- **Innovative and ambitious solutions** supporting service change
- **Maximise opportunities** for collaborative working regardless of organisational boundaries or settings
- **Enabling citizens** to become active in their healthcare through the use of digital tools and access and contribute to their health and care information

eHealth Themes

Requirement	Theme
Access to comprehensive patient records for those that need to see	Electronic Patient Record
Improved pathways Support workflows across tiers and MDTs, Dashboards. Clinical dialogue, Anticipatory Care Plans	Supporting Workflow & Teams
Virtual clinics, telemedicine / remote consultations, home diagnostics/wearables	Remote Monitoring
Self management, patient-held records, signposting	Patient Self Care
Clinical decision support, cohorts, safety nets, genetics and precision medicine	Clinical Informatics
Safer use of medicines, HEPMA, Care Assurance, support efficiency and sustainability, safe systems	Efficiency & Safety

Electronic Patient Record

- Access to comprehensive patient records for those that need to see
- **Clinical Portal**
  - An electronic system which allows clinicians and health professionals to view a patient's clinical record
  - Underpinned and fed by a range of technologies
  - Integrated with >30 other systems
  - Over 12,000 front line level clinical users, 10yrs clinical data
  - West of Scotland Portal to Portal allowing sharing of patient records with clinicians caring for the patient across the region
  - Covers over 2 million residents


View
Capture & Share
Primary Care
Acute Services
Clinical Documents
Appointments
Worklists,
ECS, KIS
PMS
Letters
Scanned Documents
Diagnostic orders
Results
Workflow
Pathways, Alerts,
ACPs
Allergies, Problem Lists
Medicines Reconciliation
IDL
eForms
Guidance
Electronic Patient Record
West of Scotland
Portal to Portal
Launch clinical
systems
Social Care
Community Services
Connect

Patient Self Care – NHS Scotland Digital Strategy

I **maintain** and **improve** my health and wellbeing through access to **digital information**, tools and services

I expect **service staff** and **carers** to **improve** my health and wellbeing by **using** and **sharing** my digital health and social care information securely

I also expect that my **digital information** will be used appropriately to **plan** and **improve services** and to help improve the health and wellbeing of others

Patient – Health Technology (Tec)

NHS SCOTLAND

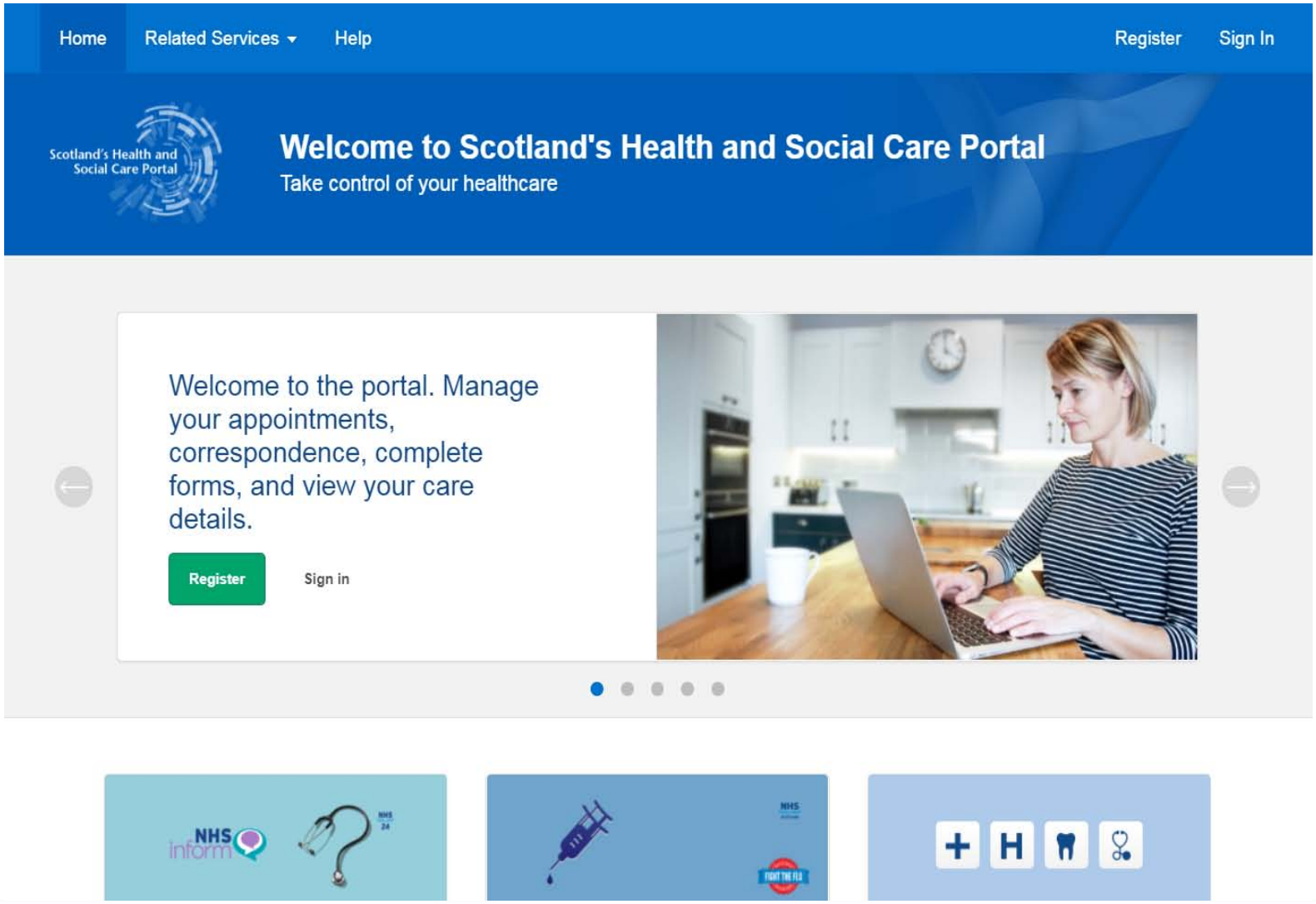
SCI-Diabetes

EPR

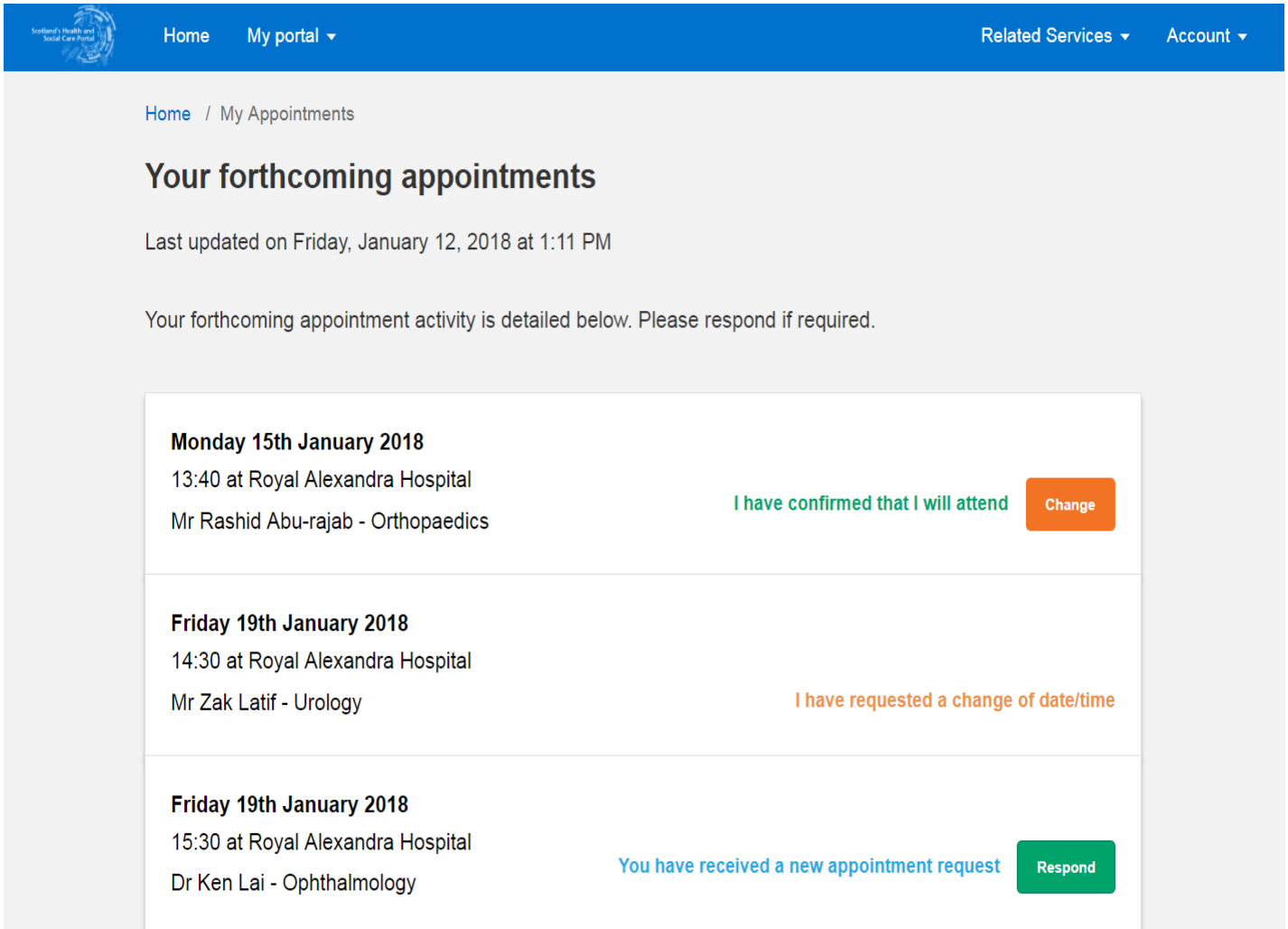
Research

Remote Monitoring

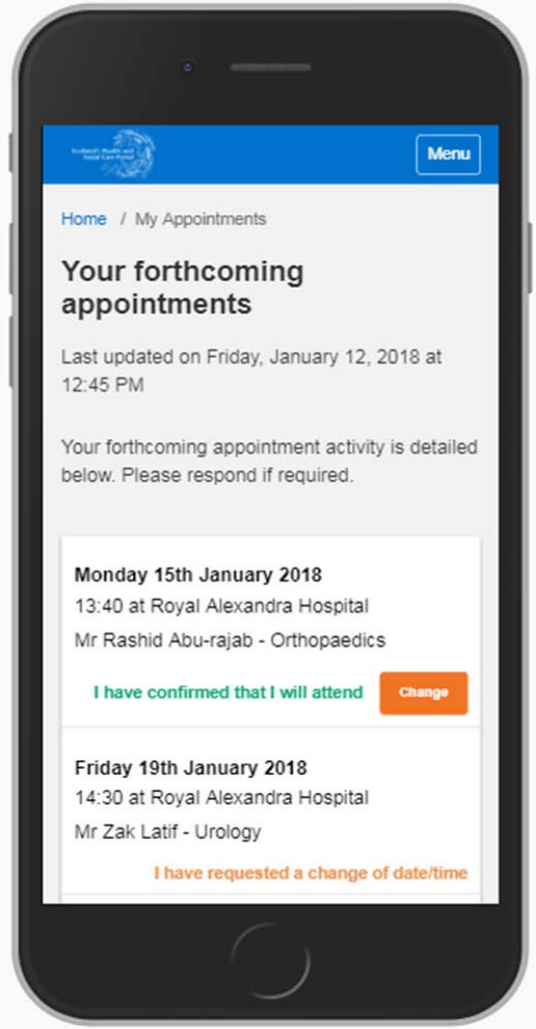
Patient Portal



Patient Portal – Manage appointments

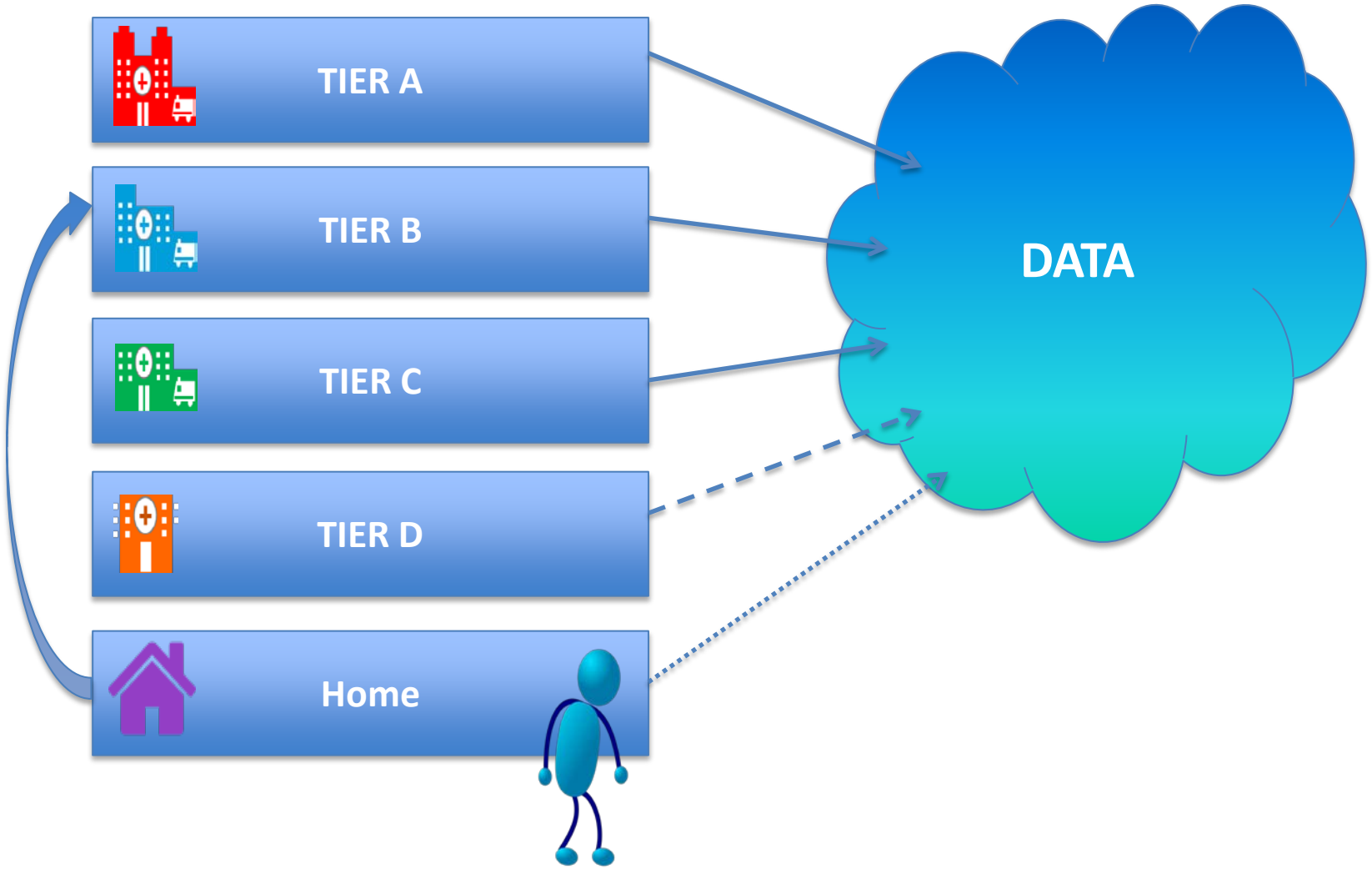


Patient Portal

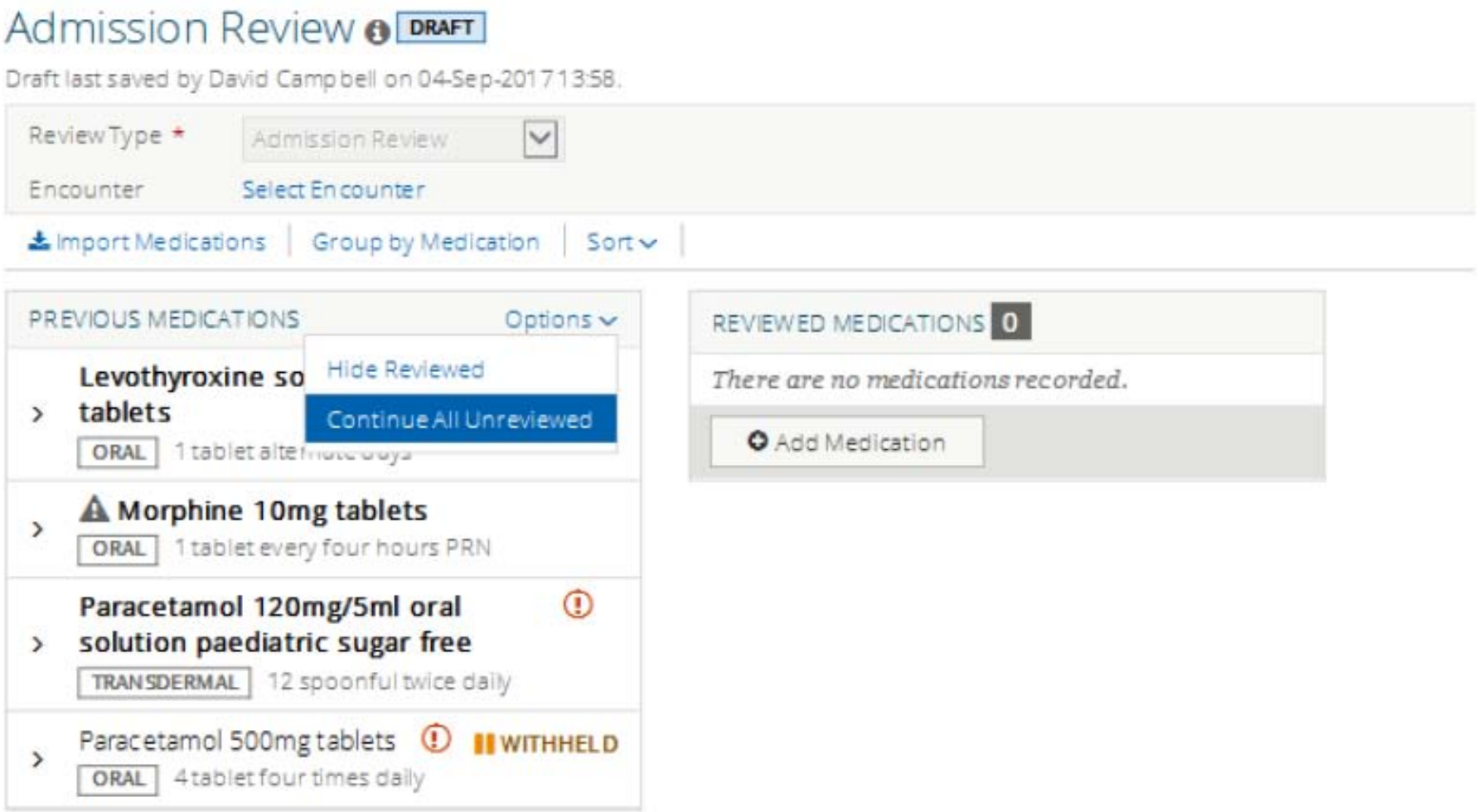


Supporting Workflow & Teams

Moving Forward Together

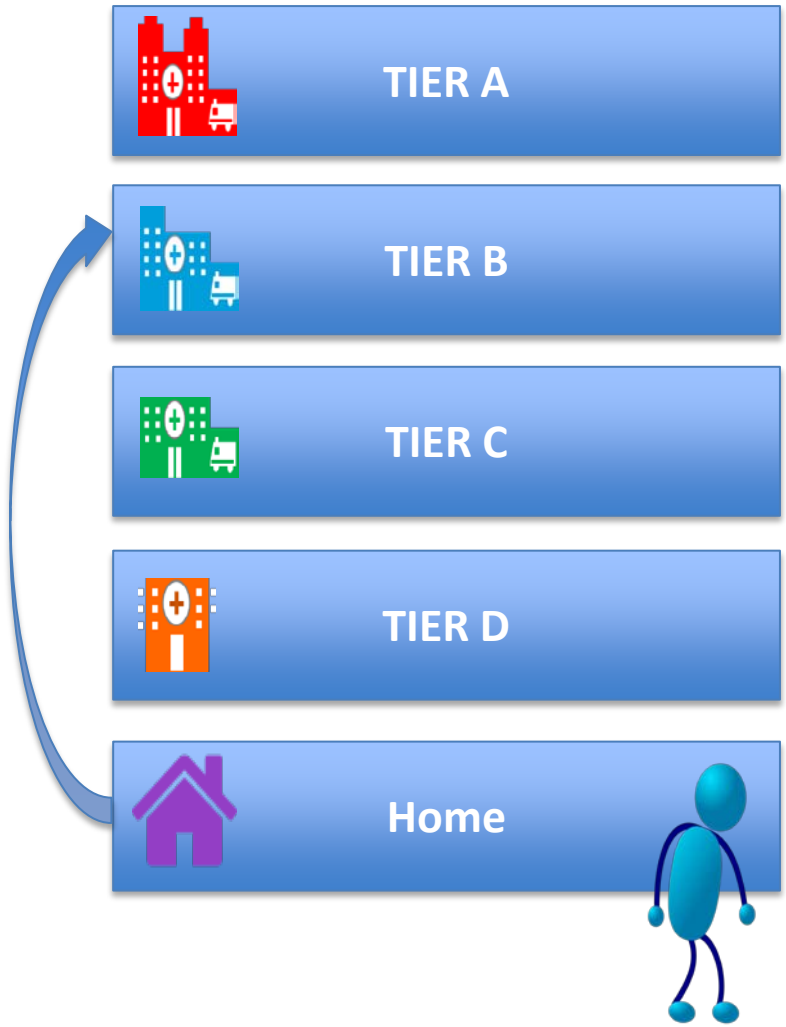


Example: a common medicines list



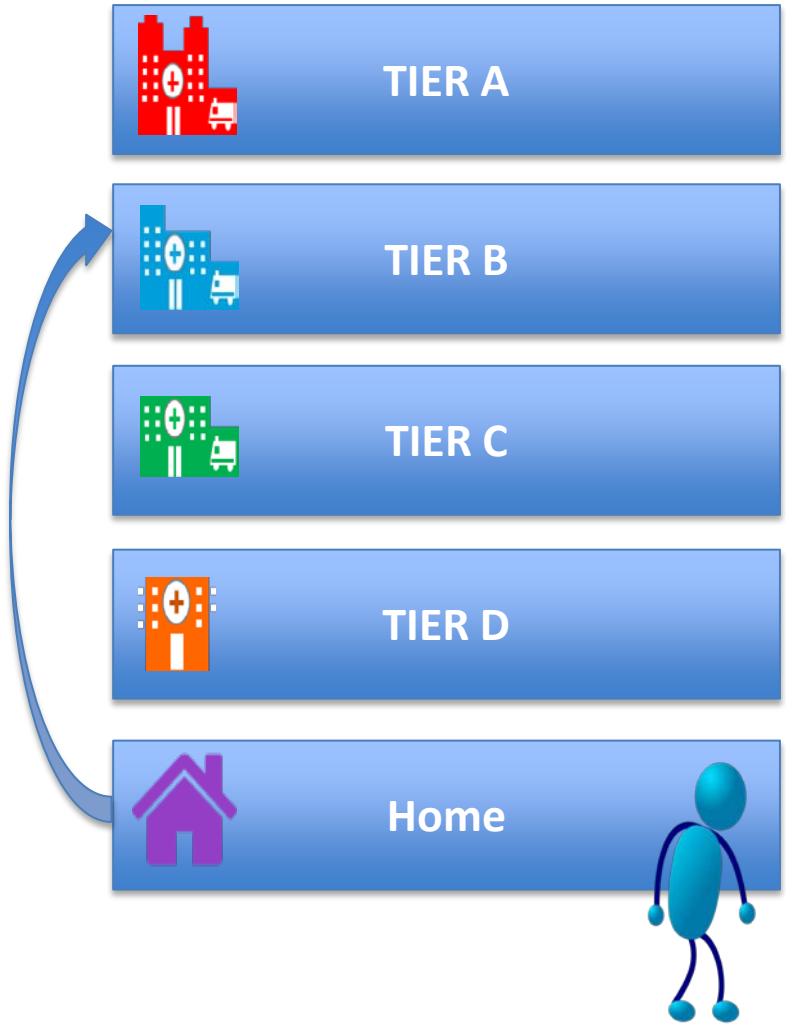
Supporting Workflow & Teams

Moving Forward Together



- ‘Advice’ Referrals
- Clinical Dialogue
- e-Workflow between sectors / silos
- Convergence of systems?

Supporting Workflow & Teams



‘Virtual’ clinics / MDT support

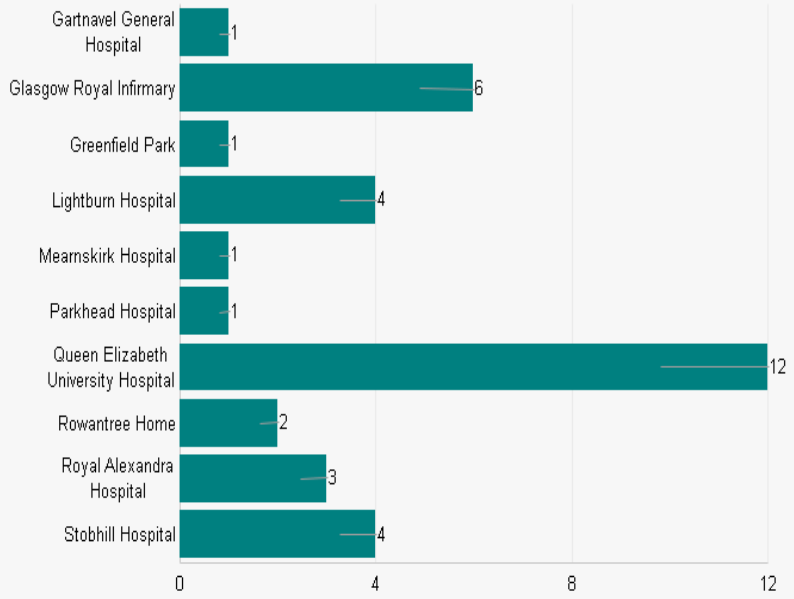
Condition ‘dashboards

Parkinson's Current Inpatients

Time Elapsed Since Admission

	7 Days or Less	8 to 14 Days	Over 14 Days
Glasgow Royal Infirmary	4	2	0
Queen Elizabeth University Hospital	2	1	9
Royal Alexandra Hospital	1	2	0
Gartnavel General Hospital	0	0	1
Greenfield Park	0	0	1
Lightburn Hospital	0	1	3
Mearnskirk Hospital	0	0	1
Parkhead Hospital	0	0	1
Rowantree Home	0	0	2
Stobhill Hospital	0	0	4
Total	7	6	22

Current Admissions by Hospital

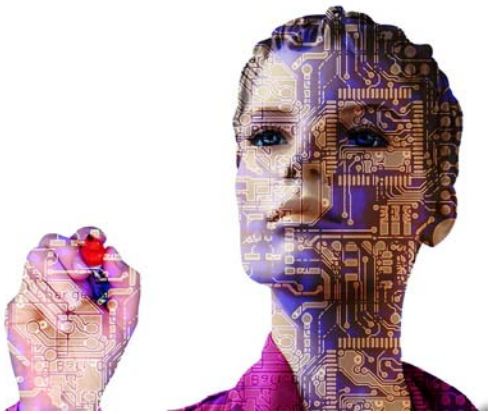


Current Inpatient Breakdown

(All) Elective Emergency

Specialty	Ward	Consultant	CHI	Patient	Admission Date	Days Since Admission
Orthopaedics	QEUH Ward 10C	Mr Andrew Marsh	[redacted]	[redacted]	09/01/2018	1
General Medicine	QEUH Ward 6A	Dr Ronald Seaton	[redacted]	[redacted]	09/01/2018	1
	RAH 6 Geriatric Medicine	Dr Iain Keith	[redacted]	[redacted]	09/01/2018	1
Orthopaedics	GRI Ward 61 Orthopaedics	Mr Martin Davison	[redacted]	[redacted]	08/01/2018	2

Patient self-care & remote monitoring



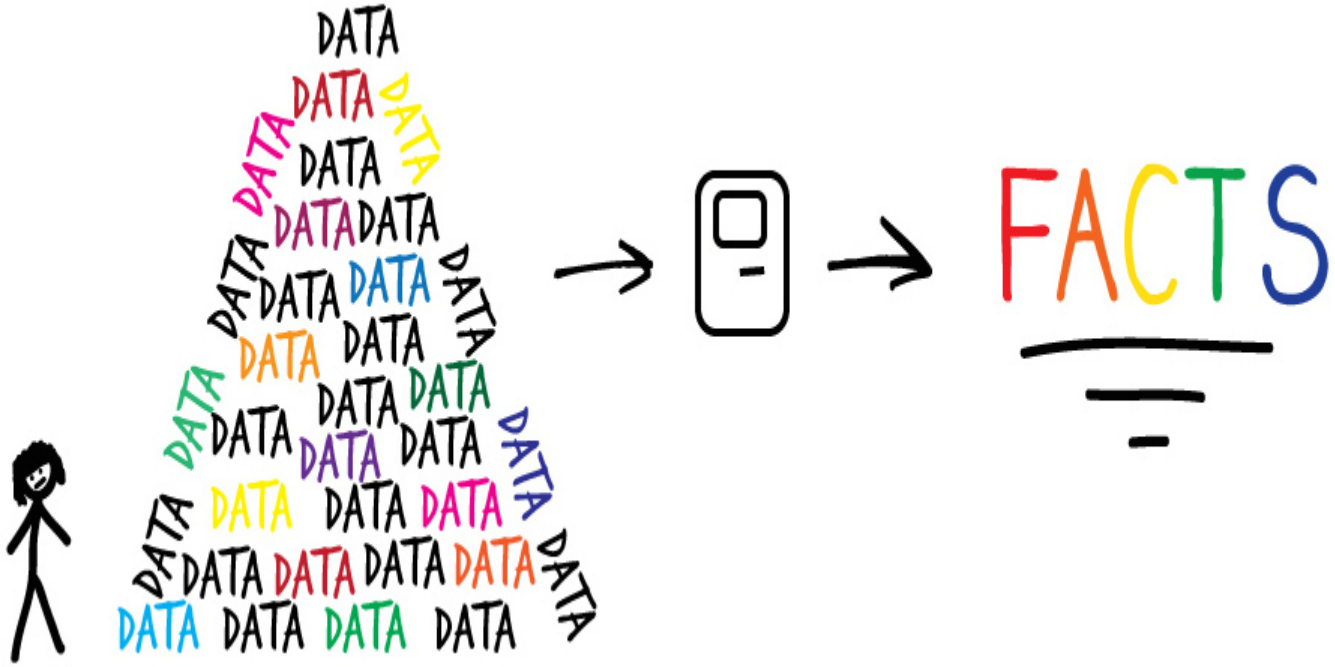
‘Wearables’

On-line tools

Anticipatory care

Making sense of it all

Clinical Informatics



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?

Moving **Forward** Together.

Transformation of Older People ‘s Services

Susanne Millar, Morven McElroy, Richard Groden

Introduction

- Context of MFT
- Examples of achievements so far
- Potential further areas of transformation
- Reflections on features of successful Transformation

HSCPs Transformation Programme – Older People

- All aspects of health and care system subject to change
- Residential and Day Care Modernisation
- Home Care – re ablement
- UCC – new models, improved performance
- Integrated operational teams – around clusters
- Technology Enable Care
- Sheltered Housing
- Supported Living

HSCPs Transformation Programme – Older People

- Continuing Focus on:
  - Early intervention, prevention and harm reduction
  - Providing greater self determination and choice
  - Enabling independent living for longer
- Setting clear expectations – not mitigating all risk
- Demographic, resource changes and practice imperatives mean we need to continue shifting the balance of care towards community

MFT programme – Older people

- Develop more preventative/anticipatory care to support more people in community – exploit new technology
- Managing more complex cases in community – improved responses and co-ordination of care – enhanced roles
- Further develop role of geriatricians working closely with GPs
- Condition specific care pathways across primary and secondary care
- Assess implications of future changes in demand and potential response to shift balance of care

Key Messages

- Build on MFT sessions to improve dialogue between primary and secondary care
- Capitalise on opportunities in new GP contract
- Exploit new technology
- Access and networks of services and support for Older People must involve third and independent sector

Conditions for Innovation and Transformation – Reflections

- Clear vision – beyond sorting out today
- Willingness to set aside old assumptions
- Guided by evidence
- Time to think and debate
- Change attitude to risk – enablement
- Organisational permission for staff to undertake tests of change – trust with accountability
- Creating right incentives in system
- Celebrate success, positive reinforcement of progress
- Shift power bases

Moving **Forward** Together.

Table Discussion One

Table Discussion One

- 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?
- In terms of transformational opportunities; what opportunities does the integration of health and social care offer? Are we realising these opportunities?
- What impact do these opportunities have on your own services, and for services working together?

Moving **Forward** Together.

Transforming Mental Health Services

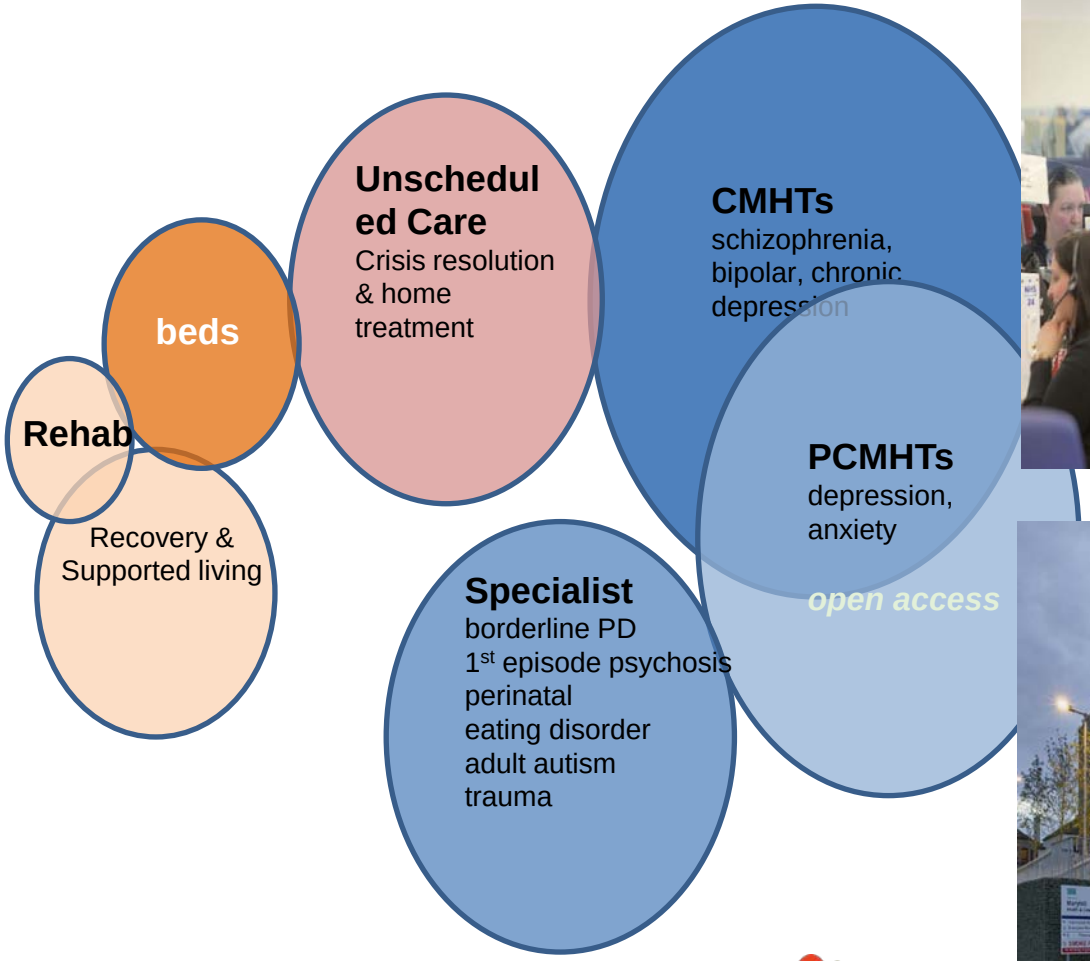
Michael Smith,
Associate Medical Director,
Mental Health & Addictions Services,

1978

4,370 Glasgow inpatient beds

Consultant- led outpatient clinics

MH system, 2018 -



See Me
End mental health discrimination

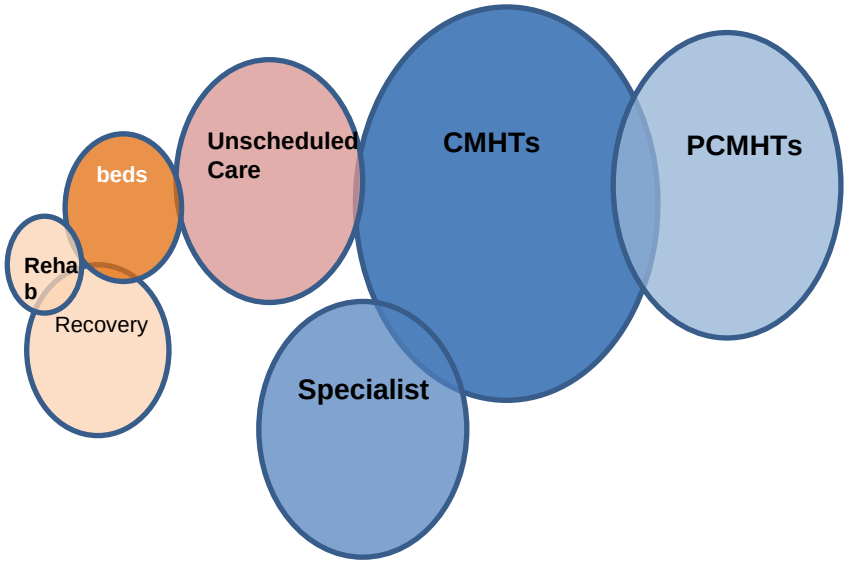
srn Scottish Recovery Network

ChooseLife
Suicide prevention in Scotland

SPACE
BREATHING

Every Person Every Time
SCOTTISH PATIENT SAFETY PROGRAMME

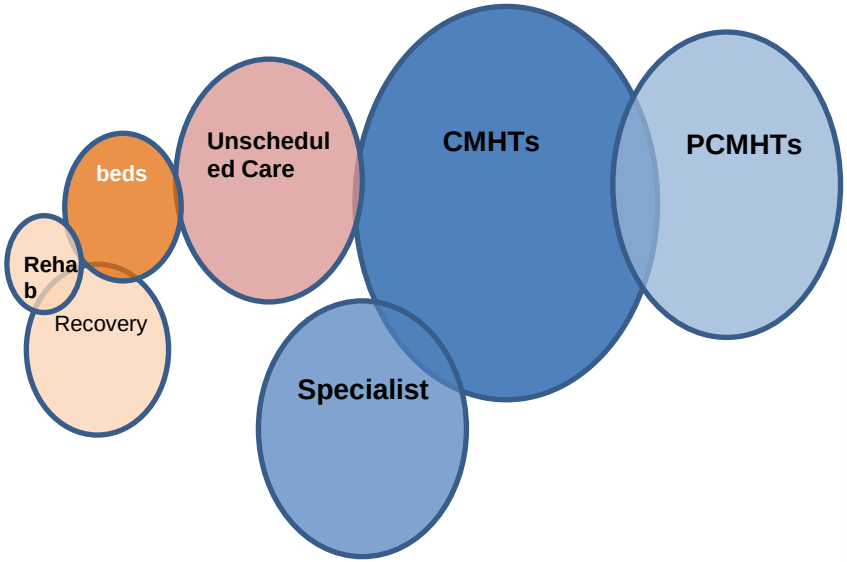
Transitions

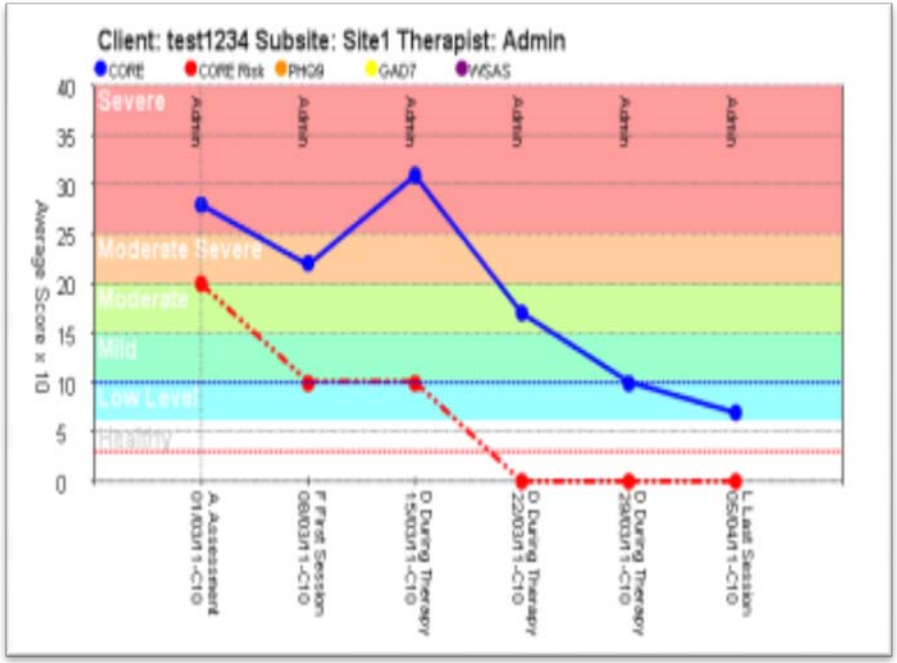


✘
Triage
Screening
Gatekeeping
Signposting
Link workers
Joint working

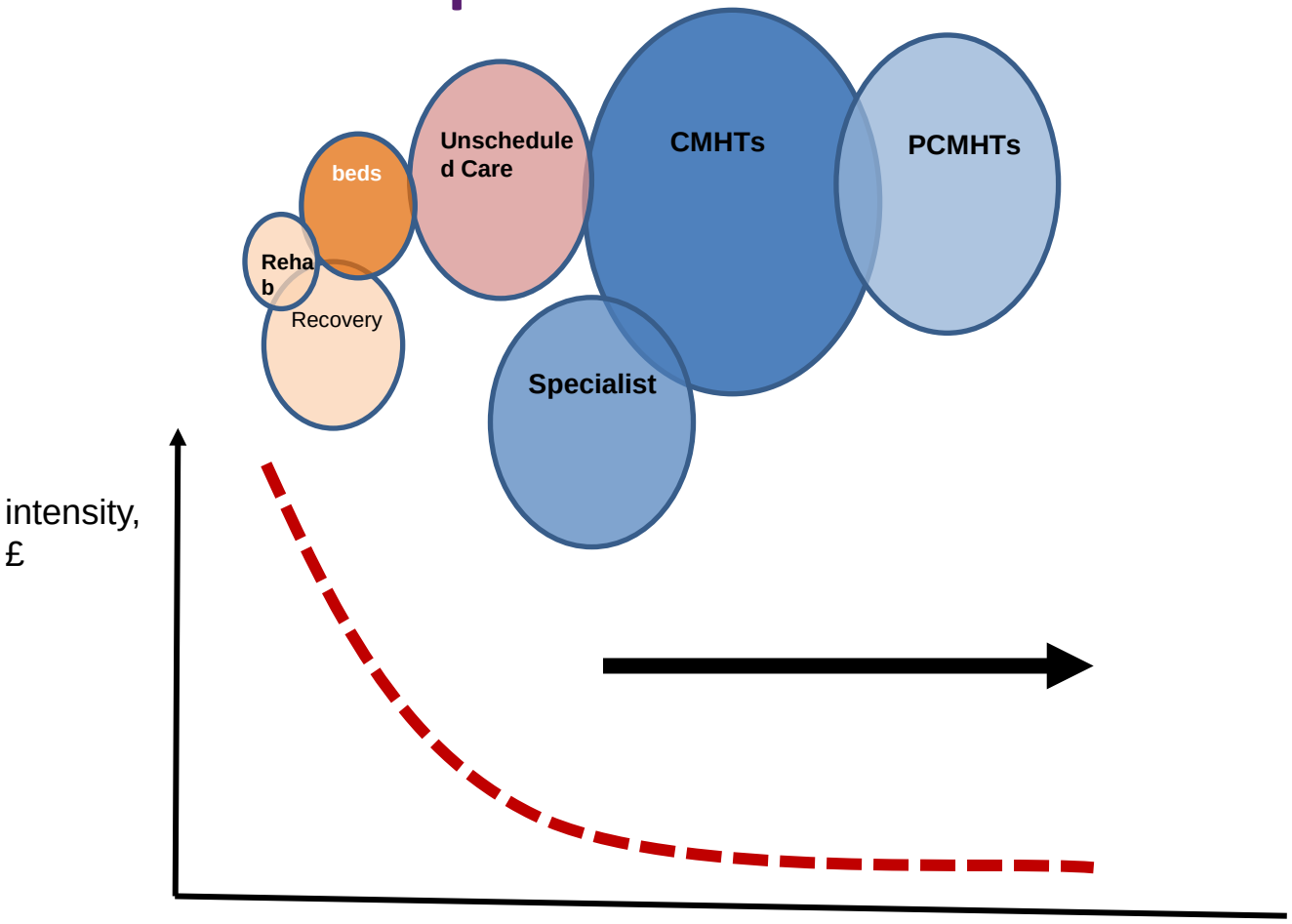
✓
Assessment without treatment
Routine review
Outcome measurement

Stepped care using CORE-Net





prevention


beds
Unschedule
d Care
CMHTs
PCMHTs
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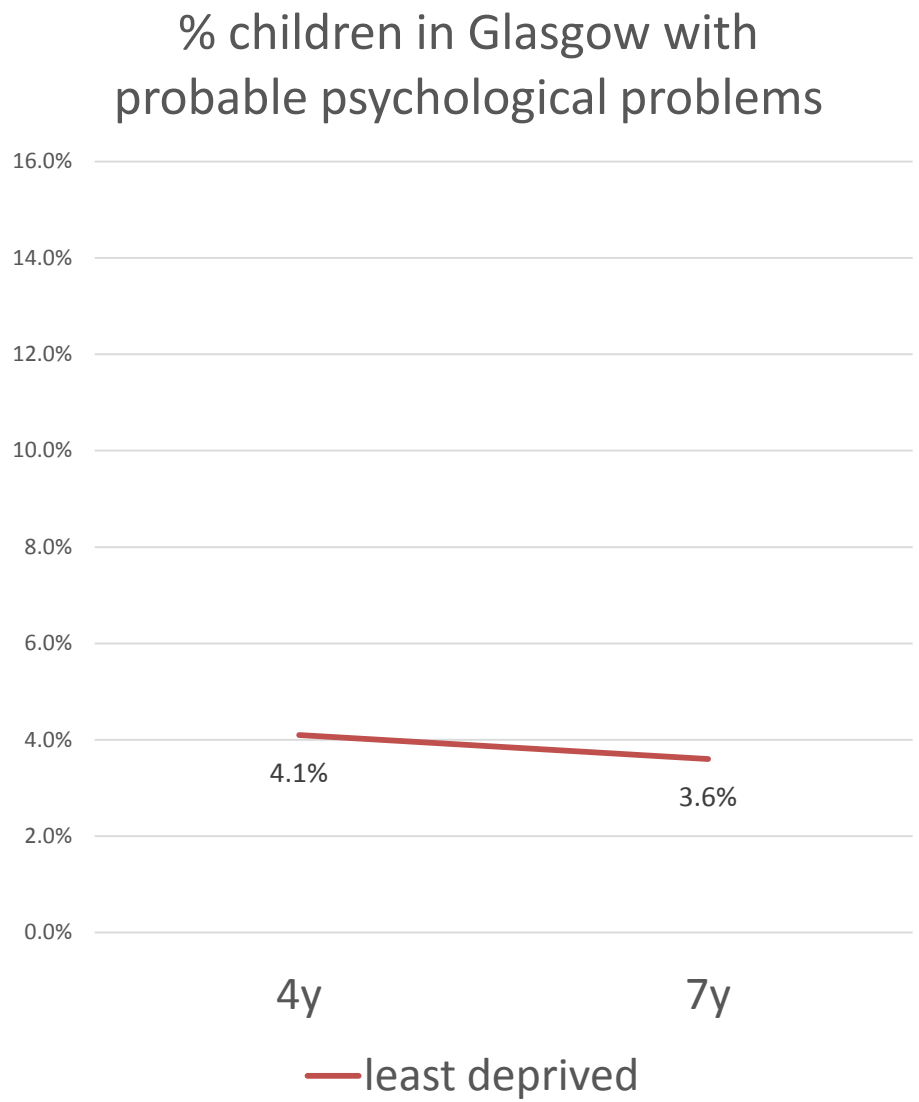
Recovery
Specialist
intensity,
£

Prevention

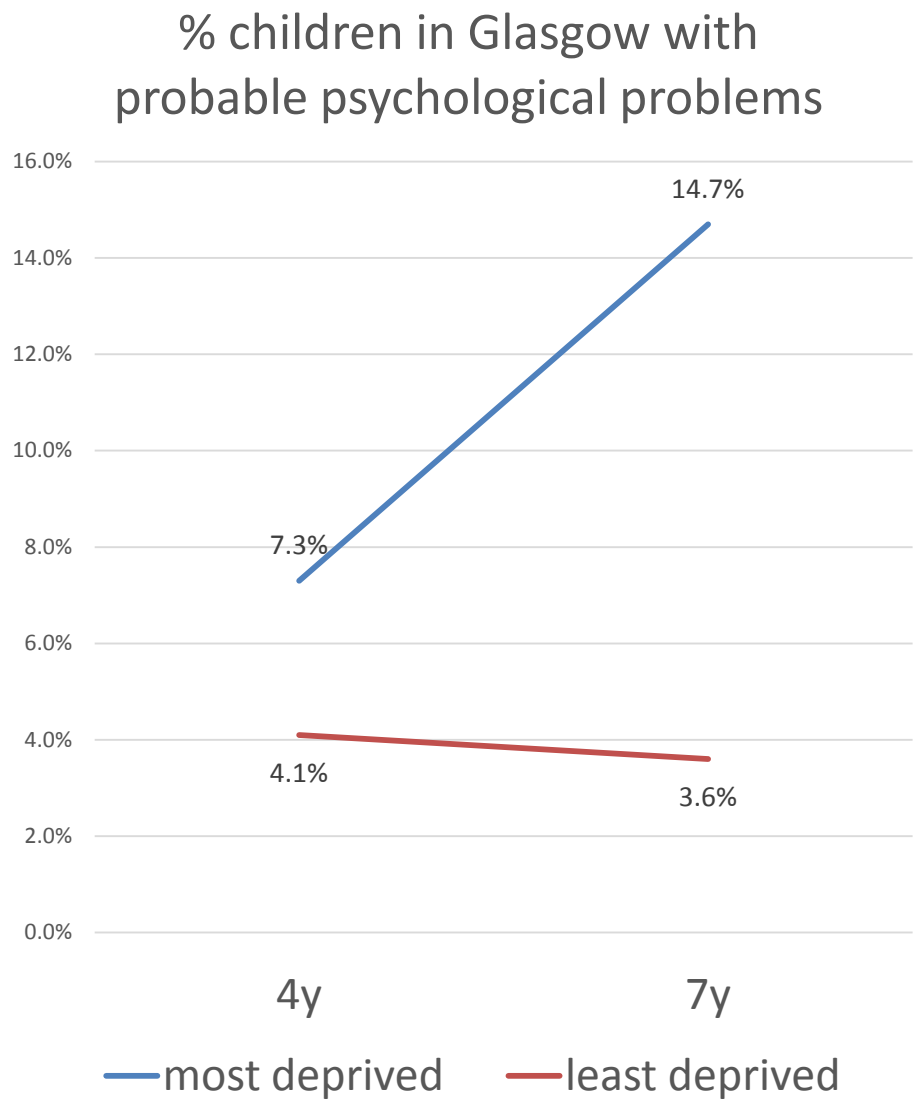
- 50% of adult MH problems have begun by 15y
- Once started, MH problems often persist



Marryat L, et al. J Epidemiol Community Health 2017

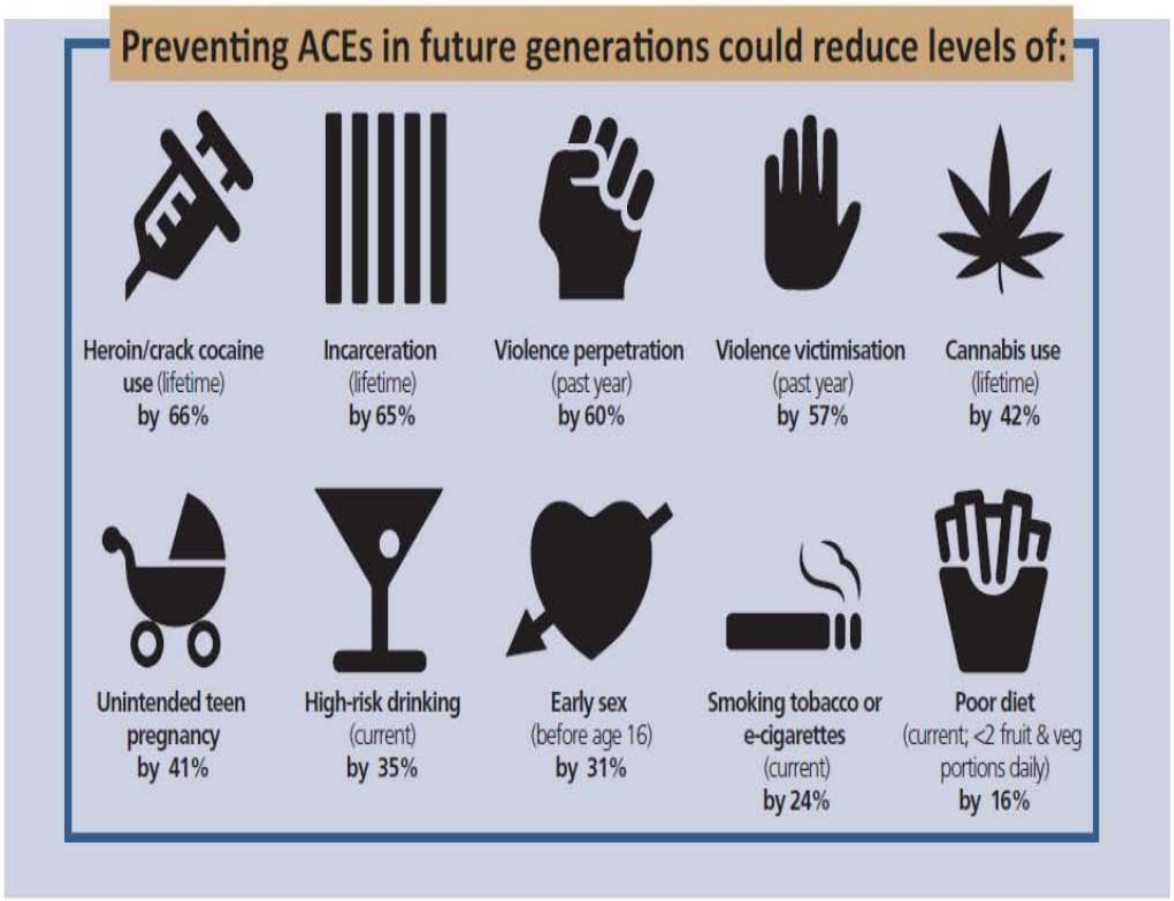
Prevention

- 50% of adult MH problems have begun by 15y
- Once started, MH problems often persist
- Childhood MH problems in Glasgow get worse from 4y to 7y



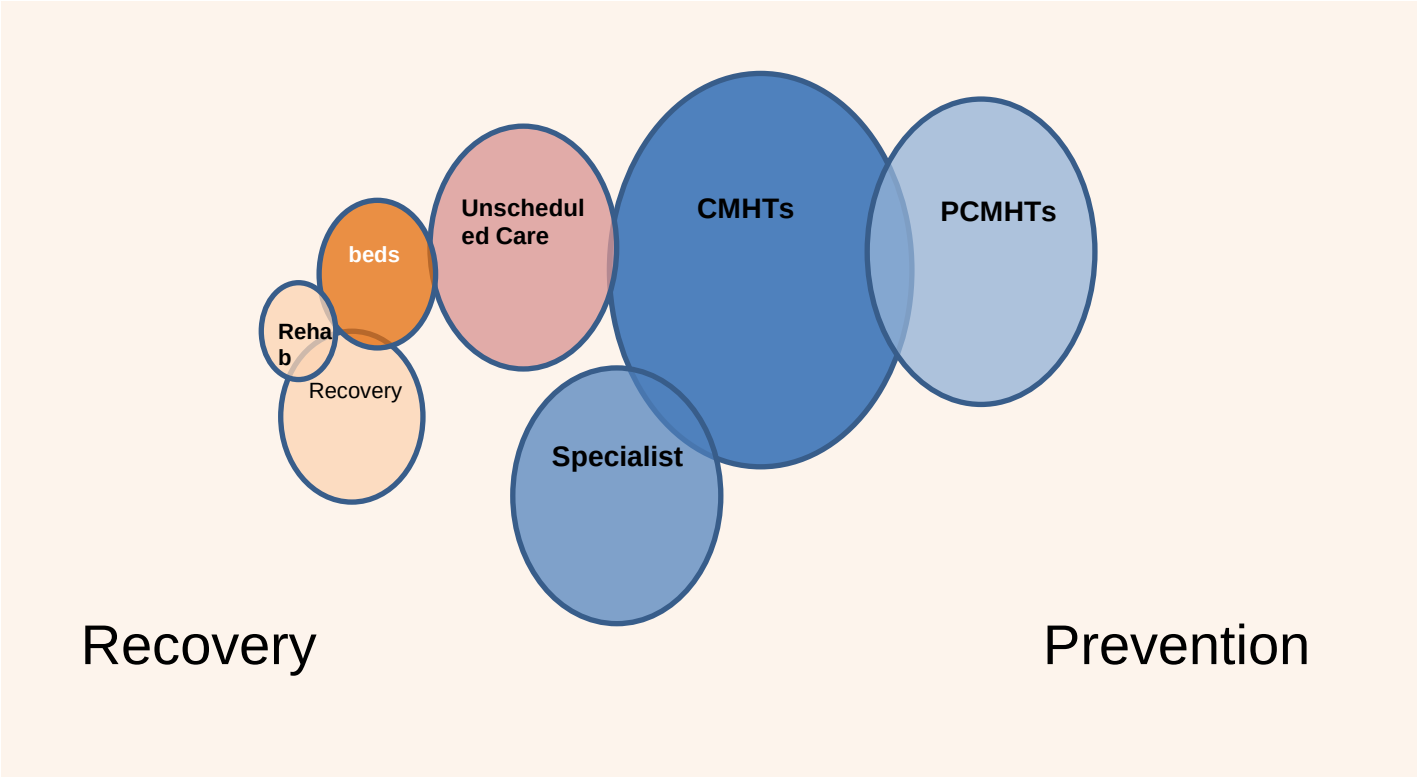
Marryat L, et al. J Epidemiol Community Health 2017

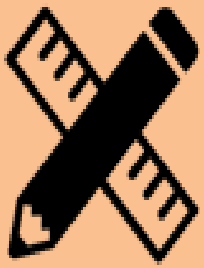
Prevention – Public Health



Recoverv

- **There's more to good health than just having fewer symptoms**
- **Confidence, relationships, employment, retraining better supported outside the clinic**
- **England ahead of Scotland in developing services**
- **Recovery communities, hubs in Glasgow addictions services**
- **Peer support (RoI £4.76)**


beds
Unscheduled Care
CMHTs
PCMHTs
Rehab
Recovery
Specialist
Recovery
Prevention

balance of care		**Reduce inpatient beds** and invest in alternative forms of health and social **care**
Productivity: specialisation & matched care		Enhance **capacity** in CMHTs, PCMHTs **Extend role** of specialist teams Rationalise, consolidate unscheduled care
Transformational		**Task & Resource Shifting**: recovery-oriented models of care **Quality Improvement**: BPD, bipolar disorder **Culture change**: compassionate, trauma-sensitive care
Prevention		**Focussed investment** in early years, conduct disorder, bullying, ACE reduction

Moving **Forward** Together.

2018 GP Contract / New Ways

Hector Macdonald – Clinical Director

Derrick Pearce – Service Manager

2018 GP Contract

- Different from England
- Informed by New Ways and other tests of change
- Negotiated by Government and BMA
- Changes already underway – Cluster Working

Aims

- Improve being a GP
- Secure income
- Reduce Workload
- Reduce Risk
- Improved patient outcomes and experience

Improve being a GP

- Focus on “Expert Medical Generalist” role
- Undifferentiated Presentations
- Quality Improvement

Reduce Workload

- Remove vaccinations
- Board/Partnership employed staff to take some workload from GPs e.g. Pharmacy teams/Physio/ANPs
- 3 yr Plan

Inverclyde New Ways

- Tests of change
- Some across Partnership others based in GP Clusters
- MSK Physio; ANPs; Paramedics; Pharmacists; Phlebotomy

Example - ANPs

- 1.4 wte ANPs (c. 23,000 patients across 5 practices in 1 cluster)
- Experienced registered nurses, masters level, full prescribers (per GGC Advancing Nursing Practice Strategy)
- Currently covering 40% of home visits across East cluster
- Shared across practices - flexible & responsive
- Propose scaling up to 50% of home visits across Inverclyde

Example - ANPs

- Workload allocated via GP triage
- Average 7 visits per day – 35 minutes each
- Can consult in practice if required
- Cover whole range of presentations - depending on GP requirement (e.g. end of life)
- Holistic, care co-ordination following assessment

Challenges

- Recruiting staff to new roles
- Retaining staff
- New role for GP’s
- Sustainable services

Moving **Forward** Together.

Table Discussion Two

Table Discussion Two

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

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

Moving **Forward** Together.

A Cross System Approach to Respiratory Care

Marianne Milligan, Team Leader, Community Respiratory Team
Pamela Vaughn, Advanced Respiratory Physiotherapist, GRI
Catherine Dunnet, Clinical Service Manager Speech and Language Therapy
Dave Anderson, Consultant Respiratory Physician, QEUH

A Cross System Approach to Respiratory Care

- Examples of good practice
- Potential In Patient Service
- Potential Out Patient Services
- Collaborations

The Size of the Problem

- COPD affects 129 000 people in Scotland
- Predicted increase of 33% in twenty years
- Most common cause of presentation to hospital in Scotland
- Responsible for 46 346 bed days in GG+C
- Bed occupancy increasing
- Accounts for 6% of all deaths in Scotland (4 500 / annum)

Specialist, reactive, coordinated

Advanced assessment

Emotional Wellbeing

ADL/ equipment

Self Management

Virtual Ward – secondary review

Breathlessness Strategies

Chest clearance

Medication Review

Nutritional health

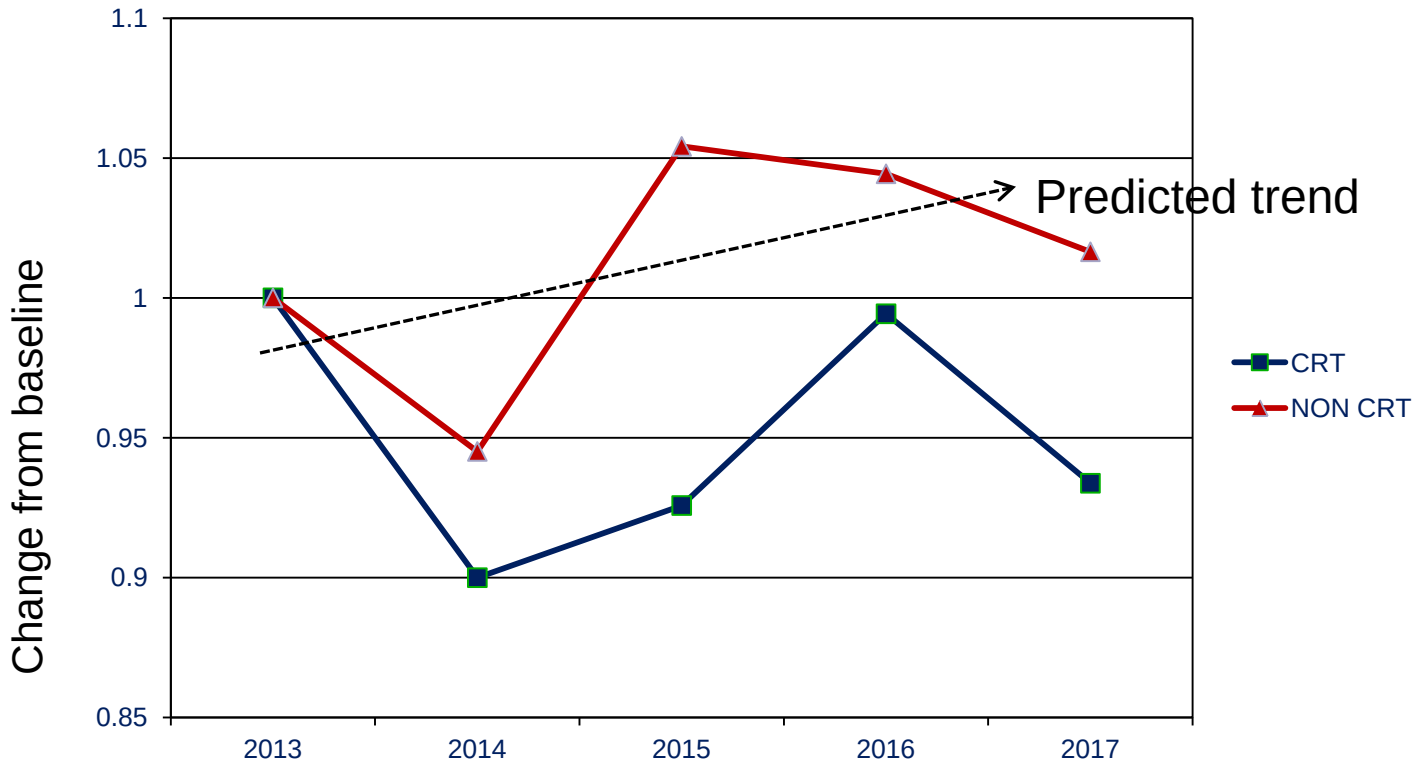
Home PR

Community links

Impact of CRT

- Comparable readmission and mortality with IP management
- Clinically and statistically significant improvements in disease impact (CAT)
- Clinically and statistically significant improvements QOL (EQ5DL)
- 85% person centred goal attainment
- GPs 75% reported reduced home visits
- 22% reduction in hospital admissions post intervention
- Est Net savings: £463,780 to £1,087,564 per annum

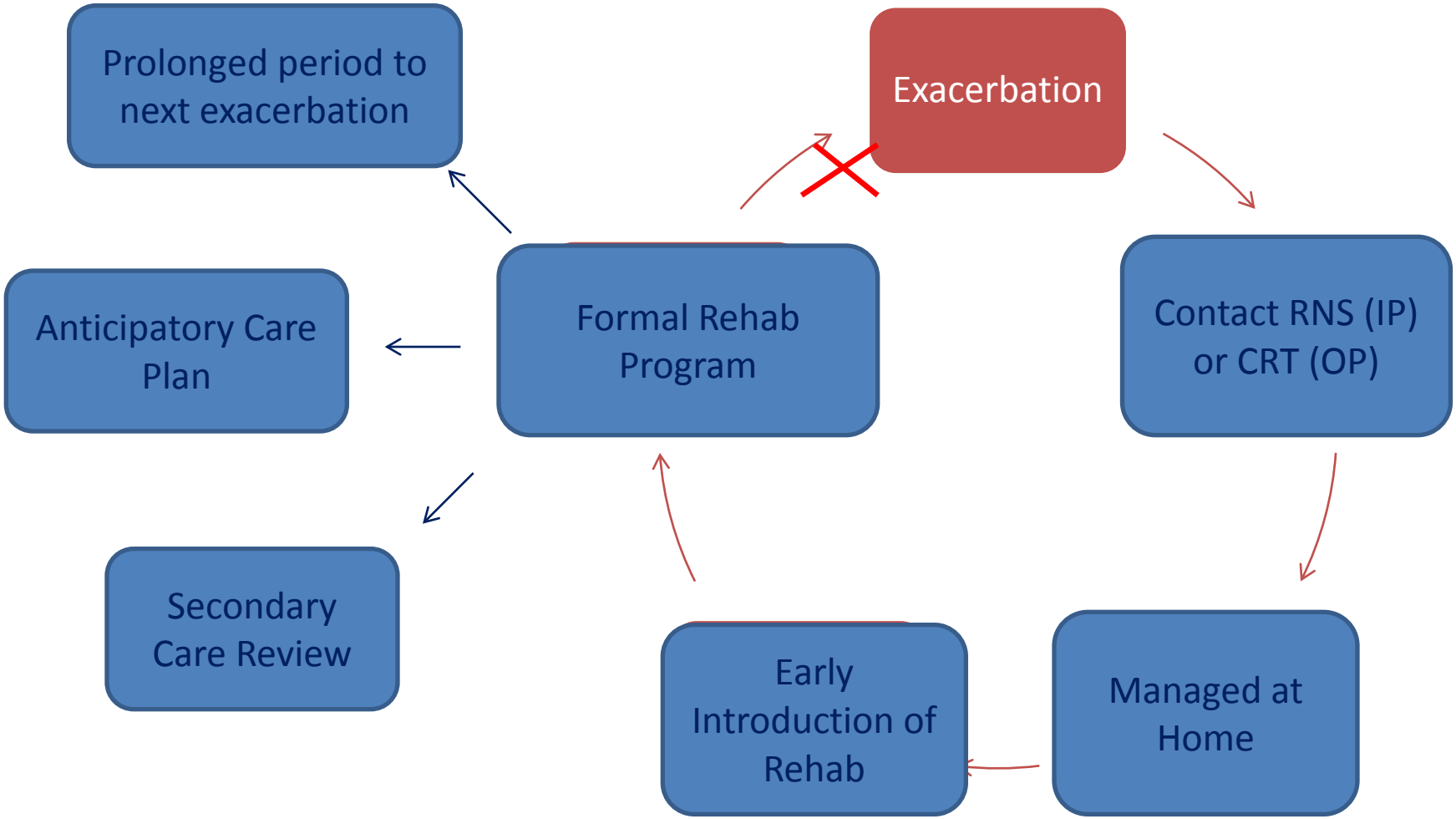
GG+C COPD (J40-44) Bed Days Change from 2013



	2013	2014	2015	2016	2017
CRT	23877	21488	22104	23741	21624
Non CRT	10709	10121	11289	11184	11006

1.0 WTE Band 7	Team Lead/ Physiotherapist
7.0 WTE Band 6	Physiotherapists
3.0 WTE Band 6	Respiratory Nurses
1.4 WTE Band 7	Pharmacist
1.0 WTE Band 6	Occupational Therapist
0.5 WTE Band 5	Occupational Therapist
1.0 WTE Band 6	Dietician
1.5 WTE Band 3	Rehab Support
1.0 WTE Band 3	Team Secretary
0.05 WTE	Resp Consultant

Integration of Services



Multidisciplinary Advanced Clinical Practice

Vision
To enable a skilled and knowledgeable Advanced Clinical Practice workforce to be used effectively to enhance the capacity of the existing health workforce to ensure a quality service for patients, now and in the future

Drivers

- Increased service and workforce demand
  Medical workforce shortages
- *AHP led clinics, improve pt journey, reduced/appropriate prescribing, non pharma Rx.*
- To reduce or avoidance of A&E admission
  - Tier 4 AHP review, Rx, D/C, support, refer
- To enable care closer to home
  - *Community Respiratory Team*
- 24/7 services,
  flexible working, extended services

Consider Allied Health Professionals

11,154 AHPs in Scotland – 8% of total 140,000 workforce

Lowest vacancy rate - 3.9%(7.4% Dr, 4.5% Nurse)

Third largest workforce in NHS

Assess, diagnose, treat and discharge

Independent practitioners

Advanced practice specialist and generalist skills

Prevention / improving health and wellbeing

Non pharmacological means in conjunction with traditional approach

Workforce transformation is key for sustainable service models.

Upskilling / utilising existing workforce

Future workforce models with new roles to be developed.

Invest in training to save

GLs and evidence supporting AHP management to favourably influence outcomes in bronchiectasis(1), asthma(2), chronic cough(3).

Triage patients to AHP led clinics – advanced practice skills, training & knowledge – equal or better effectiveness

Increase consultant NP/return appointments – more complex cases

Cost saving – suggested £240 per consultant slot v's £55 advanced practice AHP

Save 2 weeks of in pt bed – bronchiectasis – IV antibiotics - → CRT.

Community clinics – AHP led – bronchiectasis, breathlessness, VCD etc

1. Guidelines for non CF bronchiectasis (2010) Thorax; 65:1.
2. Physiotherapy breathing retraining for asthma: a randomised controlled trial. Bruton A et al. Lancet Respir Med 2018;6:19-28.
3. Physiotherapy, and speech and language therapy intervention for patients with chronic refractory cough: a multicentre randomised control trial. Chamberlain Mitchell SAF et al. et al. Thorax 2016;0:1–8.

Examples of Respiratory Physiotherapy led clinics

- Physiotherapy led bronchiectasis clinic - Lancashire
- - Patients triaged from HRCT to clinic
- - Complete case management with advanced practice skills
- Chronic cough clinic – Lancashire, Ipswich, London
- - Patients triaged from referral
- - Advanced practice skills allows for investigation referral and Rx
- Difficult asthma and breathlessness clinic – Manchester, London, Lancashire
- Physiotherapy led NIV, long term ventilation and complex airways service. In conjunction with SLT - Lancashirea

Speech and Language Therapy role in Respiratory Services

- Key role in assessment and management or oro-pharyngeal dysphagia
- SLT-led VF clinics per week (NMR status under IR(ME)R) (14% referrals from Respiratory)
- Chronic cough and vocal cord dysfunction
- Complex airway management
- Lung cancer
- Growing body of peer-reviewed evidence

Examples of SLT impact in practice

- Identification and management of dysphagia in lung cancer (Guy's and St Thomas')
- Dysphagia and COPD (Yorkshire)
- Vocal cord dysfunction in complex airway management (Lancashire)

Pharmacy Intervention

- Domiciliary pharmacy intervention in end stage COPD
- Review compliance, inhaler technique, drug interactions
- Ensure adherence to guidelines / phenotyping of patients
- Compared to control reduced
  - Admissions by 28%
  - Exacerbations by 33%
  - Antibiotic Use by 40%

A Cross System Approach to Respiratory Care Discussion Points

- Multiple Respiratory conditions which benefit from MDT approach-
  - COPD, Lung Cancer, Asthma, Non-CF Bronchiectasis, Chronic cough
- Role of Cross System approach for Prehabilitation in patients for surgical intervention (eg ENT, lung cancer, AAA repair)
- Role of Cross Speciality working- breathless clinics, cough clinics

- 57 yr old female
- Exertional chest pain and SOB
- Referral from Cardio, symptoms for 10yrs- Ix at ANO
- Multiple meds with SEs
- 4 x Cardio clinic appointments last 2 yrs
- 1 x A+E
- Echo, ETT, thallium, CT Coronary Angio, 24 hr tape, 24 hour BP, PFTs, HRCT
- Referred Resp-
- CPET- impaired ventilation- Physiology led test

- 57 yr old female
- 3 physiotherapy sessions
- Able to cycle from Glasgow to Edinburgh
- Stopped all medications

Moving **Forward** Together.

The Future of Surgical Services

Prof CJ McKay: North
Mr M McKirdy: Clyde
Mr K Qureshi: South

"GGC" provision of General Surgery 1995

Sub-Speciality	No of Sites
Pancreatic	4
Oesophagogastric	7
Acute sites	8

A POLICY FRAMEWORK FOR COMMISSIONING CANCER SERVICES

A REPORT BY THE EXPERT ADVISORY GROUP ON CANCER TO THE CHIEF MEDICAL OFFICERS OF ENGLAND AND WALES

"GGC" provision of General Surgery 2015

Sub-Speciality	No of Sites
Pancreatic	1
Oesophagogastric	1
Acute sites	5

GREATER GLASGOW NHS
ACUTE SERVICES REVIEW

22ND JULY 2005

Vascular Surgery	• Single site, colocation with A&E and renal services **New SGH**
General Surgery	• Colorectal surgery - collocate with major A&E services, large volume, two sites. **New GRI and SGH** • Upper GI surgery - major resections, low volumes, specialist equipment, collocate with major A&E single site. **New GRI**

Future of Surgical Services

- Increased demand from region for **regional specialist services**
- Increasing complexity
- Networks rather than hub and spoke
- Need to maintain local services
- Evidence based care/realistic medicine
- Different models of emergency care

Tier A Scheduled Care

TIER A
7 day access
Regional service for OG, HPB, rare and complex cancers
Full range of complex elective surgery and medicine
Full range of support services, ITU/HDU
24/7 interventional radiology
On site laboratory services
Research infrastructure

Scheduled care for general surgery

Tier A surgery

- Complex cancer (and benign) surgery
- HPB, oesophagogastric, sarcoma, lower third rectal cancer

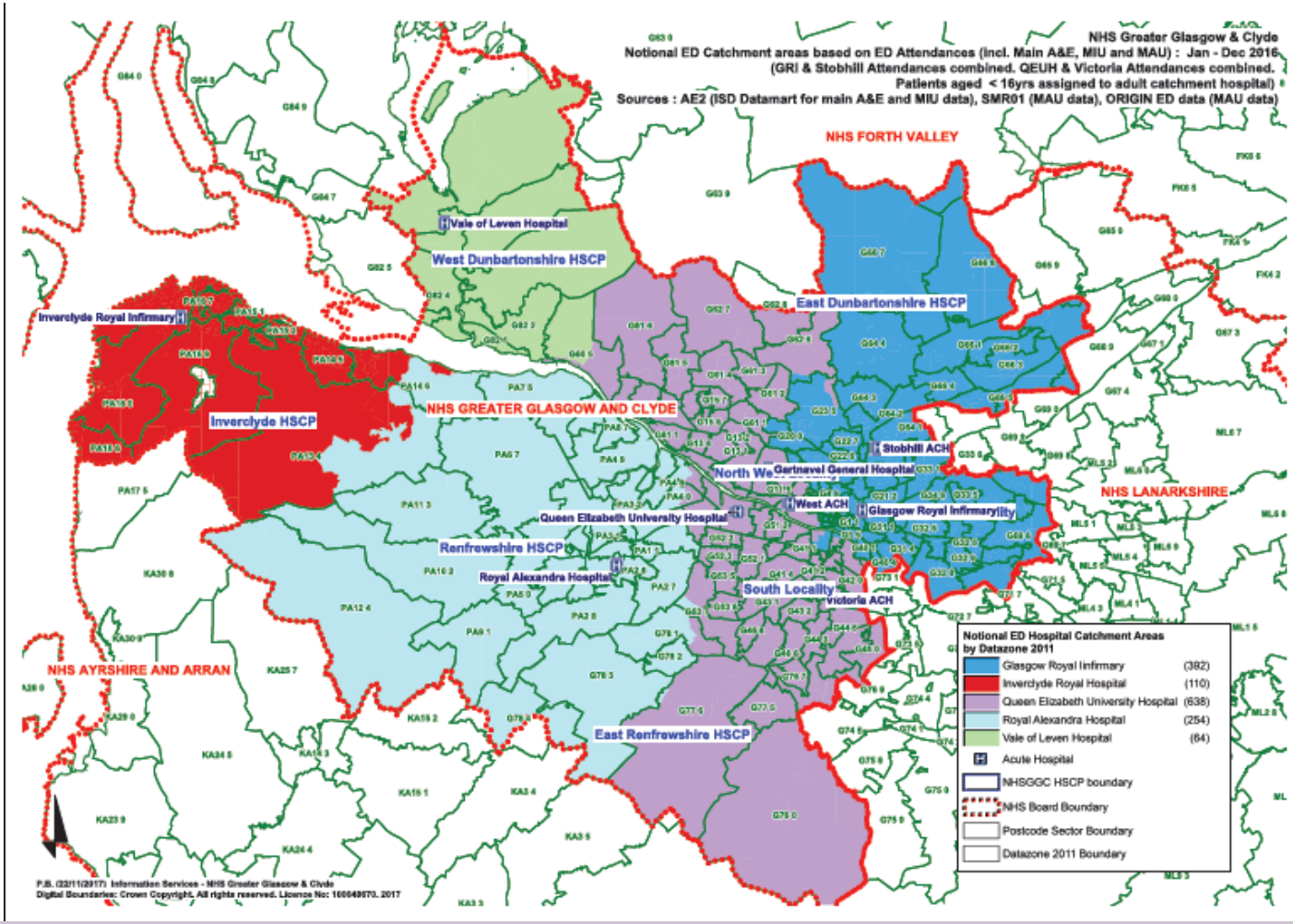
Tier B surgery

- All intermediate surgery (laparoscopic surgery, most colon cancer)
- Tier C cases that need possible HDU support

Tier C surgery

- Short stay surgery, most laparoscopic surgery, minor surgery
- Potential for some bariatric surgery, antireflux surgery

WoS Tier B Scheduled Care Network



Tier C scheduled care

Increase utilisation of ACH facilities

- Resource
  - Overnight and weekend cover - ?SNP role
- Attitudes
  - BMI restrictions
  - Availability of airway support
  - Management of deteriorating patient
  - Transfer arrangements

Unscheduled care: General surgery

- No general surgery specifically requires Tier 1 care
- Tier 2 care appropriate for emergency general surgery.
- Some patients may require specialist transfer
- Tier 3: Role in ambulatory care models
- Tier 4: No role seen in emergency care

Specialist support to front door – early involvement of senior decision makers

- GP access for discussion/early review with surgical team
- Ambulatory pathways
  - Abscess
  - Dysphagia
  - Obstructive jaundice
  - Rectal bleeding
  - RIF pain
- Hot clinics
- IMAGING

Breast Diagnostic Clinics

- High volume of referral
- Diagnostic team in one stop clinics
- Complex episode
- Specialised radiology
- Provision can be in any tier
- Efficient to focus demand and resource
  - Supported by patient engagement

Breast Cancer Surgery

- 85% day cases
- Tier C ideal except:
  - oncoplastic procedures
  - comorbidities
- 2015 lesson:
  - RAH only facility in GG&C for impalpable cancer patient with comorbidities

UROLOGY

- Not all hospitals need to deliver ALL aspects of urological care
- Rationalisation of urological services will improve outcomes and efficiency
- Complex surgery = centralised/regionalised
- WoS robotic prostatectomy service has succeeded in delivering a regional service at the QEUH

Scheduled care for urology

Tier A

RPLND and complex renal surgery [40 cases/year]

Tier B

All other major urological surgery

Tier C cases that need possible HDU support

Tier C

The majority of urological elective cases [80%]

Tier D

CNS/Consultant led diagnostic services

Unscheduled care for urology

Tier 1

No requirement for urology

Tier 2

The majority of emergency urology

Tier 3

Hot clinics

Tier 4

Catheter related issues

Moving **Forward** Together.

Table Discussion Three

Table Discussion Three

- What lessons can we learn from the experience in respiratory medicine and how could the approach taken in other services?
- What would it take to deliver these approaches on a system wide basis?
- How do we balance the increasing sub specialist nature of complex surgery with local access?

Moving **Forward** Together.

Closing Remarks

Jane Grant
NHSGGC Chief Executive

Outcome from today

- Come together as a whole system across health and social care
- Plan for our population – WOS and GGC together
- Challenge ourselves to describe and then implement whole system transformation
- Harness innovation
- Seek ideas from, and listen to, our staff
- Enhance current and build new partnerships
- Seek opinion from our service users, patients and carers
- Imagine, and begin to design, an improved health and social care system optimised for safe, effective, person centred and sustainable care to meet the current and future needs of our population