

NHS Greater Glasgow and Clyde	Paper No. 24/101
Meeting:	NHSGGC Board Meeting
Meeting Date:	27th August 2024
Title:	'Moving Forward Together' - Clinical Vision and Roadmap
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Report Author:	Claire MacArthur, Director of Planning

1. Purpose

The purpose of the attached paper is to:

- Share our 'Clinical Vision' and 'Clinical Roadmap' which have been developed to set out the next key steps in the Implementation of our 'Moving Forward Together' clinical strategy
- Highlight the significant engagement with staff, patients and the public including feedback from more than 5,000 people
- Share feedback on the recent public, patient and staff engagement we have undertaken to seek views and specific feedback on the 'Clinical Vision' and 'Clinical Roadmap'
- Seek Board support and approval of the 'Clinical Vision' and 'Clinical Roadmap' to support the next steps of the implementation of our 'Moving Forward Together' Clinical Strategy.

2. Executive Summary

The paper can be summarised as follows:

In 2018 NHS Greater Glasgow & Clyde published its Clinical Strategy which is described in the '**Moving Forward Together**' blueprint.

Significant clinical and public engagement contributed to the development of our strategy.

The key driver of the strategy is to achieve transformational change in services by creating:

- Less dependency on hospital beds by developing services in communities and a meaningful shift to prevention
- A tiered model of care with specialist centres and provision of the majority of care in homes and communities
- Whole system working – primary care, mental health services, secondary care and community care

BOARD OFFICIAL

Post covid the strategy was reviewed, and further staff engagement took place between June 2022 and April 2024 with over 700 staff to ensure the strategy was still relevant and applicable post covid. The feedback was the strategy remained highly relevant and is key to the delivery of sustainable and high-quality person-centred healthcare.

Developing the Clinical Vision

Our vision for a transformed healthcare system is one of inclusivity, innovation, and empowerment. By embracing preventive and self-care, leveraging technology, ensuring equitable access, and prioritising patient-centred approaches, we will develop a community where health is a shared responsibility and where care is available when needed, by the right team and in the right place.

The clinical vision was developed in support of the clinical roadmap and sets out the key elements of the 2025 healthcare Vision in one page, focusing on:

- Empowerment of patients
- A digital first approach in support of wider digital transformation
- Early Intervention
- Transforming urgent care
- Protecting planned care

Developing the Clinical Roadmap

A clinical roadmap has been developed to support the implementation of the strategy. The clinical roadmap sets out the high key deliverables for each of the three planning horizons of:

- Horizon 1 - 0 to 2 years – developing innovative and emerging opportunities
- Horizon 2 - 2 to 5 years – implementing Innovative and Emerging Opportunities
- Horizon 3 - 5 + years – transformational change building on Horizon 2 and future opportunities.

The clinical roadmap provides a summary overview of the immediate priorities and transformational themes we wish to deliver through the clinical strategy in the following key areas:

- Primary and Community Care
- Urgent and Unscheduled Care
- Mental Health
- Cancer Care
- Planned Care
- Maternity Services

The delivery of the roadmap changes will be supported by strong digital foundations through the implementation of our digital strategy along-side our workforce strategy.

Engagement to Date

Appendix C provides a report which focuses on the specific engagement work undertaken over the last six months. This is built upon previous engagement carried out over several years capturing feedback and insights from over 5,000 patients, service users and members of the public.

This included work to inform several core strategies including Maternity and Neonatal, Primary Care, Mental Health and the Quality Strategy.

Phase one of the current engagement commenced in March 2024 and included five in-depth focus group sessions and focused on testing public understanding and perceptions of key areas including: self-management, community-based approaches, use of technology and resource allocation.

The second phase, delivered in July and August 2024, aimed to test public opinion on the 2035 Healthcare Vision and Clinical Roadmap with activities including:

- **Public Survey:** A survey was conducted during July and August 2024, gathering feedback from 285 respondents. This survey aimed to gauge public opinion on the key principles of the 2035 Healthcare Vision and their alignment with the roadmap.
- **Focus Group Sessions:** Three targeted focus group sessions were held with 45 participants attending these sessions. Each session was led by the Deputy Medical Directors and organised around a specific work stream of the MFT strategy including: Primary and Community Care, Urgent Care, and Planned Care.
- **Social Media:** In addition to the surveys and focus groups, a social media campaign was undertaken to gather feedback from a broader audience. This helped in capturing diverse opinions and ensuring wider public participation.

Overall, the feedback has been incredibly positive with 90% of respondents in support of the proposed vision and wide-ranging support for key priorities.

Appendix C provides an overview of the more detailed feedback received from the public, patients and staff who engaged with us.

Between June 2022 and April 2024 over 700 staff participated in workshops and events to inform the development of the clinical vision and roadmap. This included discussion and engagement with the Area Partnership Forum.

In addition, further staff engagement on our clinical vision and roadmap is ongoing – during July, August and September the Director of Planning and the Corporate Deputy Medical Director will attend a wide range of existing staff groups, meetings and forums to engage with more staff and seek further and ongoing feedback.

Engagement with patients the wider public and our staff will be ongoing, as we develop tests of change and start to implement key elements of our MFT strategy we will undertake further patient, public and staff engagement to seek their feedback and ensure their involvement.

3. Recommendations

The Board are asked to consider the following recommendations:

The Board are asked to discuss, support and approve the MFT clinical vision and clinical roadmap, noting the recent very positive feedback and support from the additional public, patient and staff engagement undertaken in July and August.

4. Response Required

This paper is presented for **approval**.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- Better Health Positive impact
- Better Care Positive impact
- Better Value Positive impact
- Better Workplace Positive impact
- Equality & Diversity Positive impact
- Environment Positive impact

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity:

- Public, patient and staff online workshops on 29th July 2024, 6th August 2024 & 15th August 2024
- Public online survey – undertaken during July and August 2024
- Social Media Communication – July & August 2024
- Staff Engagement – during July, August and ongoing into September 2024

7. Governance Route

This paper has been previously considered by the following groups as part of its development:

- MFT Programme Board – March 2024
- Corporate Management Team – April 2024
- The clinical vision was presented at the Finance Performance and Planning Committee in April 2024.

8. Date Prepared & Issued

Paper prepared on: 15th August 2024

Paper issued on: 20th August 2024

Appendices:

Appendix A - Clinical Vision

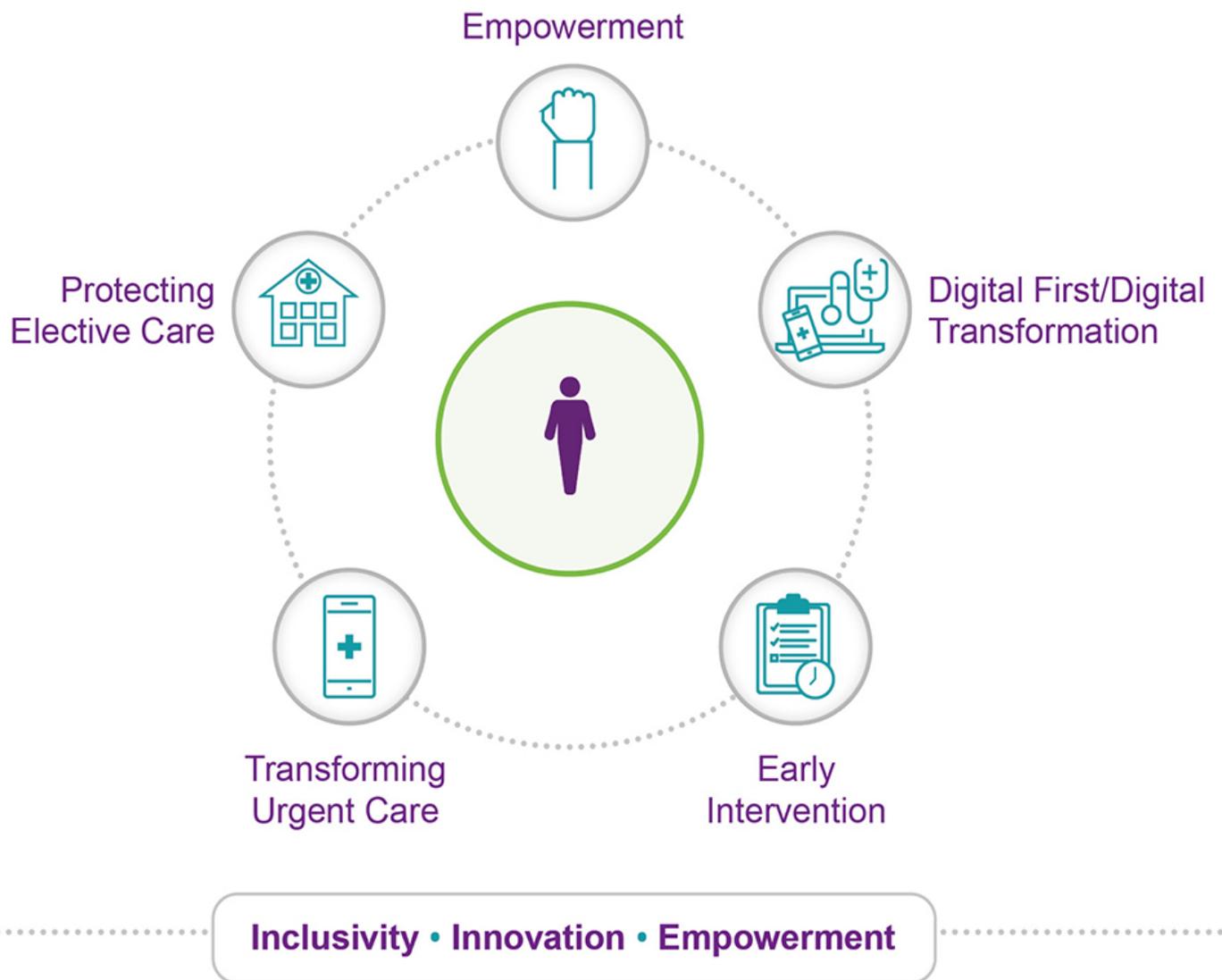
Appendix B - Clinical Roadmap

Appendix C - Summary of Public Engagement Feedback

Moving Forward Together.

NHSGGC Clinical Vision

2035 Healthcare Vision



2035 Healthcare Vision

The 2035 vision for our healthcare system is to provide person centred care, at the right time, in the right place through:

Empowerment

- Promotion of self-management and empowering people to be more involved in their own health and wellbeing, increasing awareness and knowledge of how and where to access care and advice.
- Delivering more care within our local communities with a focus on early intervention and support. We will expand our community care networks e.g. professional to professional clinical advice networks and support services, our hospital at home service and the Maximising Independence Programme. This will enable us to:
 - Increase the number of patients who can be supported to remain at home and avoid unnecessary hospital admissions
 - Increase the proportion of patient who access same day ambulatory urgent care who can then be discharged home same day with the right support
 - Reduce patients in delay through discharging patients into a supportive community environment, freeing hospital beds and reducing the risks from protracted hospital stay.

Digital First / Digital Transformation

- Further deployment of community and primary care digital solutions including asynchronous consultation, the use of wearable devices and remote monitoring technologies to support empowerment of patients to actively participate in managing their own health and maximise their independence.
- Increase the proportion of virtual patient consultations. Utilising predictive analytics will enable us to offer personalised and targeted proactive interventions. This will not only enhance the patient experience but also optimise our resource allocation, helping to reduce health inequalities.

Early Intervention

- Implementing the 'Making Every Contact Count' (MECC) initiative to increase opportunities to tackle mental and physical well-being will be taken at the earliest stage, this will help lead to early identification of mental health issues, brief intervention or effectively signposting the patient to the most appropriate community mental health service. This will be supported by the development of Primary Care Mental Health and Wellbeing hubs to increase primary care and mental health system capacity to deliver integrated responses to promote good mental health. By improving access to the right support and treatment at the right time existing demands on the wider system will reduce.

Transforming Urgent Care

- Providing immediate access to urgent advice or urgent care through a "digital front door". Emergency care will be provided in the right place at the right time, whether that is by supported self-management, primary care, community providers or in our acute hospitals. Only those who require to do so will attend our Emergency Departments, eliminating delays and optimising emergency care for our most urgent patients.

Protecting Planned (Elective) Care

- A 'tiered model' for acute hospital care will support the centralisation of complex specialist hospital care (supporting GGC patients and beyond), supported by both local hospital inpatient provision and elective surgical hubs. This will enable us to make full use of our state of the art facilities to maximise short stay surgery capacity support optimal use of resources and improving patient access.

Our vision for a transformed healthcare system is one of inclusivity, innovation, and empowerment. By embracing preventive and self-care, leveraging technology, ensuring equitable access, and prioritising patient-centred approaches, we will develop a community where health is a shared responsibility and where care is available when needed, by the right team and in the right place.

Moving Forward Together.



Clinical Road Map

August 2024

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1. Introduction

Background

In 2018, NHS Greater Glasgow & Clyde (NHSGGC) published a vision for its Clinical Strategy within the ‘Moving Forward Together’ (MFT) blueprint. This was based on the principles set out in Figure 1.

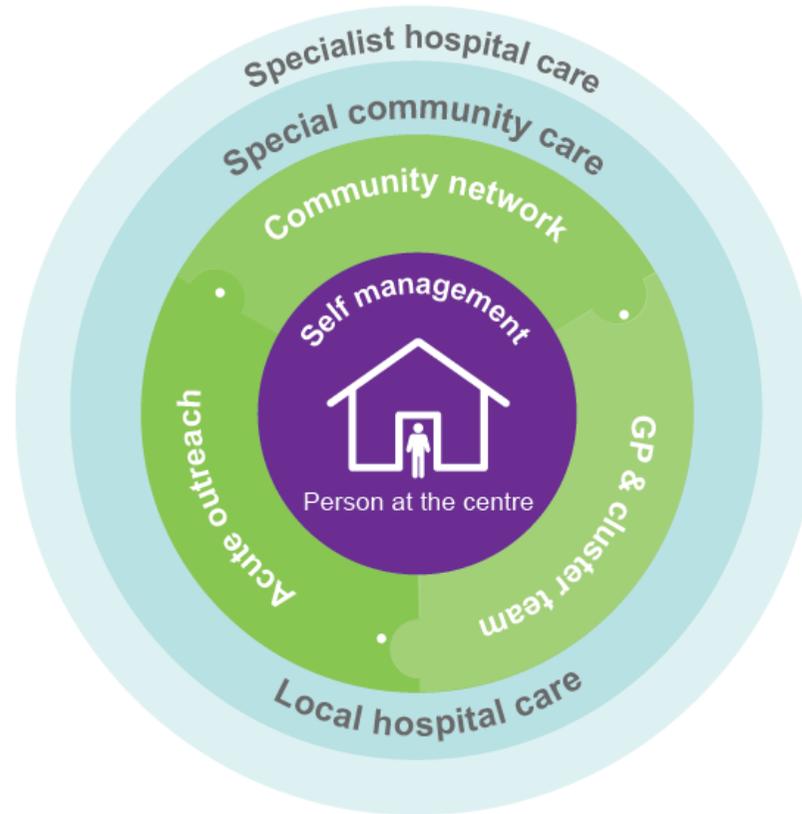
Figure 1: MFT Principles



Our MFT vision describes a whole system approach in which services are delivered by a network of integrated teams across primary, community, specialist, and acute care. Where possible, care is delivered in, or close to, home with provision of both local hospital care and specialist hospital care.

This tiered model of care, set out in Figure 2, puts people at the centre, promoting self-management and empowering our population to be more involved in their own health and wellbeing, and make better informed decisions relating to their own care.

Figure 2: MFT Tiered Model of Care



Our vision is that support is available where needed, through the primary and community networks, supported by acute outreach, focussing on early intervention and on supporting prevention of ill health.

Successful implementation will create less dependency on hospital beds and provide greater opportunity for clinical innovation and adoption of emerging technologies. This will ultimately allow NHSGGC to modernise its infrastructure, retire buildings which are no longer fit for purpose, and provide dynamic, flexible facilities that can support forecast future demand.

The MFT Implementation Strategy aims to set out how NHSGGC will deliver on this vision, while promoting and expanding upon the many examples of good work across our services and geographies. A whole system demand and capacity model and a population needs assessment will be developed to support our proposed transformation. This will provide forecast demand for clinical spaces from each service while improving health outcomes and patient experience.

Alignment to NHS GGC Corporate Objectives and Operational Priorities

The Clinical Vision and Roadmap are closest aligned to the Board's corporate objective of delivering 'Better Care and Improving Individual Experience of Care'. Implementing the Moving Forward Together Clinical Strategy is one of the 2024/25 key corporate objectives to drive service improvement and redesign in support of delivering better care for our patients.

Intended Audience

This Clinical Roadmap is for our patients, their families and the wider public, our staff and NHSGGC and key partner/provider organisations.

Specifically, the document is intended to support:

- Understanding the Health Board-wide and system level thinking that is driving the overall MFT Clinical Strategy
- Developing and implementing new models of care/care pathways that align to the overarching NHSGGC vision and objectives of MFT.

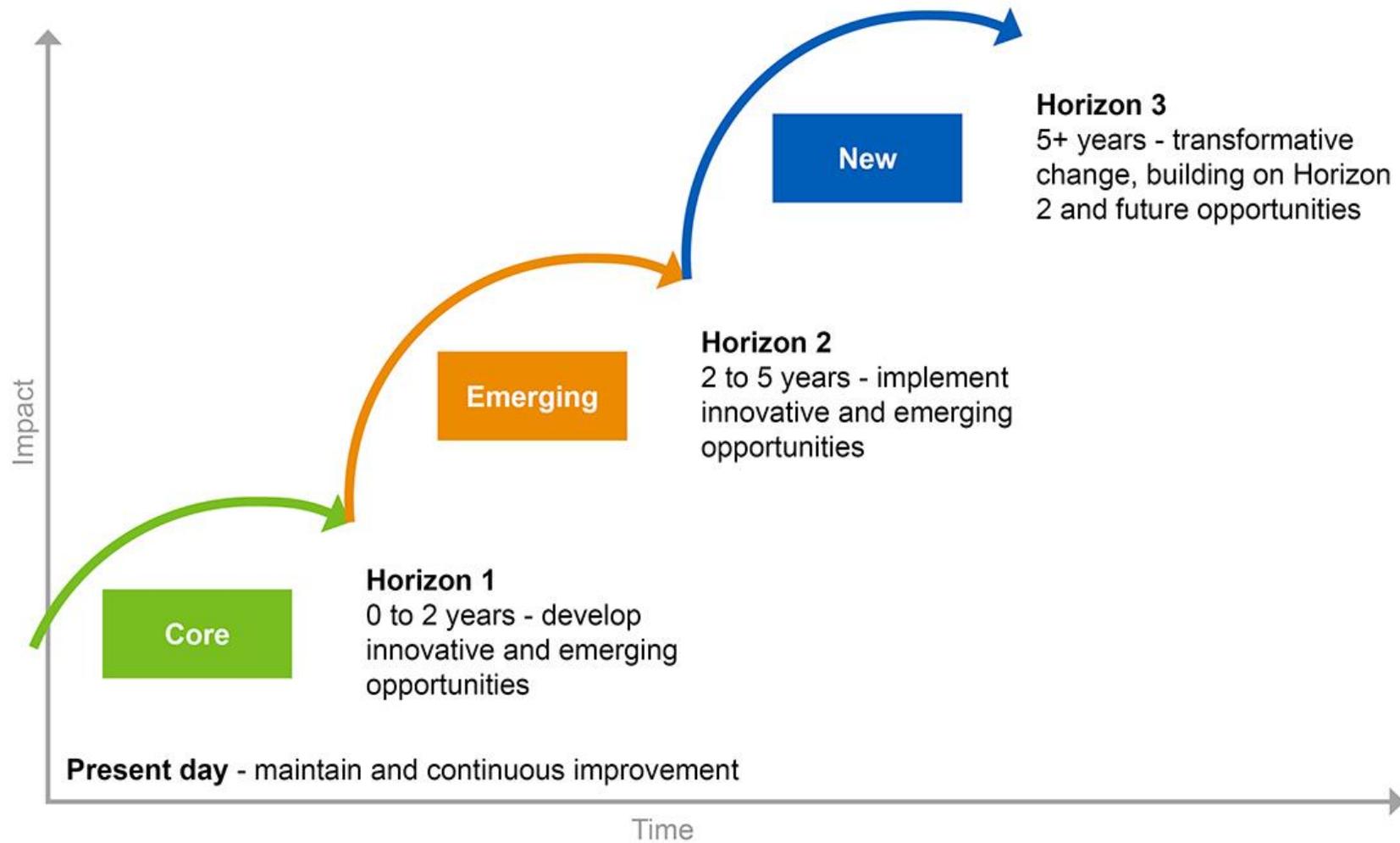
Target Operating Models

A Target Operating Model (TOM) is a tool used to describe how operational activity should flow to achieve transformation. For each service group, we have developed a TOM to describe the patient journey through the service and the actions required to support and effectively direct them. A TOM reflects the future 'ideal state.' To implement it effectively, interventions must take place to transform from the current position, with improvement being implemented over a number of years or time horizons, shown in Figure 3.

TOMs have been developed based upon the MFT Blueprint. The TOMs have been enhanced through the engagement and contributions from NHSGGC clinical and non-clinical teams. Lessons learned from the COVID pandemic and best practice, nationally and internationally, have informed their development.

This Clinical Roadmap presents each service group's TOM, along with a discussion of why change is needed, what the 'current state' of the service is and the vision for change over the short, medium and longer term.

Figure 3: The Three Horizons (Adapted from McKinsey and Co)



2. Primary and Community Care

Where We Are Now

It is estimated that up to 90% of health care episodes start and finish in primary and community care and more than 93% of all clinical contacts occur in primary and community care settings.

Primary and Community care is made up of multiple professions working within communities. Four independent contractor groups; General Practice, Community Pharmacy, Community Dentists, and Community Optometrists each provide direct access for their patients. These are supported by other professionals including community nursing, Allied Health Professional (AHPs) and mental health workers in addition to social care and third sector colleagues. The primary care workforce are 'super-connectors,' reaching across boundaries into communities, at the start of their journey, and spanning systems to support patients and have driven multiple developments improving population health.

Current care is both reactive and preventative, the vision is to ensure care has an increased focus on early intervention and promotion of wellbeing. It can be difficult for our service users to know who best to contact for advice or care and rapid access to primary care is not always as easy as it should be.

Some of our primary care is delivered from an ageing infrastructure of small practices without the space necessary for developing a multi-agency and multi-professional approach to care provision.

Our Future Vision

Our vision is to meet the need for sustainable, safe, and accessible services which deliver care 'closer to home.' It places health improvement and prevention at the core of every health and social care interaction, system wide. Embedding prevention in planned and unplanned care pathways which fully integrate the system will contribute to tackling health inequalities and support appropriate use of all services.

This vision challenges us to think differently and embed community-centred ways of working and communicating, to improve population health.

We will empower our population to take responsibility for their health and well-being, to be supported in self-management where appropriate and to seek help from the right care service when needed.

We will also make full use of emerging technology, including virtual consultations and the use of wearable devices to monitor chronic illness in the community within our available resources.

We will need to provide a more integrated service with the full range of community services, mental health services and secondary care. Primary care and community services will continue to play an important and growing role in unscheduled and urgent care.

The key themes for primary and community care are:

- A more integrated approach to care delivery
- Support sustainable unscheduled and urgent care
- Mobilisation of the multi-agency network to support community care
- Infrastructure development – Community Hubs e.g. Parkhead Hub
- Maximising independence

A More Integrated Approach to Care Delivery

Community and primary care multidisciplinary teams (MDTs), which include GPs (General Practitioners), often have unique insight to the opportunities and challenges within their localities. The development of MDTs in General Practice following the introduction of the 2018 GP Contract and Primary Care Improvement Plans (PCIPs) has enabled the wider offering of care of patients from various professionals. Their discipline lends to a deeper understanding of the complexities that stem from multi-morbidity and do not view problems through the lens of a single condition (e.g. diabetes).

Accessible primary care services and diagnostic interventions with adequate capacity to meet demand will better support patients to remain in their homes, providing appropriate alternatives to admission. The provision of effective chronic disease management clinics offers opportunities to support patients in self-management resulting in an understanding of how their condition affects their lives, how to cope with their symptoms and how to manage exacerbation in an anticipatory, proactive way. In the future, wearable devices are likely to support community management of chronic illness, as is already being seen with community blood pressure monitoring.

MDTs can yield a range of positive impacts for people and communities, including reductions in frail elderly and people with long term conditions (LTCs) requiring unplanned admissions. They can also provide professional peer support networks which can improve staff well-being and motivation.

MDTs also provide an opportunity to explore centralised programmes of care around long-term conditions so that patients are supported by teams within an agreed programme through a 'one stop shop' approach.

We will work collaboratively to develop effective and efficient whole system pathways to reduce duplication and unnecessary referral. Key to this will be development of digital solutions to enable self-care and sharing of patient information across the wider service in a seamless fashion, e.g. COPD (Chronic obstructive pulmonary disease) support for patients to check and log pulse/saturations with information shared with carers/family/GP practice.

We will support patients with patient-initiated return (PIR) pathways rather than routine follow up. We will develop pathways to support a seamless interface between acute, primary care and community services without the need for additional steps, such as direct access into community services from acute services (and vice versa) without requiring referral through primary care.

For specialties where data is key, data collection will be carried out close to where patients live with data sharing to allow safe decisions to be made remotely. We will encourage the expansion of Near Me to enable patients to access care from home.

When patients experience flares or relapses in conditions, they should be able to access specialist advice quickly and easily without requiring new referrals from their general practitioner, such as with Patient Initiated Follow Up (PIFU). This will be supported by robust information sharing from primary to secondary care so that the specialist teams can view up-to-date records at the point of contact from the patient.

We will build on existing interface services, to improve accessibility for those working across the system.

We will develop an accessible, shared healthcare record integrating information across the digital systems that are being used across our system. This would also include patients seeing their own appointments at GP, community, acute and Mental Health services. Future developments will see app-based services, accessed by patients for care advice (with a link to NHS24) and also accessing their own health record.

Support Sustainable Unscheduled and Urgent Care

NHSGGC is pioneering several improvements to urgent primary care services. The introduction of a new appointments system within its GP out-of-hours (GPOOH) service has enabled us to better manage demand. This organisational change has led to a more sustainable service by reducing patient waiting times, enabling discrete appointments, better supporting those who work in the service and improving access to GPOOH services. Further development of this and the increased adoption of virtual appointments will mean patients can access healthcare without having to travel to an urgent primary care centre or acute facility.

We will work with colleagues across the whole system to develop a comprehensive urgent care service incorporating Emergency Departments (EDs), General Practice, Acute Medicine, as well as AHPs working collectively to manage the urgent care demand. Co-location of services will be explored.

Community Pharmacy has been at the forefront of the development and expansion of the Pharmacy First programme which will give greater options for patients with minor illness. Community Optometry currently provide a wealth of eye care services and this can include urgent assessments with direct referral pathways to acute services. Better signposting and uptake of these services, through patient-facing apps and public messaging, coupled with extending the range of conditions managed through these community services, will see a reduction in referrals through ED's.

Direct access to diagnostics is already in place for certain conditions. For example, primary care already have direct access to Computed Tomography (CT) for suspected lung cancer or to CT of chest abdomen and pelvis for suspected occult malignancy. Further provision of direct access to diagnostic imaging and other tests will need to be explored and delivered within our available resources.

Expansion of social prescribing schemes will enable health and social care professionals to refer people to a range of local, non-clinical services.

We will continue to develop technology-enabled health care, maximising the potential of the digital first approach and continuing to develop the use of “wearables” to support long-term condition management in the community. Whilst the move to more digitally enabled and supported care is welcomed across primary care, these initiatives must be robustly evaluated, considering digital poverty, poor health literacy and those for whom English is not their first language.

These changes will require partnership working within a whole system approach, including all key stakeholders and further embracing and developing more links with the third sector. Engagement with local authorities to influence the factors that impact upon the wider determinants of health (e.g. housing, socio-economic factors) is essential to impact upon future outcomes.

Infrastructure Development – Community Hubs

We will explore the further development of community infrastructure, with a move to community hubs serving populations of 100-150K. This will include reviewing utilisation of existing and planned future community facilities. Multi-use flexible accommodation that is used across longer days and weekends will provide a range of services in the community that currently require attendance at an acute site. We see Community Hubs being used by primary care, acute services, mental health, community and third sector services. This will increase capacity, bring care closer to home and maximise the potential of the wider multidisciplinary team.

End of Life Care and Hospice Care

Our ambition is to provide access to safe, effective, person-centred and person-led palliative care. Providing consistency of access to holistic end of life care across GGC. People, their families and carers will have access to timely and focussed conversations with appropriately skilled professionals to plan their care and access the right support towards the end of life. We will promote the use of Future Care Plans across a wide range of clinical scenarios, including for those approaching the end of life. We will also work with our Health and Social Care Partnership (HSCP) partners, hospices and third sector partners, using their expertise to take forward new and innovative approaches to delivering holistic end of life care in the community to ensure every patients end of life needs are met and any unnecessary hospital admissions are avoided. To deliver this we will work with HSCPs, hospice and third sector partners to develop a strategy for End of Life Care that ensures a holistic approach to care that makes best use of available resources and ensures consistency of allocation of resources across GGC to support all patients and their families. In addition we will work with partners to identify any future funding opportunities.

Rehabilitation, Community-Based Care and Maximising Independence

The medium and long-term vision for social care in NHSGGC is one of empowerment, digital innovation, and strong collaboration between the statutory and third sectors. By investing in community-based care, leveraging digital technologies, and fostering effective partnerships, the anticipated outcome is a more resilient and responsive social care system, which eliminates unnecessary hospital admissions and delayed discharges and which enhances the quality of life for individuals across the country.

Over the medium term, the focus for the social care landscape will be on enabling people to remain living at home safely for as long as possible, with the right support in place for them and their carers. The vision for social care is that people live as independent a life as they can, making choices about the things that matter to them, and live as full a life as possible, accessing support only when they need it.

Through targeted investments in community-based care initiatives, people will gain increased access to preventive and supportive services, reducing the need for hospital admission and subsequent delayed discharges for social care reasons.

Digital technology will play a pivotal role in this transformation. Over the medium term, there will be a concerted effort to maximise the use of digital tools and platforms to streamline communication, coordinate care, and enhance accessibility. For instance, virtual services will become more prevalent, enabling individuals to receive medical consultations and monitoring from the comfort of their homes. Wearable devices and remote monitoring technologies will empower patients to actively participate in managing their health, preventing unnecessary hospital admissions.

Looking to the longer term, the vision for social care in Scotland is to establish a system where people are not only empowered but fully supported at home, allowing individuals to live well and with dignity in their own homes and communities. This will likely involve networks of home-based care services, including home nursing, rehabilitation, and personalised support services. Digital technologies will continue to evolve, with the integration of artificial intelligence, predictive analytics, and smart home solutions to anticipate and address health needs proactively.

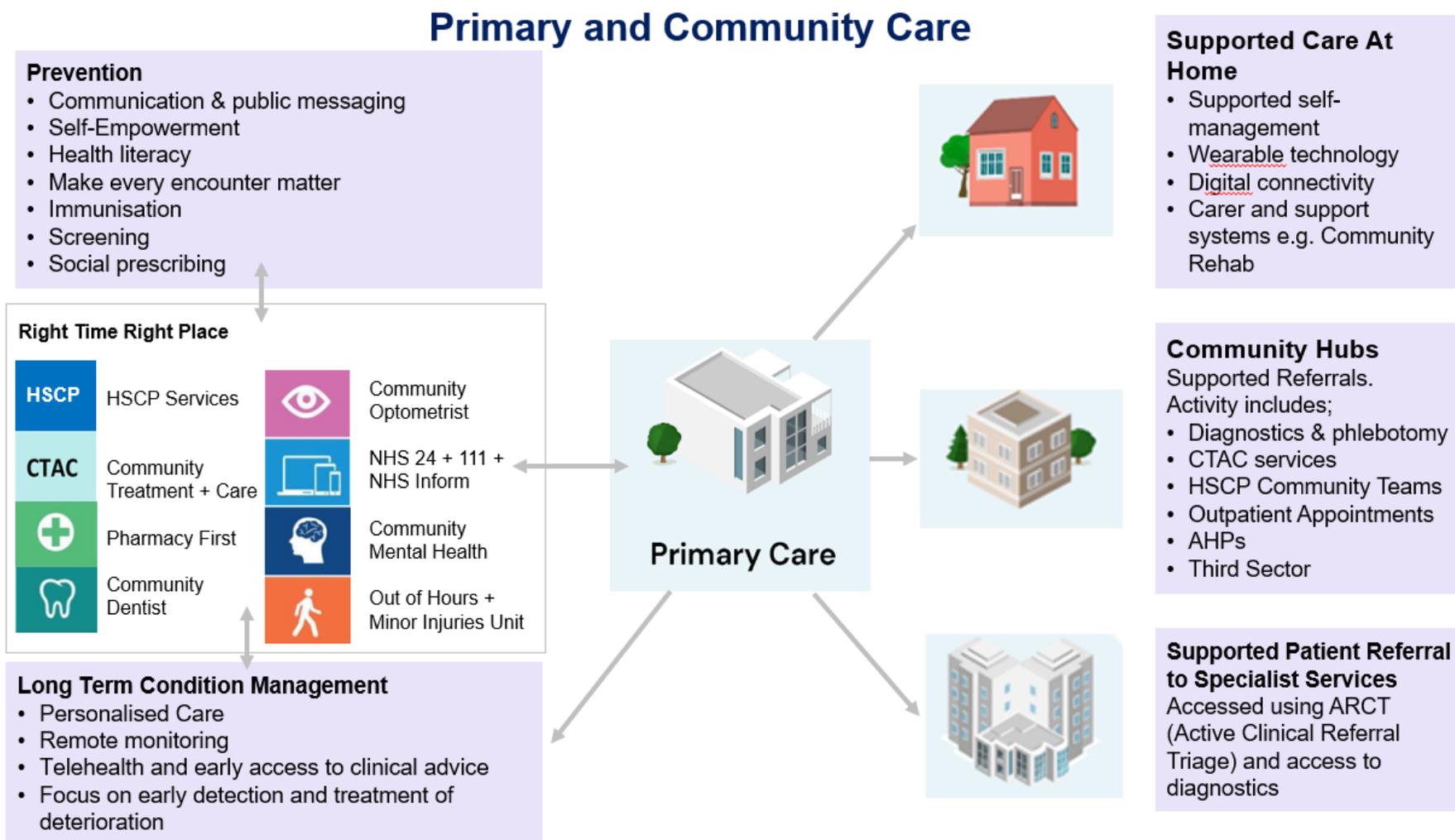
Crucially, the long-term strategy emphasises a robust partnership between the statutory sector and the third sector. Collaborations with community-based organisations, charities, and volunteer groups will enhance the reach and effectiveness of social care initiatives. These partnerships will foster a holistic and person-centred approach, addressing social determinants of health and promoting overall well-being. The third sector will play a vital role in providing additional support services, such as companionship programs, transportation assistance, and community engagement initiatives.

A summary of some examples for each of the three horizons of our proposed plan is set out in Figure 4. It is important to note that all developments will be undertaken within our available resources and we are committed to working with all of our key partners across our whole system including the third sector to ensure the best deployment of our resources and to identify any future funding opportunities.

Figure 4: Summary of Examples for each of the three Horizons within Our Proposed Plan

Horizon 1: 0-2 years	Horizon 2: 3-5 years	Horizon 3: 5 years +
<ul style="list-style-type: none"> • Opening of Parkhead Hub and pilot new ways of delivering care, working with Acute Division and the wider MDT • Greater focus on illness prevention through promotion measures including improved Healthy Literacy • Expand supported care at home, wearable technology and digital connectivity • Improved carer and support networks • Explore improved access to GP out of hour's services, expanding virtual appointments • Scope potential expansion of direct access to diagnostics • IT re-provisioning of primary care 	<ul style="list-style-type: none"> • Continued development of health promotion and illness prevention through social media campaigns, national messaging and influencing of national policy • Development of community services in existing community hubs, making best use of the multidisciplinary team and third sector agencies • Consider further opportunities to provide care closer to home through partnership with local authorities and third sector agencies • Further expansion of remote monitoring, community rehabilitation and hospital at home <p>Development of digital first approach with patient facing apps supporting self-care and signposting to appropriate care provider</p>	<ul style="list-style-type: none"> • Expand community services from existing community hubs, building on lessons learned from Parkhead Hub • Enablement of self-management and increased responsibility for health and well-being • Access to patient facing information, signposting and community services • Integrated services with seamless transition between acute, community and primary care • Develop plans for construction of new community hubs within available capital funding • AI-enabled patient facing apps, expansion of range and utility of wearables to support early warning of deteriorating health and management of chronic conditions, within available resources

Figure 5: Target Operating Model Primary and Community Care



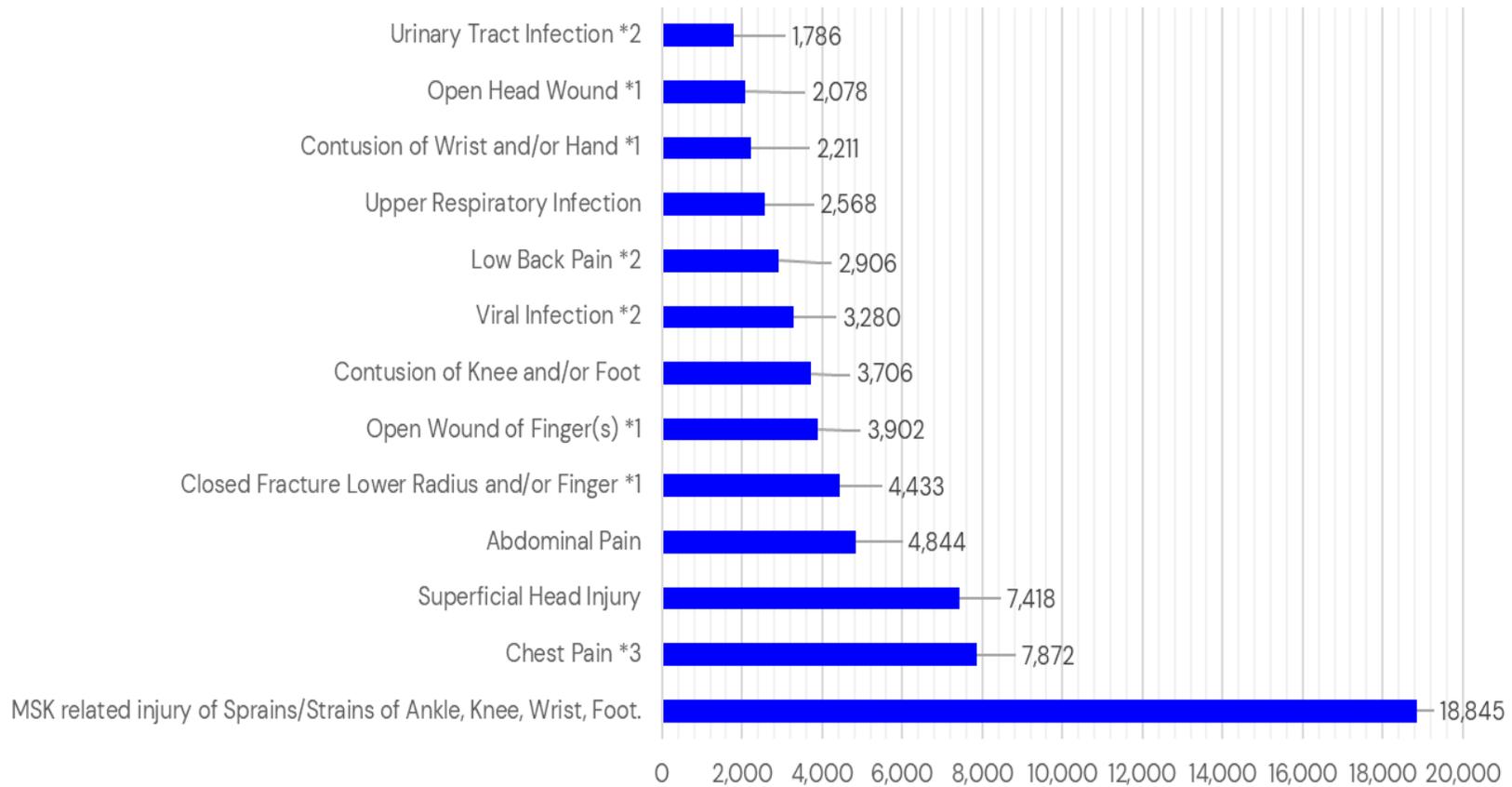
3. Urgent and Unscheduled Care

Where We Are Now

Unscheduled care is any unplanned, urgent, and emergency care provided by healthcare services and can cover a myriad of conditions but refers to care which needs to be provided quickly or in some cases immediately.

NHSGGC has persistent high hospital attendance rates, with the highest rates of emergency care utilisation by GGC's most deprived populations. A key challenge is attendance at hospital where there may have been an appropriate alternative. An analysis of self-presentation modalities and discharge patterns shows that a considerable number of patients could have been safely diverted to a more appropriate treatment location avoiding an acute ED.

Figure 6: ED Top 20 Self Presenters



These factors are compounded by the pressures that emerged from the Covid-19 pandemic, an ageing population, and challenges to workforce across the NHS. Data indicates that many bed days (81%) are occupied by 4 main groups: people with frailty, complex or multiple conditions, mental health issues or people at the end of their life. This indicates that there should be a focus on these cohorts to avoid admission.

The GP Out of Hours service is the largest in Scotland and carries out 3,500 to 4,000 contacts every week. As demographics change, the pressure of this service will need to be carefully managed as part of the wider transformation of urgent and unscheduled care (UUC).

The Flow Navigation Centre (FNC) is now embedded within NHSGGC, and this service navigates people to a variety of treatment locations via a pathway. These defined discharge pathways could be community pharmacy, back to GP, MIU (Minor Injury Units) or ED. It limits the number of touchpoints within the system that the patient must experience creating a streamlined experience.

We have already made significant changes to how urgent care is delivered but we will build on these early successes and develop a truly integrated, whole system approach providing rapid access to the right service at the right time.

Figure 7: Examples of Current Initiatives

Communication and Public Messaging	Ongoing and targeted public messaging campaign to support patients accessing care at the right time in the right place.
Managing Acute Flow & Attendance Avoidance	Direct referrals from NHS24 for patients who would have been directed to, or attended, ED directly. These patients are navigated to a range of services, e.g. MIUs, GP (General Practices), community pharmacy, or ED if required, or managed by the flow navigation centre.
Home First Response Service	This provides a frailty service at the front doors of QEUH (Queen Elizabeth University Hospital) and RAH (Royal Alexandra Hospital). The initiative aims to rapidly assess frail elderly patients within EDs and link with community and rehabilitation services to support patients to return home safely and avoid admission to hospital.
Interface Care Programme	An example of this is the Outpatient Parenteral Antimicrobial Therapy (OPAT) Programme which is comprised of an MDT team of nurses, pharmacists, and infectious disease consultants. The team offers outpatient treatment to some patients with infections who require IV antibiotics either on a short or long-term basis and avoids patient admission to hospital.

Hospital at Home	Our hospital at home service manages some acute conditions, the service is delivered within the patient’s home with the support of community nursing teams. Eligibility for the scheme is through GP referral or patients can be referred from acute care to support early discharge.
Discharge Without Delay	Simplifying the discharge process, optimising flow, and ensuring that there is a planned day of discharge.
Oral Health	Registered patients are encouraged to contact their dental practice when experiencing dental pain and unregistered dental patients are encouraged to call the dental advice helpline during working hours and NHS24 out of hours or at weekends.

Our Future Vision

The future vision for unscheduled care is for a shift towards accessible, patient-centred delivery of care which maximises the potential of technology and clinical innovation to meet the evolving healthcare needs of our population.

The vision incorporates four key themes:

- Virtual/ Digital Front Door - Virtual Consultations & Scheduled Urgent Care
- Rapid Assessment and Care (RAC) Units and Supported Discharge
- Remote Monitoring of Long-term Conditions (LTC)

Virtual / Digital Front Door - Virtual Consultations and Scheduled Urgent Care

The future vision for urgent care is for a shift towards supported self-management, increased community support and options for community-based treatment closer to home, supported by emerging technology and innovation.

We will build on our current developments to integrate further our primary care, mental health and secondary care services so that patients are seen by the right clinician at the right time. We will ensure that our systems communicate so that there is clear visibility of the patient record and that professional-to-professional (P2P) communication is facilitated. We will maximise the use of technology and virtual consultation to enable patients to be managed at home and will expand the availability of community assessment and treatment capacity through the development of community hubs.

NHSGGC's FNC, working with NHS24, accepts direct referrals navigating activity away from acute EDs to a safe and more appropriate location for care or scheduling to a less busy time where appropriate. FNCs are one of the key national changes in the NHS Scotland wide Redesign of Urgent Care Programme. The future vision anticipates significant expansion of this model, leading to a shift from unscheduled care to scheduled urgent care, with a digital first approach. Using lessons learned, we will expand the reach of the Managing Acute Flow in Hospitals scheme and FNC approach to reduce admissions from ED into the main acute hospital.

Rapid Assessment and Care Units and Supported Discharge

We will work towards a position where we have no patients in hospital with discharge delay, both through admission avoidance and through increased supported care in the community and mobilisation of the multi-agency community support network.

We will develop a framework for acute assessment in the community supported by the multi-disciplinary team to support both admission avoidance and triage to the right care provider.

Secondary care will expand ambulatory and immediate assessment capacity so that patients have access to senior decision makers, diagnostics and AHPs to support early discharge through development of the RAC model.

We will ensure we maximise our current Home First Response Service (HFRS) to support rapidly assessing frail elderly patients within EDs and link with community and rehabilitation services to support patients to return home safely and avoid admission to hospital. In the medium term we will look to facilitate the expansion of the HFRS across all of our acute sites.

Community pathways will be further developed such as the Community Integrated Falls Pathway. This initiative enables assessment of falls in the community to avoid unnecessary presentation to ED.

We will explore possibilities to expand the availability of urgent diagnostics to facilitate rapid clinical decision making and early discharge.

Remote monitoring of long-term conditions

A critical success factor is increasing the focus and support for chronic disease management, facilitating shared decision making and future care planning. This allows management of the escalation of conditions in a community setting to support care closer to home, minimising the need for admission to acute hospitals. Better integration between all tiers of care is essential to ensure shared accountability and problem-solving. Whole system pathways must be developed with a key focus on community settings allowing for effective and efficient patient care, including urgent care options for assessments.

Figure 8 sets out a summary of examples for each of the three horizons for our plan for urgent care. It is important to note that all developments will be undertaken within our available resources we are committed to working with all of our key partners across our whole system and with the third sector to ensure the best deployment of our resources and to identify any future funding opportunities.

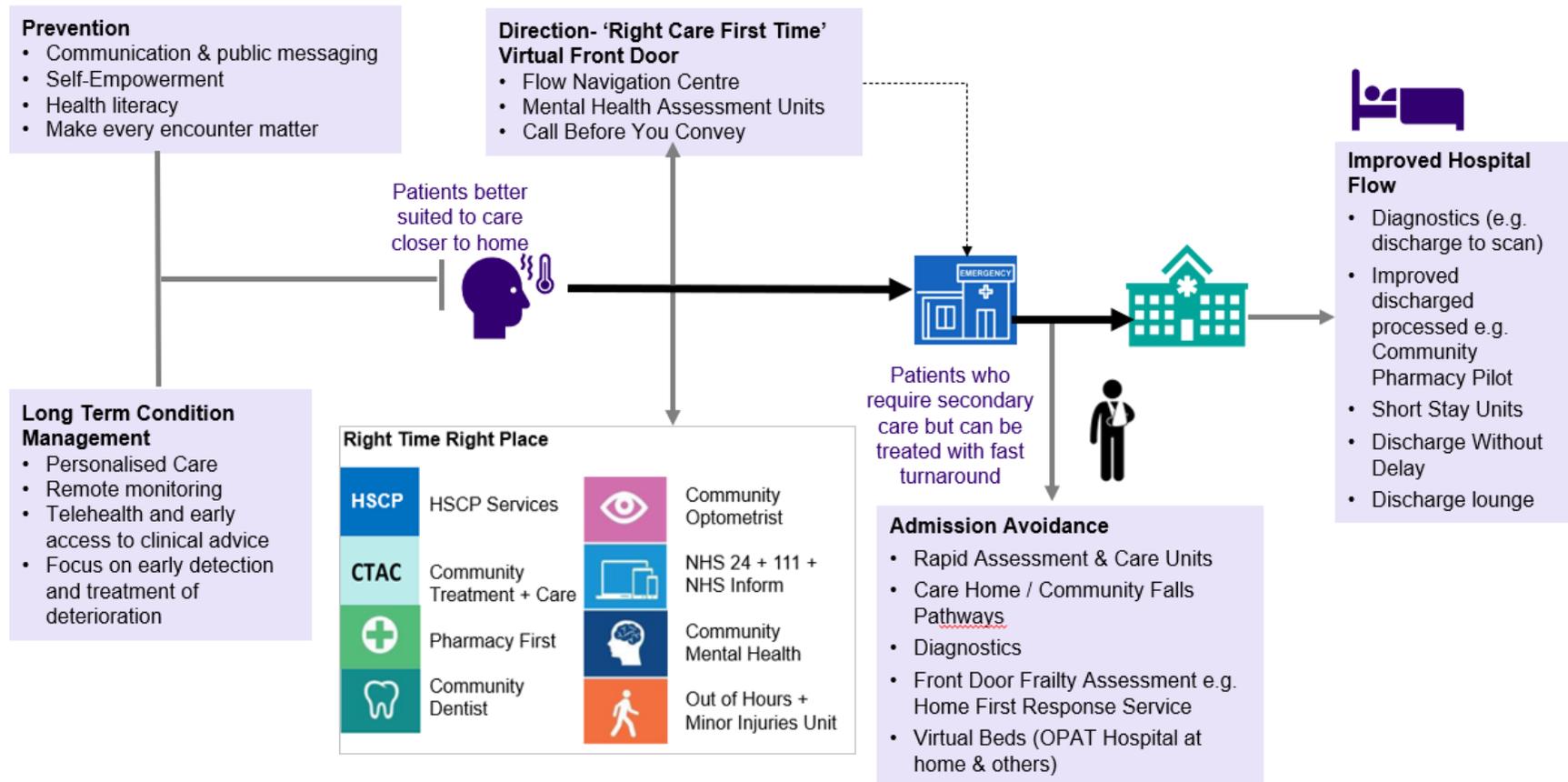
Figure 8: Summary of Examples for each of the three Horizons within Our Proposed Plan

Horizon 1: 0-2 years	Horizon 2: 2-5 years	Horizon 3: 5 years +
<ul style="list-style-type: none"> • Maximise and expand FNC pathways • Expand range of ambulatory care pathways • Implement redirection policy • Develop RAC units with re-modelling of current Acute Assessment Unit (AAU) / Medical Assessment Unit (MAU) footprint • Implement “Call Before You Convey” • Further develop our Interface Care Programme • Explore integration of FNC with GP Out of Hours service and NHS24 pathways • Redevelop mental health pathways and develop/expand Mental Health Assessment Unit (MHAU) provision • Widespread roll-out of Consultant Connect • Enhance use of digital first approach, including patient-facing apps (e.g. NHS24) • Evaluation and future plan for Hospital at Home • Continue to improve “Discharge Without Delay” across acute sites • Work with HSCPs and SG to reduce delayed discharges 	<ul style="list-style-type: none"> • Develop Virtual GGC hub with implementation of fully virtual front door • Increased utilisation of remote monitoring to avoid emergency attendance, shifting towards scheduled urgent management • Further expansion of our Home First Response Service to all acute sites • Expand and develop our virtual bed capacity with corresponding reduction in in-patient beds • Develop community outreach teams to support early discharge and admission avoidance • Community urgent assessment service delivered from primary care hubs 	<ul style="list-style-type: none"> • Utilise emerging AI solutions to support FNC triage • No walk-in attendance for EDs • Network of community-based services supporting urgent care with access to secondary care through FNC or direct access through Consultant Connect • AI-enabled patient-facing advice, signposting to support self-management

The urgent and unscheduled care target operating model is set out in Figure 9.

Figure 9: Target Operating Model Urgent and Unscheduled Care

Urgent and Unscheduled Care



4. Mental Health

Mental Health and Wellbeing is one of the major public health challenges in Scotland. Around one in six people are estimated to be affected by mental illness with no signs of this trend decreasing. The span of services to which individuals connect is broad, from early childhood through to old age, and involving preventative wellbeing strategies to specialist mental health interventions.

Mental Health (MH) issues and distress can have a wide range of causes. It is likely that for many people there is a complicated mix of factors including childhood abuse, trauma, or neglect; social disadvantage, poverty, or debt; homelessness; genetic predisposition and neurodevelopmental vulnerabilities; physical health problems; and drug and alcohol misuse.

Our Future Vision- Implementing the Mental Health Strategy

As part of the MFT strategy, the NHSGGC five-year adult mental health strategy 2018-2023 has now been refreshed, expanding on its scope to take account of the rest of the 'family' of MH services and their associated strategies. This is currently undergoing public engagement. The approach to implementation over the next 5 years includes:

- No wrong door, so any appropriate referral for secondary specialist mental health care will not be sent back to primary care but discussed and progressed between secondary specialists' services (the no wrong door approach will support equity of access and transitions both within MHS and between MH and acute)
- Improved access for situational crisis; and a commitment to more established points of access and clear referral pathways
- Self-management resources for people with long term mental health issues, that are accessible and do not exclude access to services where appropriate
- A focus on inequalities including people with protected characteristics and those affected by the socio-economic determinants of poor health

Prevention, Early Intervention and Health Improvement

A range of organised MH service responses can all contribute to their own versions of prevention, early intervention, and health improvement. It is important to make a distinction between services that promote people's mental health (and prevent mental distress and illness) from community and inpatient services that are organised to respond to people's mental illness when they are referred to secondary care. The relevant services will up-scale MH training and support for all staff in Partnerships and related services. Community planning partners will be supported to develop and implement strategies to address adverse childhood experiences and child poverty within their area. Work with multiple partners will be undertaken to build awareness of practical steps to promoting mental wellbeing and challenging stigma and discrimination with a priority focus on groups with higher risk, marginalised groups, and people with protected characteristics.

The strategy aims to improve assessment and referral pathways to ensure that people with a serious mental illness also have their physical health monitored and managed effectively with no barriers to service access.

There will be an ongoing commitment within MH to a programme of training and development for staff to ensure that opportunities are taken to address patients' physical needs (for example monitoring of diabetes) when engaging with mental health professionals. The implementation of the Making Every Contact Count (MECC) initiative recognises that millions of consultations and contacts occurring each day across the NHS and social care continuum present opportunities to tackle physical and mental wellbeing at the earliest stage. A move away from discipline silos to create a culture where staff, across organisations and departments, are collectively required to ask specific questions during a consultation. This may lead to early identification of mental health issues, brief intervention, or effectively signposting the patient to the most appropriate community mental health service. NHSGGC sees open access referral as a fundamental part of its future mental health service provision.

Primary Care

The traditional healthcare system sees GP practices as the first point of contact for the public for non-urgent physical and mental illness. NHS GGC and HSCPs have been looking to develop Primary Care Mental Health and Wellbeing Hubs to increase primary care and mental health system capacity and deliver integrated responses to promote good mental health. By improving access to the right support and treatment at the right time, existing demands on the wider system will reduce.

Social prescribing is an approach that recognises that there is more to being well than simply experiencing a reduction in symptoms. A meaningful recovery from mental illness requires attending to holistic needs, especially finding security in meaningful relationships, housing, work, and study. Community Links Workers (CLWs), commissioned through primary care and third sector organisations, have been introduced to support GP practices to signpost to community, third sector and voluntary services and supports. They can case manage and/or support patients with very complex needs as part of the practice team. CLWs support patients with non-medical issues associated with loneliness, social isolation, lack of community connectedness and associated social issues as part of 'social prescribing.'

The CLWs can spend time with patients, building a relationship, finding out what is important to them and supporting them to resolve issues and to set achievable goals. This can ease pressure on GP services and help to alleviate the impact of poverty on health, in our most deprived areas. As well as working directly with patients, CLWs keep practice staff up to date with what is going on in the community. This helps practice staff to signpost patients to relevant resources and supports. CLWs also work with organisations within the local community to develop and promote services and support that is available.

Unscheduled Care

Many individuals attend ED when struggling with a mental health condition. The MFT Strategy includes a redevelopment of unscheduled MH care pathways including:

- Ensuring patients requiring urgent Mental Health support are seen within our Mental Health Assessment Units (MHAU's)
- Provision of a single Adult MH Liaison service across NHSGGC, providing one point of access for referrals for each Acute Hospital, with defined response and accessibility criteria.
- Community Mental Health Acute Care Service (CMHACS): a new crisis resolution and home treatment service is being implemented with Board-wide access to intensive home treatment as both an alternative to hospital admission and to support earlier discharge from hospital. Teams will operate from 8am to 11pm, 7 days a week, and offer homebased care visits up to three times daily
- Additionally, an out of hours service providing a single point of access which will coordinate care across all unscheduled activity arising outside normal working hours

Shifting the Balance of Care

The vision for the future of health and social care in NHSGGC is based on demographic changes that do not currently evidence a major increase in demand for admission to psychiatric inpatient services. Within the NHSGGC mental health strategy, the aim is for a fundamental shift in the balance of care from hospital to community services.

The number of Adult and Older People's MH assessment sites board-wide is under review, with consideration of the potential to optimise provision. To support this, while managing existing and future demand for inpatient care, the recommendation is to develop an acute care pathway across all acute MH in-patient sites. There also needs to be a greater focus on addressing delays in discharge and ensuring a proactive approach to discharge planning. To support this there will be closer integration with community and social care services to ensure joint prioritisation of resources and smoother patient flow across inpatient and community settings.

Admission to dedicated MH Rehabilitation and Hospital Based Complex Clinical Care beds should be reserved for a subgroup of people with specific complex presentations and a profile of need responsive to rehabilitation. There is currently wide variation in how rehabilitation beds are used across the system. Instead, there should be operational consistency across services via standardised care pathways with system-wide access to rehabilitation beds. In parallel with the development of a Community Rehabilitation Service, we will continue to ensure we benchmark bed levels with Royal College of Psychiatrists guidelines for adult rehabilitation services. We have commissioned 12 beds within a non-hospital-based unit for service users requiring longer term, 24/7 complex care (within Olympia House).

Older People's Mental Health

It will be necessary to focus on early intervention to reduce admission to in-patient beds. This includes continued investment and focus on Care Home Liaison Services to support care homes to maintain residents in their care home environment. The aim is also to expand post-diagnostic support and access to psychological interventions for the management of "stress and distress" in dementia. We will engage with commissioning to further develop care settings in the community in terms of both individual packages and residential care.

Social Care

An even more integrated management of supported accommodation (or equivalent) and care home placements with 'health' bed management to optimise flow in and out of integrated Health and Social Care beds/accommodation will be required. We will review specialist and mainstream care home commissioning needs, including to support people over 65 years of age potentially suitable for discharge as part of the re-provision programme.

Recovery Orientated and Trauma-Aware Services

There is a clear need for recovery-orientated services to support individuals in moving forward. The MH Strategy suggests the provision of training on recovery-orientated services to all staff, patients, and carers to develop awareness. This approach would be enhanced through the delivery of several Recovery Conversation Café events to build recovery activities across the communities. We will work with partners to pilot the introduction of Recovery Colleges (a recovery college is a virtual service using peer support workers to support patients psychoeducation/self management techniques / integration back to training employment) in the NHSGGC area and develop and implement models of Peer Support Workers in the community.

Community and Specialist Teams

Community mental health teams (CMHTs) across NHSGGC have experienced a 3% annual increase in referrals in recent years (not including ADHD (Attention Deficient Hyperactivity Disorder) referrals) and future care models will need to ensure they have sufficient capacity to meet population needs. There will be a focus on maximising the efficiency and effectiveness of our CMHTs including standardised initial assessment and the Patient Initiated Follow Up pathway (PIFU). Another aim is also to have peer support in CMHTs to reduce the need for inpatient care. A matched care approach to the provision of care and treatment for Borderline Personality Disorder has been introduced and will be developed further to ensure NHSGGC wide consistency in provision.

Alcohol and Drugs Recovery Services (ADRS)

Strategic aims of ADRS include implementing the national Medication Assisted Treatment (MAT) standards; and ensuring alignment of ADRS and MH planning in relation to MAT standard 9 (MAT standard 9 Mental Health - All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery) and in response to the Mental Welfare Commission “Ending the Exclusion” report on joined up MH and substance use provision to people with co-occurring conditions.

There is also a proposal to deliver inpatient detoxification services from a single site within NHSGGC. Additional work, some of which is already underway, will include:

- Participating in regional and national commissioning work to ensure access to residential rehabilitation services across the NHSGGC area
- Continuing the recently implemented Crisis Outreach Service to provide a rapid outreach response, including to individuals who have experienced non-fatal overdose of street drugs
- Continuing the work of the Enhanced Drug Treatment Service and developing plans for a Safer Drug Consumption Facility
- Continuing the Renfrewshire Recovery Hub, a newly established recovery service, offering unique recovery support to people with mental health and substance misuse difficulties

Other Care Groups

Fuller implementation of the Child and Adolescent Mental Health Services (CAMHS) community specification will be implemented, including supporting expansion of community CAMHS from age 18 up to 25 years old for specific targeted groups. Learning Disability Services will implement 'Coming Home', particularly focusing on developing plans to return people from out of area hospital placements.

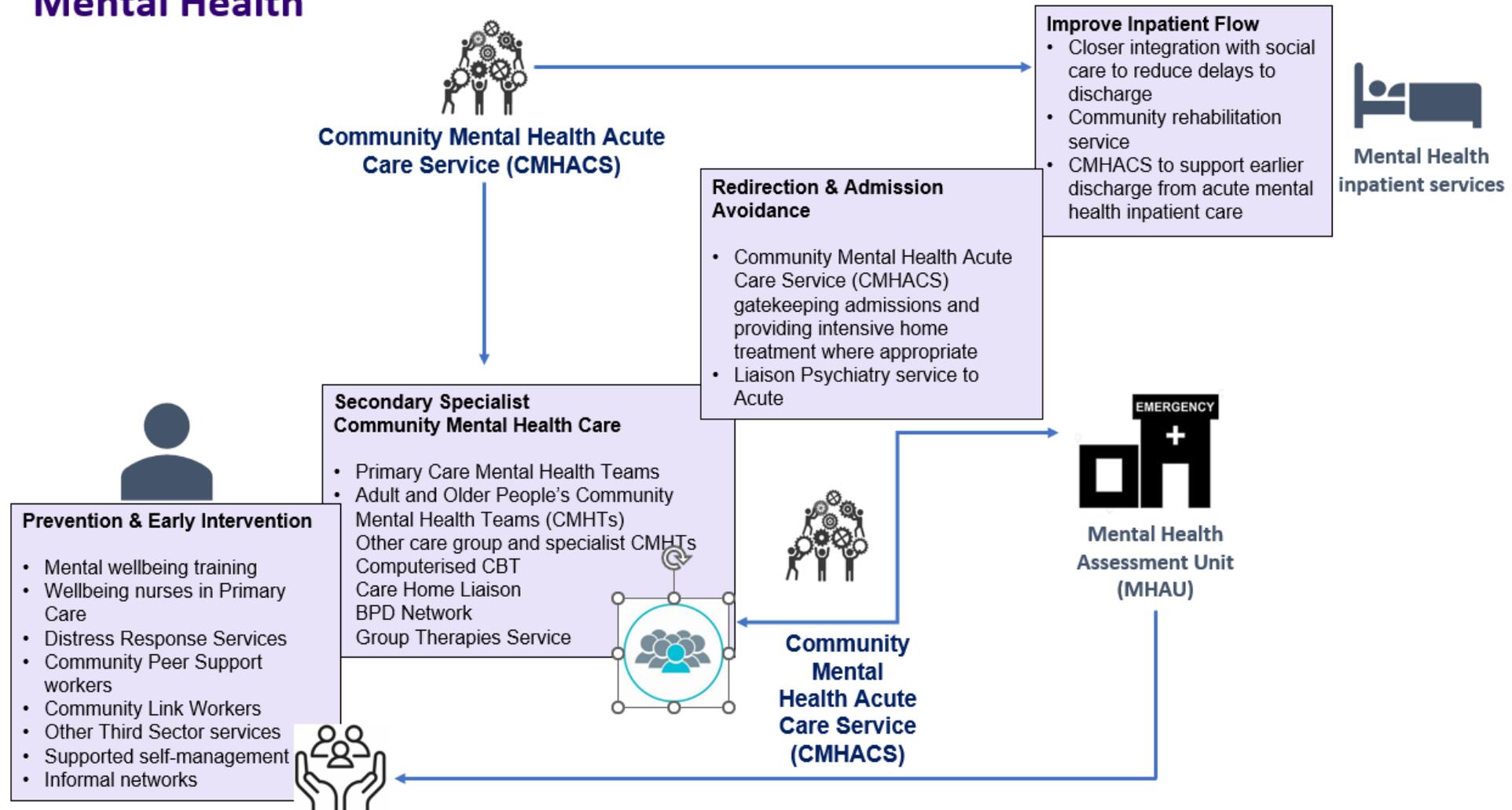
There will need to be less reliance on bed-based models with additional support for those people in the community who are at risk of admission, particularly where clinical need is not the primary reason.

Digital Healthcare

Pre-pandemic, MH services were already evolving to make better use of data and digital tools. Going forward, we need to develop a data strategy for MH that expands and ensures widespread access to clinical informatics. There needs to be continued investment to support the progression of digital technologies. We want to develop a patient facing application so patients can self-refer to services (where appropriate), choose assessment/treatment appointment slots and be able to complete information relating to equality; as well as increasing our use of virtual consultations. Our Target Operating Model is set out in Figure 10.

Figure 10: Target Operating Model Mental Health

Mental Health



5. Cancer Care

Oncology Services

It is recognised that cancer is one of the fastest changing and evolving areas within NHSGGC, with a requirement for ways of working that can adapt to new technologies. The Beatson West of Scotland Cancer Centre (BWSCC), offers a regional cancer service and is an internationally renowned cancer centre, operating within The West of Scotland Cancer Network (WoSCAN); a collaborative of the four West of Scotland NHS Boards: NHS Ayrshire and Arran, NHS Forth Valley, NHS Greater Glasgow and Clyde and NHS Lanarkshire. It is one of the busiest in the UK, in terms of clinical activity and patient numbers, as well as being the second largest cancer centre in the UK. It delivers all the radiotherapy, and much of the chemotherapy, to the population of the West of Scotland.

As well as the nine-tumour specific Managed Clinical Networks, WOSCAN lead delivery of the national Cancer Quality Improvement Programmes on behalf of Scottish Government, which includes monitoring and development of the cancer Quality Performance Indicators (QPIs). Additionally, they host a number of specialty networks and work programmes which cover all aspects of the patient cancer journey, in order to monitor, support and improve services and ensure that care for people with cancer in the West of Scotland is of the highest standard.

Systemic Anti-Cancer Therapy (SACT)

The previous model for SACT services was that for the six main tumour sites (haemato-oncology, breast, lung, colorectal, prostate and bladder cancers), 11 sites were available for administering IV and oral SACT treatment.

Five of these sites reside within NHSGGC, with a further two NHSGGC sites also delivering oral treatment for haemato-oncology only. All other tumour types would be treated at the BWSCC – and in 2017 the Beatson accounted for over one third of SACT delivery across the West of Scotland. In 2018, WoSCAN published a review of SACT services across the West of Scotland, setting out key reforms for the delivery of

SACT services.¹ The report identified that demand for SACT services across the network grew by 35% over a 4-year period from 2013-17 and is expected to continue to grow. Incidence of cancer across the region is also expected to rise 27% by 2027. Recent data would indicate that overall clinical activity has significantly outstripped the projections noted above.

Nationally, the Scottish Medicines Consortium (SMC) is the body responsible for approving SACT and individual Health Boards then have a duty to consider the recommendations made. Currently the SMC only considers the financial implications of proposed new SACT agents. The infrastructure required to allow safe delivery to patients is devolved to individual Health Boards. In addition to the multiple lines of new SACT now approved by SMC, there has been a significant change in the timing of treatment delivery. The introduction of Immunotherapy has been a major advance in the treatment of a number of solid malignancies but these agents are given on a continuous basis until progression of disease or excessive toxicity. Previously SACT was delivered in a fixed number of treatments, typically 6-10 and then discontinued. This change in delivery model, while clinically beneficial, has significantly increased the demand on SACT delivery units in both Cancer Centres and outreach facilities.

Recently there has been a move towards individually designed SACT delivery based on genomic profiling i.e. the particular genetic make-up of individual tumours which may determine responsiveness to one or other chemotherapy. Such personalised medicine requires investment in the genetic and molecular diagnostic pathways for successful implementation.

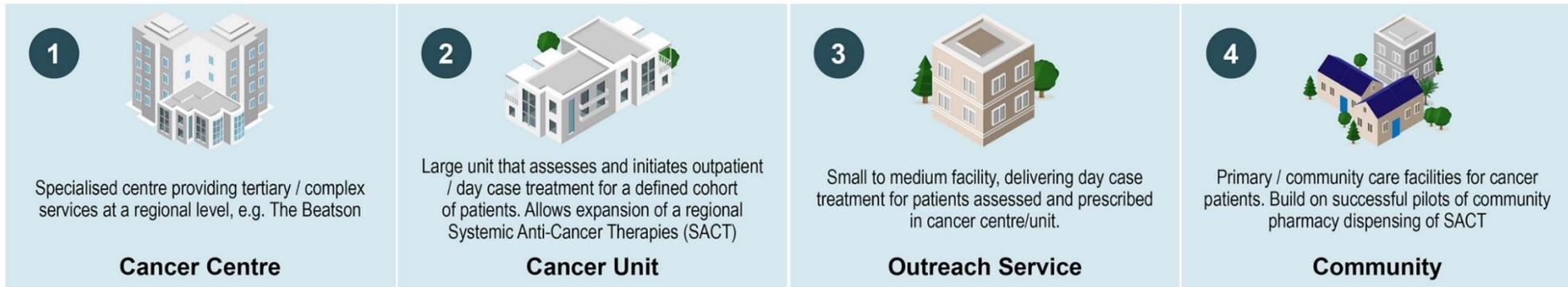
Given the pressures highlighted above, the report recognised a need to re-assess current SACT delivery models – the measures highlighted below are aligned with WoSCAN report recommendations for transforming the SACT model of care within NHSGGC and more widely for the West of Scotland.

¹ [WoSCAN Systemic Anti-Cancer Therapy Future Service Strategic Review and Emerging Future Service Model SACT-Future-Service-Strategic-Review-FOR-WEBSITE-1-v2.0-170418.pdf \(scot.nhs.uk\)](https://www.scot.nhs.uk/woSCAN/systemic-anti-cancer-therapy-future-service-strategic-review-and-emerging-future-service-model-sact-future-service-strategic-review-for-website-1-v2.0-170418.pdf)

Our Future Vision

The direction of travel for SACT services within NHSGGC and the West of Scotland is continuing the work to move towards a tiered model of care. This comprises SACT delivery from four main types of centre as highlighted in Figure 11.

Figure 11: Target Operating Model for SACT Delivery

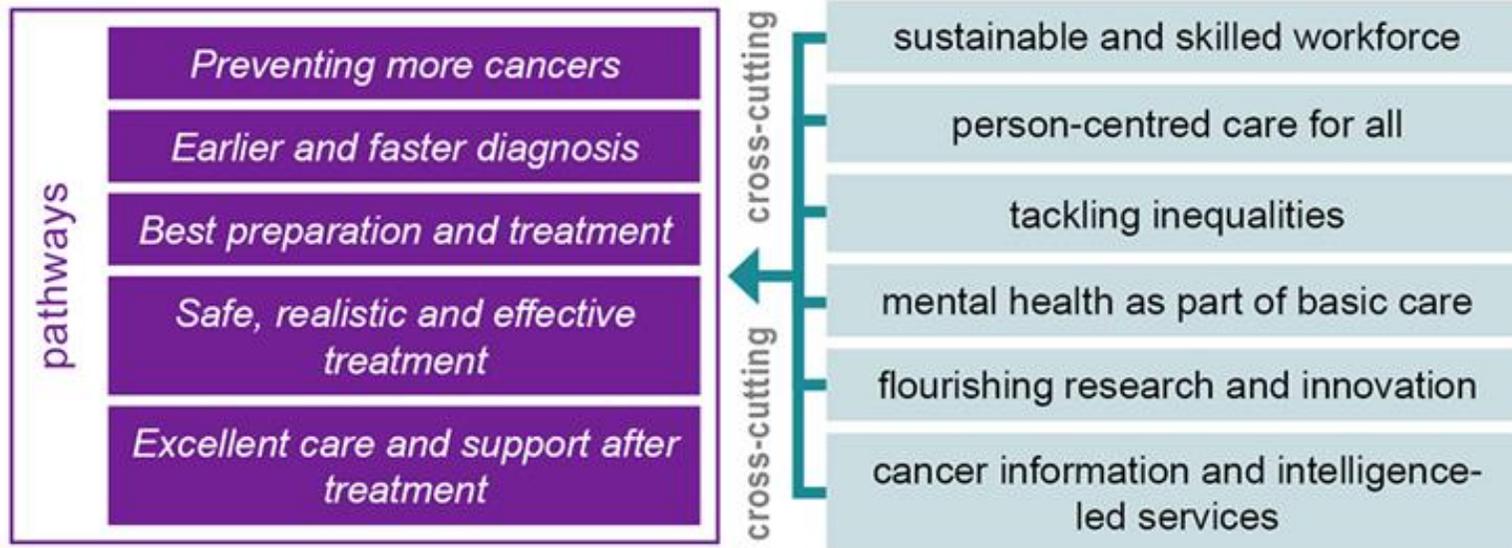


The key tenet behind the model is to bring care closer to home for patients, while relieving pressure on more centralised services where appropriate through movement of activity to other settings. Again, diagnostic services are a key enabler to realising the MFT vision.

The BWSCC will take a lower proportion of SACT activity in total, with an estimated 20% of SACT activity being delivered within Cancer Centres. The remainder of activity will take place within Cancer Units (30%) and Outreach Services (50%). Community, in addition to providing care to cancer patients locally, also has a role in dispensing select oral SACT to patients. It should be recognised that patients receiving oral SACT will still need to be assessed medically and have treatment prescribed typically within the Cancer Unit setting.

To successfully implement the tiered approach, we must align investment in facilities and staff, with the appropriate infrastructure and diagnostic capability, to support the anticipated increase in SACT activity at outreach/cancer unit levels. There is also a need to further build on the successful pilots of community pharmacy dispensing of Systemic Anti-Cancer Therapies (SACT) and develop linked ‘satellite’ units,

Figure 12: SACT Clinical Pathways



Cancer Prevention

There is more we need to do within our communities to reduce cancer risk. Public health initiatives are required to continue to drive down smoking rates, improve diet and physical activity to reduce levels of obesity and to promote safe levels of alcohol consumption.

Public health interventions in these areas likely offer the most significant benefit in reduction of cancer incidence to mitigate the effect of an ageing population.

Cancer vaccines & chemoprevention offer an exciting opportunity for cancer prevention in the years ahead, as has already been achieved with the roll out of HPV vaccination. Identification of high-risk groups is now possible using genetic profiling and some patients at high risk of cancer

may benefit from cancer chemoprevention within the community, such as tamoxifen in those at high risk of breast cancer, or be offered more regular screening.

Earlier and Faster Diagnosis

Earlier diagnosis of cancer is the key to improved survival. Screening programmes are established for some common cancers but uptake in our population can still improve, particularly in our most deprived communities. Key to earlier diagnosis will be enhanced screening programmes and better uptake across our communities and hard to reach groups.

A national review of Scottish Cancer referral guidelines pathways is underway with draft proposals expected in October 2024. Currently more than 90% of patients referred through such pathways do not have cancer and we need to develop more accurate means of streamlining high risk patients to urgent diagnostic tests.

Novel diagnostic tests such as tumour markers and circulating tumour DNA testing may offer opportunities to both refine referral criteria in symptomatic patients and offer targeted screening to others.

Streamlined, One-stop Pathways

We are already seeing early efforts to streamline cancer pathways as with the National Lung Cancer Pathway, but for too many patients there are still sequential visits for diagnostic and staging investigations leading to delays in diagnosis and starting treatment. One-stop clinics, bringing together diagnostic tests, staging investigations and senior clinical review should become the norm.

Primary care-based trackers could improve uptake and address inequalities within screening programmes and support patients through the cancer pathways.

Improved Cancer Treatment

One of the most promising areas of development in the coming years will be expanded genetic sequencing of tumours to guide targeted treatment, improving outcomes and reducing cost.

One of the factors which we know impacts negatively on cancer outcomes is individual fitness for treatment, which too often deteriorates during the diagnostic and staging process. We need to build on the current prehabilitation programmes within the community, making full use of the existing multi-agency support in the community.

All patients should be screened for frailty or nutritional failure at point of diagnosis to highlight those most likely to benefit from prehabilitation and medical/nutritional optimisation. Cancer treatment needs to be safe, realistic and effective. We are likely to see expansion of neoadjuvant approaches to cancer management as well as a reduced need for longer adjuvant (therapy applied after initial treatment for cancer) treatment protocols. We anticipate an increasing number of cancers achieving a complete clinical response with neoadjuvant (treatment given as a first step to shrink a tumour before the main treatment), treatment, supported by developments in precision medicine.

For those patients who do need surgery, we will see expansion of minimally invasive approaches with robotic surgery at the heart of delivery leading to reduced surgical morbidity, less need for critical care and shortened hospital stays.

Expanding our virtual beds would further support rapid discharge of surgical patients, in addition there will be further expansion of a day surgery approach to many cancer operations e.g. breast cancer.

For certain cancer types we know that high-volume surgeons are essential to increasing quality outcomes and we expect further specialisation within many cancer types, with development of further regional or national services.

As part of the wider recovery of planned care we will see elective hubs developed to reduce the impact of emergency admissions on elective surgery and a significant proportion of cancer surgery should be suitable for this environment.

Improving Care after Treatment

We will see further standardisation of clinical management pathways and implementation of evidence-based follow up protocols. A digital PSA follow up service (Connect Me Prostate Cancer Service) is being piloted in within NHSGGC.

Summary

In summary, we will see many changes to cancer diagnosis and management in the years ahead and NHSGGC is likely to be at the forefront of research and development in this field. Key to these developments will be the realisation of the promise of precision medicine and molecular screening. In addition development of a streamlined, digitally enabled cancer pathway and delivery of minimally-invasive surgery by an increasingly specialised surgical workforce will shorten time to treatment and improve patient outcomes. With increasing demand for cancer care and improvements in treatment options, cancer care will be a key priority within our MFT strategy.

6. Planned Care

Where We Are Now

Demand for out-patient and many in-patient services has never been higher. Waiting lists were growing prior to the pandemic and NHSGGC, like other Health Boards across the country, was reliant on waiting list initiatives and other short-term additionality to meet RTT (referral to treatment) and TTG (treatment time guarantee) targets. The pandemic has seen waiting lists grow across all services and planned care activity levels have still not returned to pre-pandemic levels.

Seasonal pressures on unscheduled care demand often lead to reduction in the number of available beds for elective care, leading to inefficient use of theatre capacity.

Our current model provides “everything everywhere” which leads to inefficiencies, recruitment challenges and unwarranted variation in management.

Patients often have to attend several appointments for investigations and follow up leading to delays in diagnosis and management.

Our model of delivery of care is increasingly dependent on the consultant workforce, often not operating at the “top of their licence”.

Transforming how we deliver planned care will require an ambitious programme of service redesign, based on the MFT principles, which maximises the potential of our real estate, embraces new ways of working and incorporates rapidly emerging technologies.

Our Future Vision

Technology and virtual assessment will play an increasing role in how we manage patients at the point of referral and in how patients with chronic illness are managed in the community. We are already seeing the introduction of AI (Artificial Intelligence) into health care settings to support rapid radiology reporting and the potential of AI to support administrative tasks, triage, diagnostics, and patient pathways is likely to transform many aspects of the patient journey in the future.

Wearable devices that allow home monitoring of patients with chronic illness can help prevent emergency admissions but also prevent routine out-patient clinic appointments. Earlier discharge supported by virtual ward rounds of patients at home may shorten the hospital stay for more major surgery, as will the further roll-out of robotic surgery. Increasing separation of acute and elective care will see elective hubs deliver a range of diagnostic, outpatient, and surgical services.

Streamlining the patient journey through increased use of “one stop shops” and MDT clinics will minimise the disruption to patients’ lives and avoid delays in accessing tests and test results.

Direct access to investigation from primary care, as already happens for suspected lung cancer, will mean that fewer patients have unnecessary referral to secondary care and will lead to earlier diagnosis and better outcomes for patients. Patients needing several tests can have them done in one day, rather than waiting longer for multiple visits to hospital.

Community access to routine investigations through community hubs will be enhanced by preventative initiatives, group classes and online resources, mobilising the full range of multi-agency resources to support patients and their carers in the community.

Maximisation of the utilisation of our resource will necessitate new ways of working with an ambition to move towards a 7-day model of care and in some settings, extended day working. We will need to facilitate the movement of both patients and staff across existing boundaries, eliminating post-code lotteries. We will need to embrace new clinical roles and enhanced roles for existing staff groups, such as Nurse Practitioners and Anaesthetic Associates.

The principles of the MFT vision for planned care are:

1. A tiered model for delivery of care
2. Whole of system pathway re-design
3. Separation of elective from emergency care
4. Maximise the use of emerging technology

All four of these principles will be incorporated into the different aspects of service re-design so that our patients have equitable access to advice and care, are fully informed and enabled to manage their own health needs and have timely access to safe and effective treatment when required.

A Tiered Model for Delivery of Care

NHSGGC currently has four acute hospitals providing a wide range of elective activity with some centralised specialist and regional activity. In addition we have two ambulatory care hospitals and both out-patient and short stay surgical activity at the Vale of Leven Hospital and Gartnavel General Hospital.

The MFT vision is to deliver a tiered model of planned care with the most complex surgical services for patients across GGC and beyond, provided within specialist centres with the full range of supporting clinical services. Most elective in-patient activity will be managed across our acute hospitals and elective hubs, with the expectation that staff will work across more than one elective site to deliver the full range of services and that patients will be prepared to travel to receive timely treatment. We will also develop capacity in diagnostic hubs and treatment rooms, either on or off-site.

To achieve this vision we anticipate:

- **Whole of System Pathway Re-design**

To be sustainable, pathway transformation needs to break down traditional barriers and focus on optimising the patients' experience and outcomes. This needs a system-wide approach to re-imagine delivery models.

Working across primary and secondary care we will agree referral pathways and new referral guidelines that incorporate Realistic Medicine principles and maximise the potential of our non-medical workforce.

We will use existing and emerging digital technologies to improve how we communicate with our patients and how we manage our waiting lists and to support our patients in self-management where appropriate.

We will continue to expand the role of community services such as optometry, podiatry and physiotherapy to deliver planned care in the community.

We will also expand the role of community first contact practitioners, for example in initial orthopaedic assessment.

- **Separation of Planned Care from Emergency/ Urgent Care**

The impact of the pandemic on elective care as a consequence of having to re-purpose in-patient capacity for emergency care has led to long waiting times across the NHS, with certain specialties (such as orthopaedics) being disproportionately affected.

There is now a broad consensus that separation of elective from emergency care is required, both to improve the efficiency of service delivery and to minimise the impact of elective cancellation during periods of peak emergency activity. This can take three forms:

- Stand-alone hub
- Hub within a hospital
- Specialist hub

NHSGGC is fortunate to have existing elective hubs and has the capacity to develop this model in other sites in the years ahead.

To achieve these goals we will need a coordinated approach to train a new workforce and support our existing workforce through a period of change. We will need strong clinical leadership to support colleagues through the challenges ahead.

- **Maximise the Use of Emerging Technology**

Perhaps the most significant opportunity to develop a sustainable model of health care delivery comes with the rapidly growing range of products utilising digital technology for use in health care. Some of the benefits of this were realised during the rapid roll-out of virtual consultations during the pandemic and there is ongoing work to increase the uptake of this approach across planned care.

We have also introduced robotic surgery which has reduced post-operative stay for prostate, colorectal and gynaecological cancer surgery. The potential of AI to support administrative tasks and to improve the speed and accuracy of diagnostic reporting needs to be fully realised.

Figure 13 sets out a summary of examples for each of the three horizons for our plan for planned care. It is important to note that all developments will be undertaken within our available resources. Figure 14 sets out our TOM for outpatients and inpatients.

Figure 13: Summary of Examples for each of the Three Horizons within our Plan

Horizon 1: 0-2 years	Horizon 2: 2-5 years	Horizon 3: 5 years +
<ul style="list-style-type: none"> • Review surgical provision against existing theatre/bed capacity to optimise resource use • Maximise short stay surgery and relocate activity from theatres to treatment rooms • Create protected elective capacity • Develop and implement whole system pathways, maximising opt-in and advice-only • Implement PIR and PIFU • Utilise full capacity of Patient Hub for communication, appointments management and waiting list validation • Maximise use of virtual (video) appointments and digital pathways (such as dermatology) • Implement theatre management system, virtual pre-op and e-consent • Increase use of virtual pathways supported by “wearables” • Develop ‘Right Decision’ Platform • Increase community care for e.g. glaucoma follow up 	<ul style="list-style-type: none"> • Implement plan to maximise elective surgical capacity • Train and expand non-medical workforce • Develop elective hubs to complement existing ACHs • Maximise potential of true day case surgery • Expand the use of “wearables” to minimise unnecessary out-patient appointments 	<ul style="list-style-type: none"> • AI-supported patient facing apps • Molecular screening for early cancer diagnosis and targeted therapy • AI-supported imaging and pathology reporting • Virtual post-op wards to support early discharge • Increased robotic surgery • Regional delivery of high complexity low-volume surgery • Day surgery and short stay surgery as the norm, facilitated by virtual post-op management and community outreach • A range of elective hubs delivering 7 day diagnostic and surgical services for a wide series of indications, and only the more complex patients being managed on acute sites • Use Artificial Intelligence to support diagnosis and triage through patient-facing apps

Figure 14a: Target Operating Models - Planned Care Outpatients

Planned Care - Outpatients

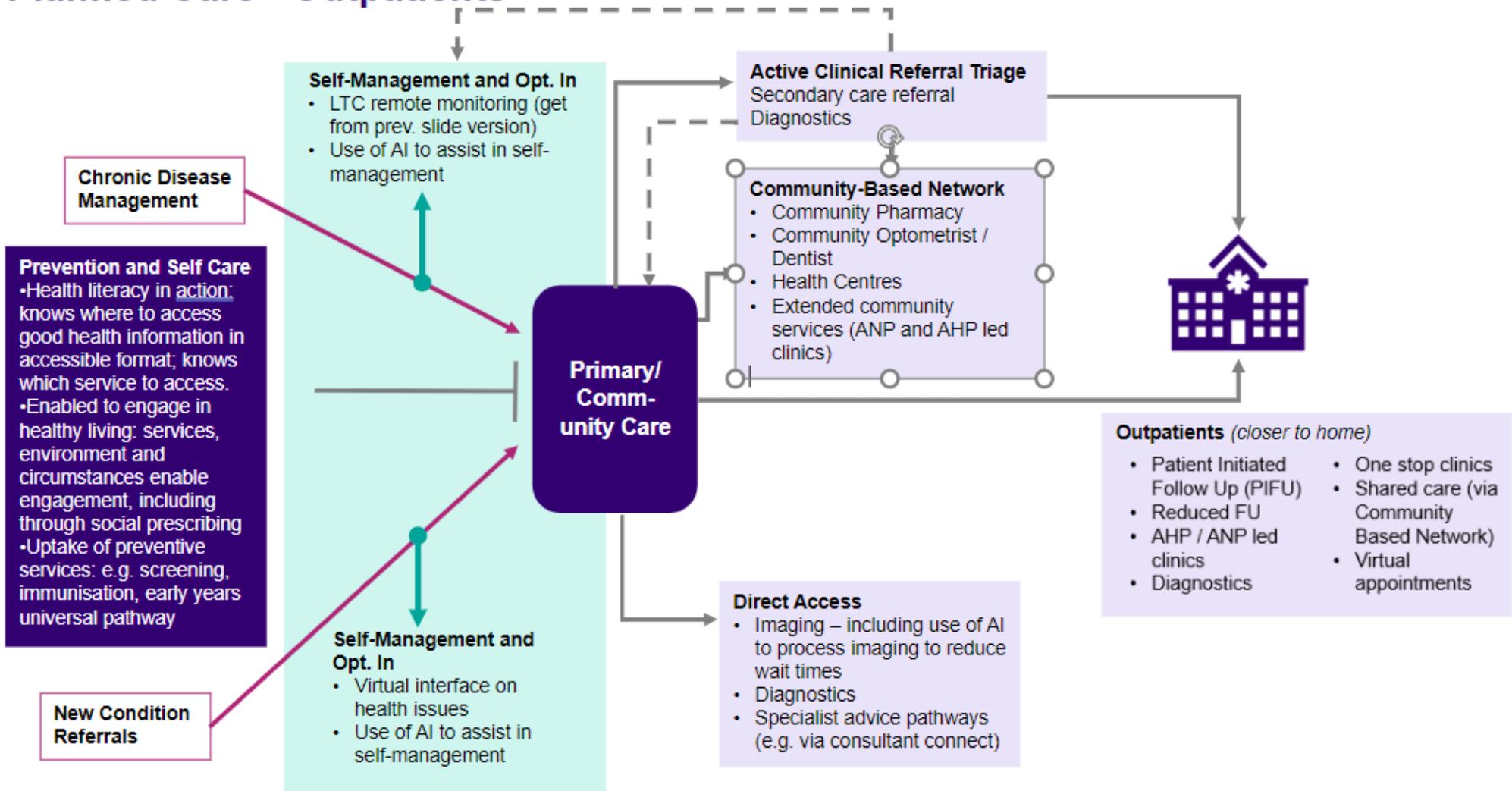
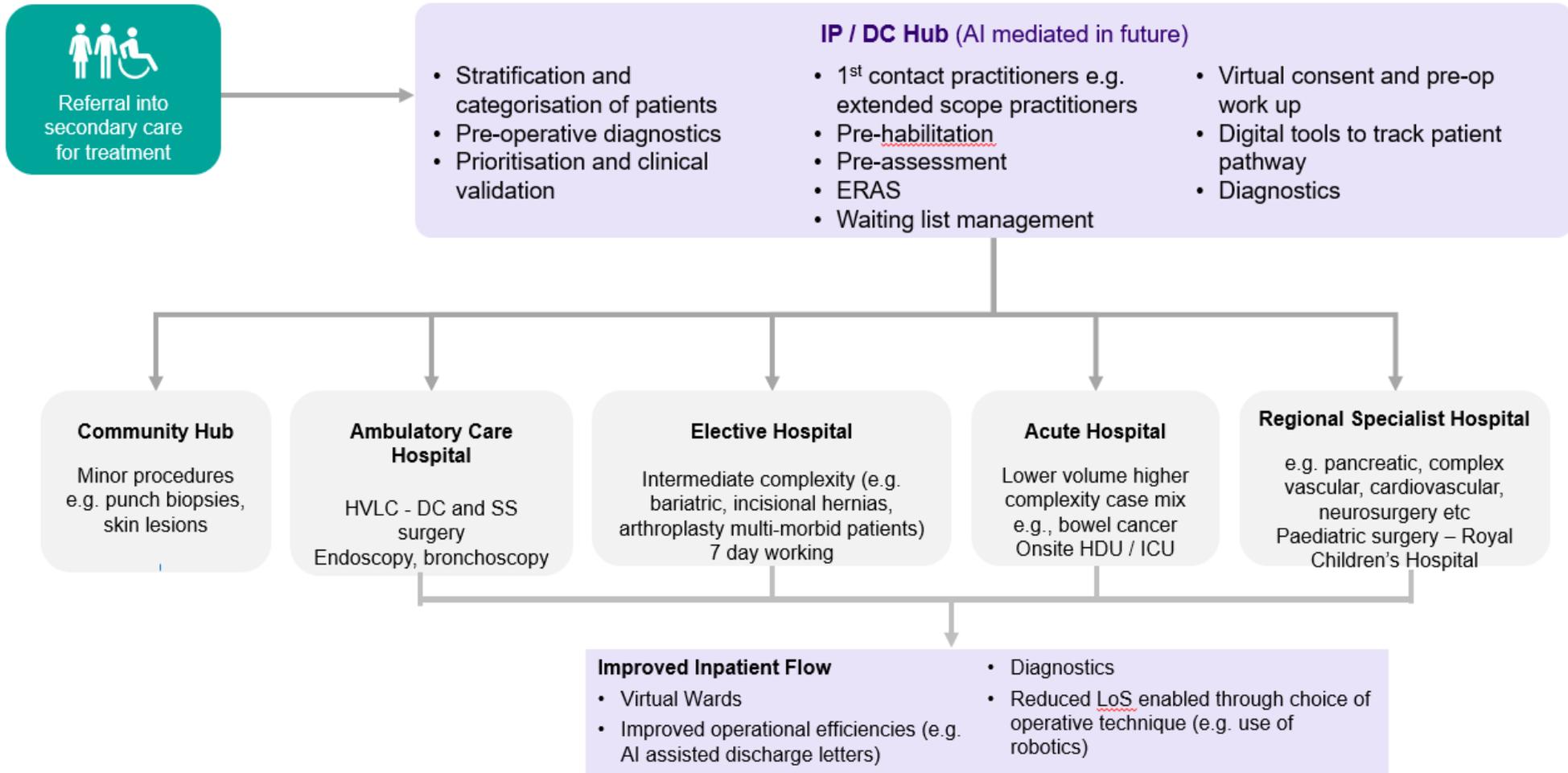


Figure 14b: Target Operating Models - Planned Care Day Cases (DC) & Inpatients (IP)

Planned Care – Day Cases & Inpatients



7. Maternity and Neonatal Services

Where We Are Now

Unlike many other specialities who are responding to treating a population with ongoing health issues, maternity services care for many healthy individuals going through a healthy life event, while also caring for a population of pregnant women with increasing levels of medical complexity, who require very specialised care. Reducing the impact of health inequalities and supporting positive lifestyle change is an important element of maternity care.

Maternity care consists of a universal pathway of care, where all women receive care from midwives, with a specialist pathway of care and a proportion of women requiring specialist care from obstetricians. Most of the universal maternity care can take place in community settings: including in women's homes, in multi-agency primary care settings or community hubs. This is not currently the way that care is provided, with a significant proportion of universal care taking place in hospital settings. Universal maternity care includes antenatal consultations with midwives, ultrasound scans and a range of screening tests. Midwives should ideally be co-located with other key providers of community based universal care including general practitioners and health visitors to support smooth transitions between services.

Our Future Vision

Our Maternity services continue to evolve guided by the vision set out in the 'Best Start Review' (Scottish Government, 2017), as shown in Figure 15. It recognises the power of maternity services to connect with women, babies, and families to develop services that put them at the centre of practice. It focuses on forging strong connections and relationships that permeate through the whole system. We have made significant progress over the last seven years to effectively implement many of the key recommendations set out in the Best Start review. We are committed to embedding and completing the implementation of the key recommendations and principles of Best Start and Women's Health Plan over the coming five years, as part of our forthcoming Maternity and Neonatal Strategy.

Figure 15: Best Start Future of Maternity and Neonatal Services in Scotland

The future vision of maternity and neonatal services across Scotland is one where:

- All mothers and babies are offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences.



- Fathers, partners and other family members are actively encouraged and supported to become an integral part of all aspects of maternal and newborn care.



- Women experience real continuity of care and carer, across the whole maternity journey, with vulnerable families being offered any additional tailored support they may require.



- Services are redesigned using the best available evidence, to ensure optimal outcomes and sustainability, and maximise the opportunity to support normal birth processes and avoid unnecessary interventions.



- Staff are empathetic, skilled and well supported to deliver high quality, safe services, every time.



- Multi-professional team working is the norm within an open and honest team culture, with everyone's contribution being equally valued.



Aligned with the Best Start review and current evidence, initiatives are outlined in Figure 16.

Figure 16: Best Start Initiatives

<p>Continuity of Carer During the Maternity Journey</p>	<p>This has a strong research evidence base, identifying the positive impact on both experience of care and key outcomes of care.</p> <p>Continuity of carer has been found to reduce preterm birth, stillbirth, dissatisfaction with childbirth experiences and a range of medical interventions.</p> <p>This requires the maternity service and systems to evolve so that they are designed to maximise the ability of the midwives and obstetricians to provide continuity of carer.</p>
<p>Working Alongside Partners in Primary Care</p>	<p>We will provide an integrated clinical pathway to improve outcomes for women. Informed decision making is a key element of a modern high quality maternity service – women should be provided with evidence-based information from their maternity care providers to enable them to make informed decisions about their chosen type of birth, place of birth and a range of other elements of their pregnancy, birth, and postnatal care.</p> <p>Antenatal education should form a central part of maternity care – enabling women and their partners to make informed decisions about their care and supporting them to prepare positively for their labour and birth and for parenting. A range of digital solutions could support the development of antenatal education and informed decision making.</p>
<p>Provision of Midwife Led Intrapartum Care Facilities</p>	<p>Women who are well and have a healthy pregnancy without significant medical or obstetric complexity, is a central part of maternity care now and in the future.</p> <p>There is a well-established evidence base labour and birth both from home and in midwife led units (regardless of proximity to consultant led units) is safe, can improve women’s experience and can reduce the rates of unnecessary medical intervention.</p>

<p>Separate Care for women experiencing any kind of pregnancy loss</p>	<p>Women experiencing any kind of pregnancy loss, including miscarriage, termination of pregnancy for foetal abnormality and stillbirth, should be cared for in environments away from other parts of maternity care, with a good level of follow up support and bereavement care. Separate maternity loss areas should also be provided to support women and families going through pregnancy loss and stillbirth in more appropriate surroundings.</p> <p>Finally, Best Start recommends that partners and fathers should be supported to stay with women during any stay in maternity units, this should be facilitated as part of our long-term plan.</p>
<p>Supporting the national programme for Perinatal Mental Health Services</p>	<p>We also recognise the importance of supporting the ongoing national programme for the development of perinatal mental health services. This will further embed NHS GGC’s commitment to improving the mental health of mothers, fathers, carers, and infants.</p> <p>We have a well-established Maternity and Neonatal Psychological Interventions (NMPI) team and we will use the capability inherent within maternity services to connect into communities and across organisational boundaries.</p>

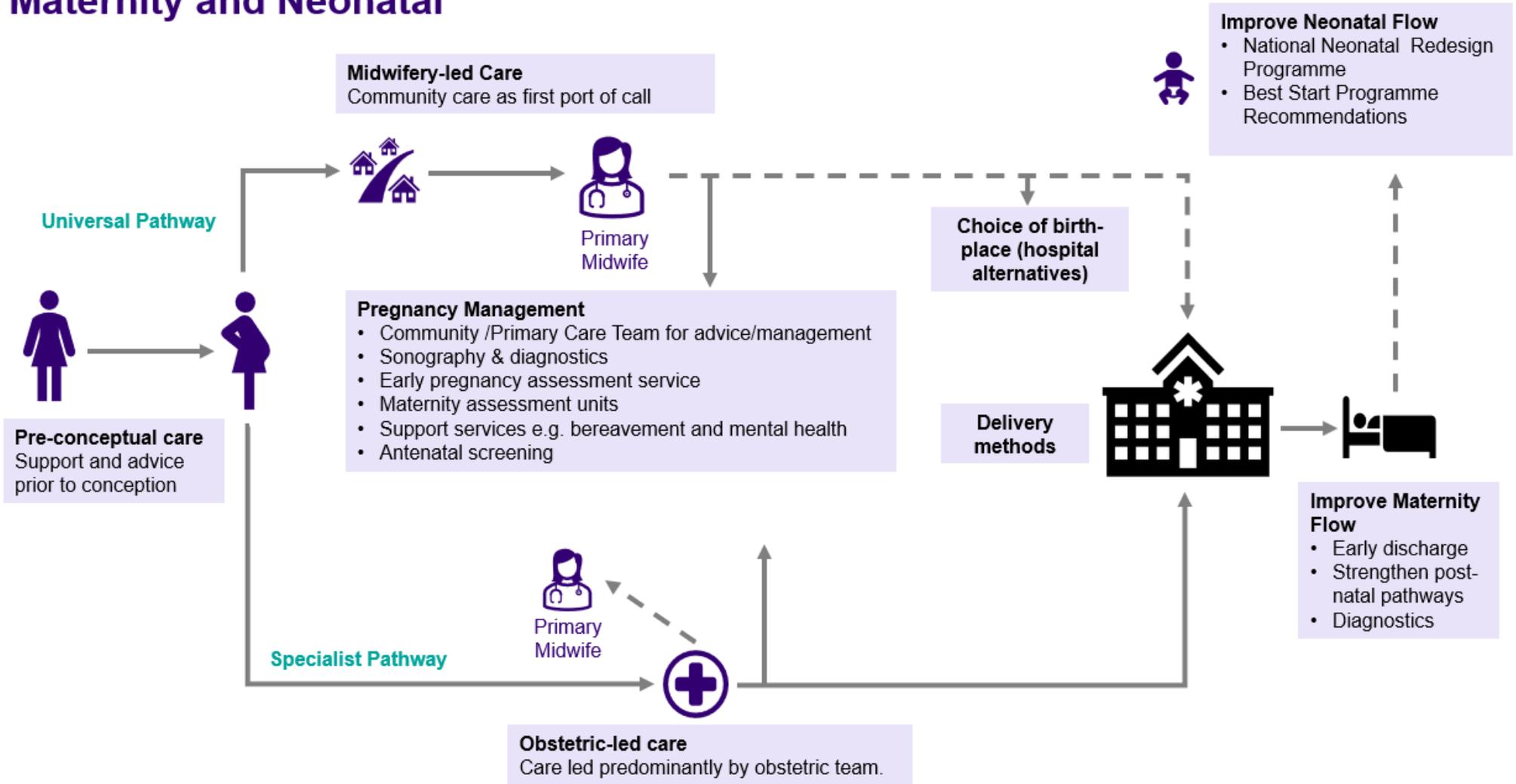
Of significance, national reports and data identify that Black, Asian and other ethnic minority women are more likely to have poor experiences and outcomes from maternity care – with higher rates of perinatal and maternal mortality among global majority women. Maternity services need to evolve to ensure that they are welcoming and accessible to the growing number of global majority women living and having families across NHSGGC. This includes consistent use of interpreting and translation services, advocacy services and seeking to ensure that the maternity workforce reflects the community we care for.

Additionally, there is evidence from UK wide reviews and service developments that could influence the further development of NHSGGC services to improve experience and outcomes for service users from black/minority ethnic communities. This should also include ensuring that the workforce is more diverse and reflects the culturally enriched communities served. Therefore, increased representation from all local communities, but specifically black/minority ethnic backgrounds, on the Maternity Voices Partnership is an important mechanism to inform future services configuration.

Our Maternity Target Operating Model is presented in Figure 17.

Figure 17: TOM Maternity and Neonatal Services

Maternity and Neonatal



8. Workforce

New workforce models are integral to support the delivery of this Clinical Roadmap and the wider MFT and will help to meet the national strategic care aims. Successful delivery of the workforce strategy is critical to support delivery of the MFT strategy.

NHSGGC is facing a shortfall in particular hard to fill locations and specialities e.g. consultant psychiatrists and registered nurses within care of the elderly. Strategic workforce planning is a continuous process, with modelling and forecasting of our future workforce needs and available supply. This is captured within the Boards Workforce Plan 2022 – 2025, the 2025-2028 plan is under development.

One of the key challenges arising from the MFT will be how we support staff to work differently in the future which will include the following challenges and opportunities:

- New and innovative methods of delivering care to patients, for example remote consultations and virtual clinics
- New approaches to how and where we work
- Working closely and in partnership with other health and social care colleagues
- Adapting to new ways of working including new technology

It is essential our staff, our patients and wider GGC communities continue to be active participants in the process of change. To date over 5,000 patients, service users and members of the public have participated in workshops and events to inform the MFT vision and clinical strategy. Further staff engagement has also taken place between June 2022 and April 2024 (with over 700 staff participating). Further staff and partnership engagement is ongoing throughout July, August and September 2024. Engagement will be a continuous process as more detailed plans and strategies emerge.

Delivery of the MFT will be supported by the NHSGGC Workforce Strategy 2021-2025, (the 2025 – 2030 strategy is currently in development), which sets out how we will attract and nurture the most talented people available, both locally and from around the world, whatever their

background. Our current and future employees are our greatest strength, and the strategy lays out the foundations, framework, support, and opportunities which underpin our four workforce pillars of: health and wellbeing, learning, leadership and recruitment and retention.

We will support our employees at every point in their career journey, starting at attraction and recruitment; to nurturing those at the beginning and developing throughout their careers; and providing opportunities for flexible working to support a work life balance approach.

NHSGGC also has a significant relationship with independent contractors and third sector organisations, and the strategy recognises partnership working and that there is a shared aspiration towards achieving ambitions and values collectively, and that where relevant, access to support and services are clearly set out and there is ongoing engagement. Whilst COVID-19 has undoubtedly been particularly challenging for NHSGGC it has also enabled us to deliver substantial projects and make changes quickly. The strategy captures learning and opportunities from COVID-19.

The key aspects of the Workforce Strategy focus around:

- Flexibility in the workforce, agile and multi-skilled teams
- Further innovation, expansion, and rollout of technology
- Wellbeing, individual and organisational resilience
- Celebrating and recognising the value of our workforce
- Diversity and inclusion and embedding of inclusivity across all parts of the organisation

Delivering the MFT will pose significant challenges and whilst the Workforce Strategy provides the framework to support the staff changes involved, we will need review progress and adapt to challenge and change as they arise.

9. Digital and Data

Successful delivery of the MFT will be dependent on an effective and proactive approach to the use of digital technology and data to support the service changes required.

The NHSGGC digital strategy has been produced to provide information to our citizens, patients, staff, clinicians, and partners. The strategy outlines a five-year plan, covering important themes and programmes that will be the focus of the Board's Digital Delivery Plan 2023-28. The aim of the strategy is to provide direction for our staff, and reassurance for our citizens that NHSGGC is aware of and delivering the priorities that matter to them and aligned with NHSGGC aims and objectives and operational priorities.

A key aim of the strategy is to communicate how important digital technology and online services are across services within NHSGGC and how this will continue to grow and expand over the coming years. The strategy references various projects, programmes and initiatives that are either underway, or will be implemented to deliver positive improvements to health and care across greater Glasgow and Clyde, the West of Scotland and nationally. Successful implementation of the digital strategy is vital to support delivery of the MFT.

Delivery

To deliver our Digital Strategy, we need to:

- Continue to engage actively with citizens and patients to inform service improvements
- Replace paper processes with digital alternatives
- Modernise and enhance existing systems to be fit for the future
- Maintain our ability to respond to future challenges such as another pandemic
- Transition to “living with COVID-19”, focusing on prevention and early intervention
- Build digital approaches into our broader population health improvement effort
- Increase the use of technology to support patient care including virtual consultations

- Support blended working for our staff

Our shared vision is to connect citizens and staff, to deliver the best care possible. We will listen to and learn from citizens and staff to help deliver solutions now which are ready for the future, and provide robust, connected digital services which maximise the benefits of technology. And we will help citizens and staff access information to better inform decision making.

Major investments will support the introduction of key digital tools including a new Laboratory Information Management System, GP system modernisation and the unified electronic care record.

By giving our staff access to accurate, up-to-date information where and when they need it, we will support high quality decision making. Data capture and robust storage will be enhanced, working with our academic partnerships to ensure that data is securely used to maximise benefits for healthcare. There will be a focus on data quality and data visualisation to ensure information is accessible and as effective as possible.

We aim to support improvements in patient outcomes and care co-ordination and decrease fragmentation for citizens as they move across services, by making information more easily available to those that require it at the right time and in the right place. Our vision is for an integrated health and social care system which will rely on technology to support new ways of working.

Our rich and well-established Digital Health & Care Record (DHCR) will be built upon to create an extended clinical record supporting clinical pathways.

Our vision is for citizens to access and contribute to their own health record online, while ensuring that people who cannot make use of these options always have appropriate alternatives. We want to empower people to access and use their personal data, and digital appointments, and actively manage their health and wellbeing.

Our staff need the skills and confidence to use technology to its fullest extent: digital literacy. We will engage with staff to ensure that they have the support and guidance they need, and embed digital skills in recruitment, induction and the learning and development process. Significant digital changes across Primary Care will enable more integrated care and information sharing between professionals.

Re-provisioning GP Clinical and Document Management systems will enhance MDT working for extended practice staff, help underpin improvement plans and be an enabler for patient-held records.

We need to continue work to create a web of connectivity across health and social care to develop a coordinated, combined digital patient health record, noting that fragmentation between disciplines, and between primary and secondary care and between health and social care regarding access to patient was consistently highlighted as a major barrier to integrated working at the Clinical Workshops in 2022.

Supporting Delivery of the MFT Clinical Strategy

eHealth is a vital contributor to the development of the MFT to ensure that the digital dimension is built in to short, medium, and long-term plans. Alongside the MFT, the digital strategy will support and enable the wider transformational change sought over the short, medium, and long term:

- New and innovative methods of delivering care to patients, for example remote consultations and virtual clinics
- New approaches to how and where we work
- Improving patient access to services and information while eliminating inequalities to that access
- Enabling self-diagnosis, treatment, and care
- The move towards “smarter buildings”
- Transformation of how we use, manage, and operate space
- To support the transition to new models of care, the immediate priority is to increase the virtual offering to our patients.

A number of specialties already make extensive use of virtual consultations. The priority is for all specialties to build on this to maximise uptake. In years 1-2, a change in approach is required to move to “virtual by default” for patient consultations. This change should be one component of NHSGGC’s wider outpatient transformation plan including better use of patient-initiated review, patient-initiated follow up, ACRT (active clinical referral triage) and advice referrals.

The recent pilot of Patient Hub (sending electronic appointment information to patients instead of paper) has seen opt-in to the Digital offering by around 70% of citizens, suggesting that public acceptance of Digital options is widespread. Virtual consultations can help address inequity in terms of waiting times, by enabling patients to be seen in a timely manner regardless of their geographical location.

Initial analysis of consultant-led outpatient activity indicates that if each specialty could raise uptake of virtual consultations in every site to the level of the highest site, over 10,000 consultant appointments per month could change from face-to-face to virtual. Every service should focus on achieving this as an immediate priority.

A communications plan will be implemented to regularly highlight to staff the benefits of virtual consultations, share “user stories”, and emphasise the need to maximise uptake of virtual. This will include corporate communications, presentations at relevant clinical and managerial groups, and direct engagement with clinical services. We will engage with Corporate Communications to identify opportunities to increase public awareness of virtual consultations.

Equipment will be provided where required to support virtual consultations. Learning resources will be publicised to ensure staff can gain the skills and confidence they need to use Digital tools.

Increasing virtual-only clinics will reduce utilisation of physical clinic space. It may also enable increase in throughput via shorter appointments in some services. Support for advice referrals should be spread to all specialties where appropriate. Outpatient pathways should be unified across each specialty, Board-wide. In the future, AI tools may help streamline the vetting process.

eConsult and Asynchronous Virtual Consultations

Focused work has commenced again with the GP OOH Service to commence a test of change (ToC) to offer a Near Me consultation as an alternative to telephone consultation. Discussions with SAS are ongoing to support using Near Me with clinicians and/or crews primarily engaging in the Flow Navigation Centre (FNC) pathways.

The eConsult system provides a mechanism for patients to communicate “asynchronously” with their GP practice. For example patients can ask for non-urgent advice electronically and receive a response within the same or early the next working day. This will be piloted in two GP clusters. Use of “asynchronous” consultation methods can avoid the need for an appointment. This can include clinician/clinician communication e.g. advice referrals, and clinician/patient communication. A test of change is underway within primary care further roll out will be subject to availability of additional resources.

Future expansion of provision of community facilities to enable patients to have virtual consultations (e.g. Johnstone Library) will support digital access. GP practices could play a key role in publicising the availability of these facilities and encouraging patients to use them where appropriate.

Expansion of Virtual Capacity

We have increased our virtual pathways as set out below. These developments are currently supported through non-recurring resources and provide an increase in our 'virtual bed' capacity and have a positive impact on hospital occupancy and support an improved flow in the admitted pathway from Accident and Emergency.

- Adult OPAT (Outpatient Antimicrobial Therapy) – provision of treatment as an outpatient avoiding admission to hospital and reducing acute beds pressures
- Respiratory Community Pathways - there are existing respiratory ambulatory care models across GGC which work to reduce hospital admissions for individuals with COPD who are at risk of admission. We are exploring the potential to add capacity in existing CRT (cardiac resynchronisation therapy) services across our HSCPs that currently deliver CRT as well as look at how we expand into others at pace.
- Heart Failure & Cardiovascular admissions, including heart failure (HF), continue to rise steeply. Much of this acute-level care can be redistributed to the out-patient setting with an integrated cardiology ambulatory platform.

Our aspiration (subject to available resource) is to increase the opening hours of our Flow Navigation Centre to extend the day and or open up to 24 hours 7 days a week and provide additional ANP (advanced nurse practitioner) and supplementary primary care out of hours support to the FNC through increasing GPOOHs virtual ANP capacity. This will increase our capacity to support our Call Before Convey model for Care Homes and the Scottish Ambulance Service in the OOH period.

10. Summary and Next Steps

The Future Horizon

The MFT clinical roadmap has been developed in partnership with staff from across our whole system and represents our vision for how we will deliver services in the years ahead.

The key drivers for change are understood by all and we have already started on the journey towards new models of care. We need to work together to develop at pace the structures and workforce necessary to support this vision and to describe to our population how this will improve access to care and overall health and well-being. Fundamental to this is a change in culture towards increased prevention, self-care and maximising independence by creating a truly integrated system, responsive to patients' needs.

Our workforce is central to the successful delivery of the required change. We will continue to ensure our staff, our patients and wider GGC communities are active participants in the process of change.

The opportunities presented by emerging technology will enable care closer to home through increased virtual management, technology-enabled support for chronic condition management and improved communication both with our service users and between the multi-agency network.

The Target Operating Models presented provide the foundation to guide the development of effective plans to ensure we have the right service, accommodation and workforce to deliver the MFT strategic vision.

It is important to note that all developments will be undertaken within our available resources we are committed to working with all of our key partners across our whole system and with the third sector to ensure the best deployment of our resources and to identify any future funding opportunities to support the delivery of the MFT Clinical roadmap.

Glossary

AAU	Acute Assessment Unit
ACRT	Active Clinical Referral Triage
ADHD	Attention Deficient Hyperactivity Disorder
ADRS	Alcohol and Drugs Recovery Services
AHP	Allied Health Professional
AI	Artificial Intelligence
ANP	Advanced Nurse Practitioner
BPD	Borderline Personality Disorder
BWSCC	Beatson West of Scotland Cancer Centre
CAMHS	Child and Adolescent Mental Health
CBT	Cognitive Behavioural Therapy
CLWs	Community Link Workers
CMHACS	Community Mental Health Acute Care Service
CMHTs	Community Mental Health Teams
COPD	Chronic Obstructive Pulmonary Disease
CRT	Cardiac resynchronisation therapy
CT	Computed Tomography
CTAC	Community Treatment and Care
DC	Day Case
DNA	Deoxyribonucleic acid
ED	Emergency Department
ERAS	Enhanced Recovery After Surgeries
FNC	Flow Navigation Centre
GP	General Practice

GPOOH	General Practice Out of Hours
GPs	General Practitioners
HDU	High Dependency Unit
HF	Heart Failure
HFRS	Home First Response Service
HPV	Human papillomavirus
HSCP	Health and Social Care Partnership
ICU	Intensive Care Unit
IP	In Patient
IT	Information Technology page
LoS	Length of Stay
LTCs	Long Term Conditions
MAT	Medication Assisted Treatment
MAU	Medical Assessment Unit
MDTs	Multidisciplinary Teams
MECC	Making Every Contact Count
MFT	Moving Forward Together (NHS GGC's Clinical Strategy)
MH	Mental Health
MHAU	Mental Health Assessment Unit
MIU	Minor Injury Units
NHSGGC	National Health Service Greater Glasgow & Clyde
OPAT	Outpatient Parenteral Antimicrobial Therapy
P2P	Professional to Professional
PCIPs	Primary Care Improvement Plans
PIFU	Patient Initiated Follow Up

PIR	Patient Initiated Return
QEUH	Queen Elizabeth University Hospital
QPIs	Quality Performance Indicators
RAC	Rapid Assessment and Care
RAH	Royal Alexandra Hospital
RTT	Referral to Treatment
SACT	Systematic Anti-Cancer Therapy
SAS	Scottish Ambulance Service
SG	Scottish Government
SMC	Scottish Medicines Consortium
ToC	Test of Change
TOM	Target Operating Model
TTG	Treatment Time Guarantee
UUC	Urgent and Unscheduled Care
WoSCAN	West of Scotland Cancer Network

1. Introduction

Over the last six months, NHS Greater Glasgow and Clyde has undertaken a focused engagement exercise to support the development of Moving Forward Together (MFT).

Starting in March 2024, this work built upon previous engagement carried out over several years capturing feedback and insights from over 5,000 patients, service users and members of the public. This included work to inform several core strategies including Maternity and Neonatal, Primary Care, Mental Health and the Quality Strategy.

The current activity aimed to build on the insights captured from this to support the further development of MFT. It initially focused on testing public understanding and perceptions of key areas including: self-management, community-based approaches, use of technology and resource allocation.

This was further refined during July and August 2024 as the engagement centred on testing the 2035 Healthcare Vision and the priority areas emerging through the Clinical Roadmap.

This report outlines the work undertaken and the feedback captured from this.

2. Feedback received through engagement

Ongoing engagement has allowed NHSGGC to capture in-depth feedback on specific Board strategies, through ad hoc engagement and via the Care Opinion feedback system. A summary of the key points captured consistently through this work is listed below and has been used to inform the current engagement.

This includes:

Reducing waiting times and improving appointment systems: Across all areas of healthcare (maternity, primary care, and mental health), there has been significant feedback to support work to reduce waiting times for appointments and treatment.

Expanding community-based and digital services: There has been a strong desire in feedback received for increased community-based services and the integration of digital platforms to improve access to care. This includes increasing the availability of community-based services, enhancing 'telehealth' options, and ensuring digital services are accessible to all demographics, particularly those with digital literacy challenges or without easy access to technology.

Integration and coordination across services: There is a strong emphasis on the need for better integration and coordination between different healthcare services and levels of care. This includes seamless communication between primary, secondary, and community care providers, as well as between different departments within healthcare facilities. Improved integration will lead to more cohesive care, reduce duplication of efforts, and enhance the overall patient experience.

3. Phase one: March – April 2024

In March and April 2024, an engagement exercise was delivered to support the further development of the MFT strategy.

This engagement included five in-depth focus group sessions advertised through the NHSGGC social media channels, Involving People Network and via targeted promotion to local community networks and forums.

A total of 64 participants took part from diverse backgrounds including patients, carers, former healthcare professionals and third-sector representatives.

Participants identified several benefits of the MFT approach, including:

- Increased person-centred care through local services.
- Reduced need for hospital visits, lowering risks and costs.
- Potential for technology to support independent living and better diagnostics.

However, participants also raised some issues relating to:

- The adequacy of community infrastructure and safety of home-based care.
- Risks of digital exclusion and privacy issues in using technology.
- The need for improved involvement in decision-making.

The feedback captured for the topic based discussion is summarised under the following points:

Self-Management and Care: Participants emphasised the importance of empowering individuals with long-term conditions to manage their health, while also expressing concerns about third-sector organisations bearing too much responsibility without adequate support.

Community-Based Approaches: While participants supported the idea of providing care within communities to reduce hospital dependency, they raised issues with the existing infrastructure's capacity to support this shift.

Role of Technology: Recognising the risk of digital exclusion the potential for technology to enhance self-management and reduce waiting times was acknowledged.

Resources: Discussions highlighted the need for efficient use of resources, with participants expressing awareness of the financial challenges facing the NHS and the importance of transparency and public involvement in decision-making.

4. Phase two: July – August 2024

The engagement activities conducted in March and April 2024 served as a foundation in shaping the next engagement phase. The initial sessions provided critical feedback on the key themes of self-management, community-based approaches, technology in healthcare and resources.

Building on this, the second phase aimed to test public opinion on the 2035 Healthcare Vision and Clinical Roadmap.

The engagement during July and August 2024 sought to capture wider feedback on the vision and key aspects of focus with activities including:

Public Survey: A survey was conducted during July and August 2024 receiving 285 responses. This aimed to capture public opinion on the key principles of the 2035 Healthcare Vision and their alignment with the roadmap.

Focus Group Sessions: Three targeted focus group sessions were held, with 45 participants attending these sessions. Each session was organised around a specific work stream of the MFT strategy including: Primary and Community Care, Urgent Care, and Planned Care.

Social Media: In addition to the surveys and focus groups, a social media campaign was undertaken to gather feedback from a broader audience. This helped in capturing diverse opinions and ensured wider public participation.

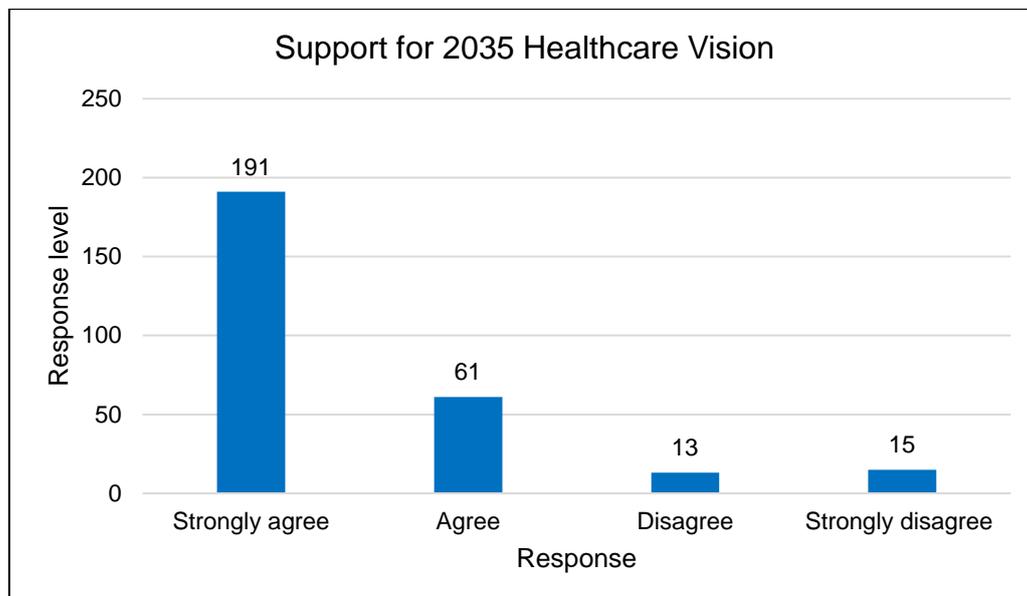
5. Feedback:

The 2035 Healthcare Vision and underpinning principles were described with people asked the extent to which they agreed that the vision is the right one, to help achieve the transformational change needed.

Our 2035 Healthcare Vision is one of inclusivity, innovation, and empowerment. By embracing preventive and self-care, welcoming technology and innovation, ensuring equitable access, and prioritising patient-centred approaches, we will develop a community where health is a shared responsibility and where care is available when needed, by the right team and in the right place.

There was a strong endorsement of this vision with 252 respondents (90%) of the 280 responses received in support of this.

Figure 1: Support for the 2035 Health Vision



To test further key priority areas of development, we shared examples of proposed actions emerging from the Clinical Roadmap and asked people the extent to which they agreed with

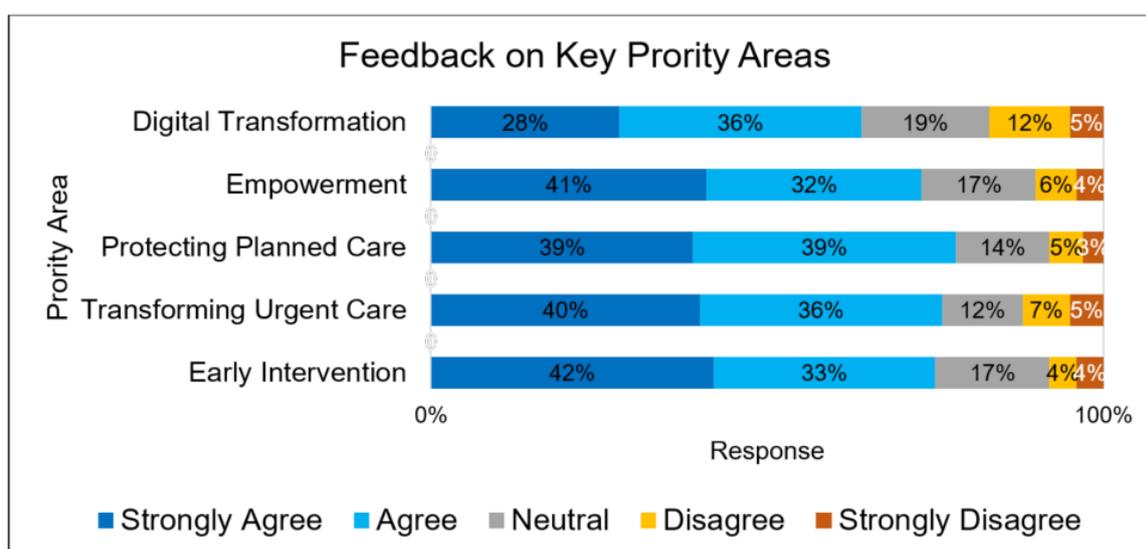
these. These related to our five key priorities of Empowerment, Digital Transformation, Early Intervention, Transforming Urgent Care and Protecting Planned Care.

The proposed actions asked people to state whether they ‘strongly agreed’, ‘agreed’, ‘disagreed’, ‘strongly disagreed’ or were ‘neutral’ on these areas of development. In total 18 areas were outlined under the five priority areas with responses indicating strong support for these suggested areas. The table below summarises the average level of agreement to proposed developments within each section, with figure 3 below providing further breakdown on the spread of responses.

Figure 2: Summary of feedback on priority areas

Priority Area	Agreement
Empowerment	73%
Digital Transformation	64%
Early Intervention	75%
Transforming Urgent Care	76%
Protecting Planned Care	78%

Figure 3: Feedback on Key Priority Areas



From this, it can be seen that there was strongest support for the elements of protecting planned care which outlined steps to enhance patient access and involvement in their care by developing tiered models with elective hubs and using technology to minimise delays.

Digital transformation seen the lowest level of support (64%), and when analysing this, comments related to ensuring a balance between digital/virtual developments versus in-person approaches, particularly for those that may not have access to technology or be disadvantaged in this way.

The wider feedback captured from respondents is summarised under the following headings:

1. Innovation and Technology: Many respondents see the integration of technology and innovation as necessary for the future of healthcare. However, there is concern that the use of digital services might lead to a decrease in physical services, which could disadvantage those who are not “tech-savvy”, particularly the elderly.

2. Preventive and Self-care Approaches: There is broad support for a shift toward prevention and self-care, with the public being encouraged to take more responsibility for their health. Educating the public on this aspect was viewed by respondents as crucial for reducing long-term NHS costs and improving health outcomes.

3. Implementation and Current System Constraints: While the vision was positively received, some highlighted challenges with political, financial, and social issues being noted.

4. Local and Accessible Care: There is a strong desire for healthcare services to be available locally. The need for improved patient experiences, such as reducing waiting times and enhancing the quality of care, is highlighted as a priority.

5. Staff and Resource Management: Respondents felt that the success of the vision heavily depends on adequate funding, staffing, and resource allocation. Respondents stress the importance of investing in and supporting healthcare professionals to prevent burnout and ensure the delivery of high-quality care.

6. Focus group sessions:

Three focus group sessions were facilitated by clinical leads with support from the Planning Team and the Patient Experience Public Involvement (PEPI) Team. These sessions aimed to provide a detailed overview of the 2035 Healthcare Vision and Roadmap, discuss the ‘Three Horizons’ model for future healthcare planning, and present case studies highlighting successful practices within each focus area.

The focus group sessions included participants from previous MFT engagement activities and the general public. Invitations were extended via the Board’s Involving People Network, social media and targeted invites through local community networks and forums. This ensured a diverse group of participants, including patients, service users, carers, members of the public and representatives from third-sector organisations.

a) Urgent and Unscheduled Care Focus Group:

The focus group session on Urgent and Unscheduled Care was led by the Deputy Medical Director (Acute) and highlighted several key points of consideration and discussion which included:

Public Awareness: Participants discussed the importance of educating the public about the available services and the best pathways for care, particularly concerning Minor Injury Units (MIUs) and A&E services.

The group emphasised the need for clear definitions of what constitutes a “minor injury,” noting that the distinction between minor and non-minor injuries needs clarification to improve patient understanding and access to appropriate care.

Balancing virtual care with patient preferences: While there was recognition of the potential benefits of virtual care and technology, comments were made about the considerations around access for some patients particularly those who might prefer or need face-to-face interactions.

Increasing understanding: The importance of sharing detailed information about the services offered at different sites was highlighted as a way to improve clarity and reduce confusion.

Participants noted that politics can at times complicate service delivery and communication, leading to confusion among patients.

b) Planned Care Focus Group:

The focus group on planned care services was led by the Deputy Medical Director (Corporate Services) and the session began with a discussion on the 2035 vision for planned care, with the description of a tiered model for elective procedures and developing elective hubs within NHSGGC.

The key discussion points and feedback included:

Long Waiting Times: There was discussion on how the proposed model would impact waiting times. The staff explained that treating less complex cases more efficiently would free up resources for more severe cases.

Digital Approaches: Participants were pleased with the introduction of digital solutions but raised some concerns on the accessibility of digital communications for the elderly and those that may be digitally excluded. Staff emphasised that while digital options offer helpful access for many, traditional in-person services will remain available for those who prefer or need them.

Community-Based Resources: There was consensus on the need to enhance community resources to reduce hospital visits. Examples like the MSK Physiotherapy hub model, which offers direct access without referrals, were highlighted as successful innovations that could be expanded.

Communication and Engagement: The need for clarity in messaging and the need to avoid politicisation of health services was raised. It was suggested that involving local communities more directly in decision-making could improve the effectiveness of communication and reduce confusion.

The session concluded with a positive outlook on expanding digital and community-based care while ensuring the needs of all patient groups are met.

c) Primary and Community Care Focus Group:

The focus group on planned care services was led by the Deputy Medical Director (Primary Care). This session focused on primary and community care services within NHS Greater Glasgow and Clyde and identified several key themes and insights:

Mental Health Integration: Emphasis on the need for consistency and proper signposting in primary care services for mental health patients. Participants highlighted the effectiveness of digital platforms, like video consultations, which can offer a comfortable and less stressful alternative to in-person appointments.

Digital Approaches and Accessibility: Digital consultations significantly reduce missed appointments and enhance flexibility for patients with busy schedules. There is a growing need for better access to personal health information to empower patients in their healthcare journey.

Collaboration across Services: The importance of cross-sector collaboration was emphasised, especially in managing resources and addressing issues like fuel poverty. The discussion highlighted a desire for more integration among general practitioners (GPs), pharmacists, and practice nurses to provide comprehensive care.

Communication and Expectations: The group discussed the need for communication to manage public expectations and understanding of the roles of different healthcare services, highlighting issues with health literacy and the impact of COVID-19 on Patient-GP relationships.

Innovative Solutions and Future Planning: There was an acknowledgment of the need for creative solutions in light of financial challenges and the complexities of linking patient data across different systems. Participants expressed support for innovations that would lead to improved patient care.

7. Conclusion and next steps:

In conclusion, feedback on the 2035 Healthcare Vision and Clinical Roadmap received strong support. The focus group sessions and survey feedback emphasised the importance of balancing digital and in-person care, enhancing community resources, and ensuring clear communication to support the public.

The engagement highlights a strong commitment to enhancing patient care through increased person-centred approaches, integration of technology and community-based services to improve accessibility and to meet the evolving needs of patients.

This feedback will help to inform the ongoing development and implementation of the MFT strategy. The next steps should include incorporating feedback into strategic implementation, the development of communication and engagement plans to support the next steps in strategic implementation.