



Meeting of East Renfrewshire Health and Social Care Partnership	Integration Joint Board
Held on	15 August 2018
Agenda Item	10
Title	Moving Forward Together – Greater Glasgow and Clyde’s Vision for Health and Social Care
<p>Summary</p> <p>This report sets out Moving Forward Together: Greater Glasgow and Clyde’s vision for health and social care document as the Blueprint for the future delivery of health and social care services. The Blueprint provides a framework for a Transformational Programme to develop and implement change across Greater Glasgow and Clyde’s Health and Social Care Services.</p>	
Presented by	Julie Murray, Chief Officer
<p>Action Required</p> <p>The Integration Joint Board is asked to approve Moving Forward Together: Greater Glasgow and Clyde’s vision for health and social care document as the Blueprint for the future delivery of Health and Social Care Services in GGC, in line with Scottish Government national and West of Scotland regional strategies and requirements and the projected needs of the GGC population.</p>	
<p>Implications checklist – check box if applicable and include detail in report</p> <p> <input type="checkbox"/> Financial <input type="checkbox"/> Policy <input type="checkbox"/> Legal <input type="checkbox"/> Equalities <input type="checkbox"/> Efficient Government <input checked="" type="checkbox"/> Staffing <input type="checkbox"/> Property/Capital <input type="checkbox"/> IT </p>	

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EAST RENFREWSHIRE INTEGRATION JOINT BOARD

15 AUGUST 2018

Report by Chief Officer

MOVING FORWARD TOGETHER GREATER GLASGOW AND CLYDE'S VISION FOR HEALTH AND SOCIAL CARE

PURPOSE OF REPORT

1. To seek the approval of the Blueprint which provides a framework for a Transformational Programme to develop and implement change across GGC Health and Social Care Services.

RECOMMENDATION

2. The Integration Joint Board is asked to approve Moving Forward Together: Greater Glasgow and Clyde's vision for health and social care document as the Blueprint for the future delivery of Health and Social Care Services in GGC, in line with Scottish Government national and West of Scotland regional strategies and requirements and the projected needs of the GGC population.

BACKGROUND

3. In its first report on Health and Social Care Integration in 2015, Audit Scotland emphasised the significant opportunities associated with integration for improving outcomes for individuals and communities and argued that a measure of success would be the extent to which integration provides a vehicle for Health Boards, Councils and IJBs to move to a more sustainable health and social care service, with a greater emphasis on anticipatory care and less reliance on emergency care.
4. In this context and aligning to the Scottish Government 2020 Vision, National Clinical Strategy and Health and Social Care Delivery Plan, the NHSGGC Board, in partnership with the 6 GGC Integration Joint Boards, gave a mandate in October 2017 for the development of a framework for a Strategic Transformation Programme for health and social care services.
5. The approved aim of the Programme was:
 - to develop and deliver a transformational change programme, aligned to National and Regional policies and strategies that describes NHSGGC's delivery plan across the health and social care services provided by our staff, which is optimised for safe, effective, person centred and sustainable care to meet the current and future needs of our population.
6. The supporting objectives were:
 - to update the projections and predictions for the future health and social care needs of our population
 - to produce a clinical case for change
 - to review existing National, Regional and NHSGGC published strategies and model the impact of their delivery on our population

- taking the information above, to develop new models of care delivery which provide safe, effective and person centred care which maximises our available resource, provides care in the most efficient and effective way and makes the best use of innovation and the opportunities presented by new technology and the digital age
 - to support the subsequent development of delivery plans for these new models of care, which describe the required changes in workforce, capital infrastructure and procedures and processes which ensure the intended and projected benefits are realised.
7. A target delivery date for the Blueprint framework was set as the NHSGGC Board meeting on 26 June 2018 with subsequent presentation to the 6 IJB meetings thereafter.

REPORT

8. This framework provides a strategic document through which the NHSGGC Board and 6 IJBs would set the direction for the delivery of integrated health and social care services in line with the NHS Scotland Health and Social care delivery plan, optimised to the current and future needs of the GGC population and aligned to the extant national and regional strategies.
9. The framework is comprehensive and sets a policy direction across a wide range of health and social care services which takes account of the national and regional policies.
10. This Blueprint has been developed in partnership with our public, our staff and wider stakeholders. We have used existing communications channels and established new mechanisms and built relationships.
11. We developed a comprehensive Stakeholder Engagement and Communications Plan at the outset and this has been delivered as planned. Central to this engagement has been the work to seek the views of and listen to the opinions of our population. We have established a Stakeholder Reference Group which has been involved throughout the process, giving opinion and valuable insight into the views of the patient, service users and carers who benefit from our care services and guiding us in how we engage with and inform our public.
12. We have engaged widely with the public through a series of open meetings across our localities to test our thinking and seek views on our Blueprint.
13. We have engaged with, and learned from, the knowledge and experience of our staff from across health and social care services. This includes those who work in hospitals, in our communities and in primary care. We have established 31 expert service modelling groups who have helped us shape our vision of future services and have convened a whole system event where our thinking has been shared and tested. We have had 20 open staff sessions in locations across our 6 IJB areas and in hospital and community venues to seek the views of and listen to our staff.
14. What we have heard from our people and our staff has provided the basis for the development of this Blueprint.
15. Approving this Blueprint will provide a mandate for future work to develop options and proposals which would see the delivery of changes to move toward the realisation of the Vision for health and social care services set out in this document. This Blueprint will shape the development of our future financial, capital and workforce strategies, ensuring that they support the strategic direction set by the NHSGGC Board and IJBs.

16. These specific changes will be developed in partnership with our public and our stakeholders, building on the networks and relationships built so far in this process. There will be a need for further effective engagement, option development and appraisal and consultation on our preferred options.
17. Consistent and ongoing communication and engagement will be a key feature of the work going forward, building on what has been achieved to date and maximising the relationships with our stakeholders. We would seek to continue the inclusive approach to option development we have used in developing our Vision and use the relationships we have built during this process, empowering our public and our staff.
18. It is envisaged that the delivery of our Vision will take 3 to 5 years to develop the full range of changes necessary.
19. If approved the proposed first phase of this development process will focus on determining and then populating the best structure to take forward the programme and identifying priorities for the first tranche of proposals in primary, community, hospital and specialist care.
20. The whole system approach described in the MFT Vision will be adopted across Planned and Unscheduled Care as well as in working with the West of Scotland Region to develop proposals for specialist services through regional clinical networks.
21. An early focus will be on determining the maximum potential of our community networks in delivering care to our population in their communities and the impact that will have on the need for hospital and other specialist services.
22. The proposed phasing of these next steps and associated timelines are described below:

Phase One: July to October 2018 Setting Priorities and Scoping Change Proposals

- Seek IJB confirmation that this framework aligns with their strategic plans
- Establish priority changes which support delivery of the Vision
- Develop and establish a structure based on the priorities and commission work streams and short life working groups

Phase Two: November to December 2018 Develop Detailed Option Appraisal and Recommendations for Prioritised Areas

- Develop prioritised options for the delivery of changes with stakeholders
- Complete option appraisals on proposed changes
- Develop business cases for preferred changes
- Assess whole system impact and coherence
- Seek NHSGGC Board and IJB approval, as appropriate, for first tranche of proposed changes

Phase Three: January 2019 onwards

- Continue to develop implementation plans for approved priority changes
- Continue to assess impact and benefit realisation
- Extend scope to next priority areas

FINANCE AND EFFICIENCY

23. No issues in the immediate term, however the outcome of the completed Programme will contribute to GGC's delivery of the Scottish Government aim of Better Value. Detailed business cases will be developed to support the specific changes and will be incorporated into the NHS Board's financial plan.

CONSULTATION AND PARTNERSHIP WORKING

24. In addition to the system wide engagement detailed in the report. Anne Marie Kennedy, from East Renfrewshire, has been an active member of the stakeholder reference group.
25. Our Voice hosted an open locality engagement event in Thornliebank, in conjunction with the Moving Forward Together team.
26. The Strategic Planning Group held in January considered and commented on a Moving Forward Together presentation.

IMPLICATIONS OF THE PROPOSALS

Risk

27. None

Policy

28. None

Staffing

29. No issues in the immediate term, however the outcome of the completed Programme will recommend changes to our workforce. Again, any specific changes will be incorporated into the overall NHS Board's workforce plan.

Legal

30. None

Property/Capital

31. None

Equalities

32. No issues in the immediate term, however the outcome of the completed Programme will contribute to GGC's delivery of improved health equality.

CONCLUSIONS

33. The NHSGGC Board, in partnership with the 6 GGC Integration Joint Boards, gave a mandate in October 2017 for the development of a framework for a Strategic Transformation Programme for health and social care services.
34. The framework is comprehensive and sets a policy direction across a wide range of health and social care services which takes account of the national and regional policies. This Blueprint has been developed in partnership with our public, our staff and wider stakeholders.
35. Approving this Blueprint will provide a mandate for future work to develop options and proposals

RECOMMENDATIONS

36. The Integration Joint Board is asked to approve Moving Forward Together: Greater Glasgow and Clyde's vision for health and social care document as the Blueprint for the future delivery of Health and Social Care Services in GGC, in line with Scottish Government national and West of Scotland regional strategies and requirements and the projected needs of the GGC population

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26 June 2018

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BACKGROUND PAPERS

Moving Forward Together webpage:
<http://www.movingforwardtogetherggc.org/>

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Moving Forward Together.

Greater Glasgow and Clyde's vision for health and social care



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1: Introduction

Greater Glasgow and Clyde (GGC) health and social care services provide care to the 1.15 million people resident in our area. We also provide specialist services on behalf of the West of Scotland for the population of 2.7 million people and provide a number of national services which are accessed from across Scotland.

The provision of high quality health and social care to our population is at the centre of everything we do. This has been the case for the last 70 years and will continue to be our focus as we move forward together. The successes of the last 70 years have contributed to advances in medical and non medical care that have enabled our people to enjoy an increase in healthy life expectancy over those that have gone before.

With this success comes greater demand for the services that we offer. Illnesses and diseases that would previously have led to premature death are now survivable. People are living longer and are able to do so with multiple conditions.



Demographic projections for the Greater Glasgow and Clyde population indicates an **increase of 17%** in the number of people over 65 years of age by 2025 which is an **additional 43,000 people over the age of 65** who will require our health and social care.

We must continue to be able to meet these increased requirements for health and social care within the resources allocated to us. This is a very challenging task which requires us to work differently. We do not believe that just doing more of the same thing will meet these challenges nor would it be the right thing to do.

Our Aim and Objectives

We have set out the aim of the Moving Forward Together Programme as:

- To develop and deliver a transformational change programme, aligned to national and regional policies and strategies, that describes GGC's delivery plan to provide safe, effective, person centred, accessible and sustainable care to meet the current and future needs of our population.

The objectives are:

- **To update the projections and predictions** for the future health and social care needs of our population by November 2017
- **To review existing national, regional and NHSGGC published strategies** and model the impact of their delivery on our population by November 2017
- **To produce a clinical case for change** by January 2018
- **To develop new models of care delivery** which provide safe, effective and person centred care which maximises our available resource, provides care in the most efficient and effective way and makes the best use of innovation and the opportunities presented by new technology and the digital age by April 2018
- **To support the subsequent development of delivery plans** for these new models of care, which describe the required changes in workforce which ensure the intended and projected benefits are realised by June 2018.

This paper is the first step in the GGC transformation programme. It outlines our vision for the future delivery of health and social care services in GGC and will form the strategic context in which we will work with our full range of stakeholders including the public, staff and partners, to develop proposals which deliver the transformational change and improved care delivery that underpins our vision. It looks beyond today's constraints to tomorrow's solutions.

These principles have been established in partnership with our stakeholders and are aligned to national and regional policies. In the development of this strategic vision we established a stakeholder reference group comprised of patient and carer representatives from across GGC who met regularly throughout the process to give their views on our principles and communication plans. We have also worked with our HSCP partners to encourage wider public engagement through a series of local public conversations on our direction of travel and principles.

We have also worked with over 400 members of the clinical and managerial teams from across health and social care in GGC. We have incorporated the advice and views of our wider staff through a series of open staff events. These events have been held across the extent of GGC hospital and community facilities and have enabled us to engage with nearly 1000 staff.

This document will provide strategic direction for our decision making for the coming years and will give us the basis on which to discuss innovative ways to meet our challenges and plan together with our population and partners innovative ways of delivering care for our people.

Our Principles

The key principles on which the Moving Forward Together Programme has been based are as follows:

- Aligned to national strategic direction
- Consistent with West of Scotland Programme
- A whole system programme across health and social care
- Using the knowledge and experience of our wide network of expert service delivery and management teams
- Involving our service users, patients and carers from the outset
- Engaging with, and listening to, our staff and working in partnership
- Embracing technology and the opportunities of eHealth
- Affordable and sustainable.

The National Clinical Strategy describes the need to make changes to the processes of care and structural changes to the way in which services are planned. It advocates services being delivered locally wherever possible but when these services require specialist skills or equipment it advocates a population approach to planning which would see the creation of a fewer number of centres of excellence where the bringing together of skills and equipment into selected locations providing services across a geographical region would provide:

- Clinically proven better outcomes through increased volumes
- Better use of new technology
- A more sustainable workforce.

We believe that investing in community-based services will better support our population. Our intention would be to meet the increased demands on our services by enhancing and maximising the effectiveness of our community-based services and by better linking these services with our specialist and hospital-based services as one single integrated networked system of care.

There is strong evidence that staying in hospital beyond the time which is clinically appropriate is detrimental to people and can lead to a loss of independence. We do not believe that more hospital beds are the best way of addressing the future demand. Neither is it the best way of caring for our population.

There is a well-known challenging financial environment in place now and that is unlikely to change in the near future. This challenge drives us to focus on maximising the output of our resource and to make well-judged investment choices when that opportunity arises.

We believe that if we work together to deliver transformational change aligned to the principles described in this vision we will meet these challenges without the need to expand our hospital-based infrastructure. We shall aim to invest in enhancing community-based services and will ensure our hospital infrastructure remains capable of delivering first class specialist care and that care is delivered in fit-for-purpose facilities.

Embracing Modern Technology

Delivery of our vision is underpinned by the intelligent use of modern information technology and communications platforms. The creation of a single integrated care record and integrated care plan for individuals which is shared across our network and owned by the person is key to our success. Linking the providers of care to enable shared decision making and team building is the enabler which will bring our teams together and will allow us to realise the benefits of networked integrated care described in our vision.

Realistic Medicine

Entirely in keeping with our principles is the concept of Realistic Medicine, which puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and social care workers to find out what matters most to the person and ensures that the care offered fits individual needs and their situation. Realistic Medicine recognises that a one size fits all approach to health and social care is not the most effective approach for our people. Realistic Medicine is not just about doctors. 'Medicine' includes all professionals who use their skills and knowledge to help people maintain health and to prevent and treat illness and, as such, includes every profession in our whole system.

Precision Medicine

Future advances in treatment through the introduction of precision medicine can be seen as the ultimate in person centred care. Precision medicine allows the selection of treatments which are optimised to an individual's genetic and molecular make up.

There is a current focus on cancers but a longer term aim to generate knowledge applicable to the whole range of health and disease.

Research has already revealed many of the molecular lesions that drive cancers, showing that each cancer has its own genomic signature, with some tumour specific features and some features common to multiple types. Although cancers are largely a consequence of accumulating genomic damage during life, inherited genetic variations contribute to cancer risk. This new understanding of oncogenic mechanisms has begun to influence risk assessment, diagnostic categories, and therapeutic strategies, with increasing use of drugs and antibodies designed to counter the influence of specific molecular drivers.

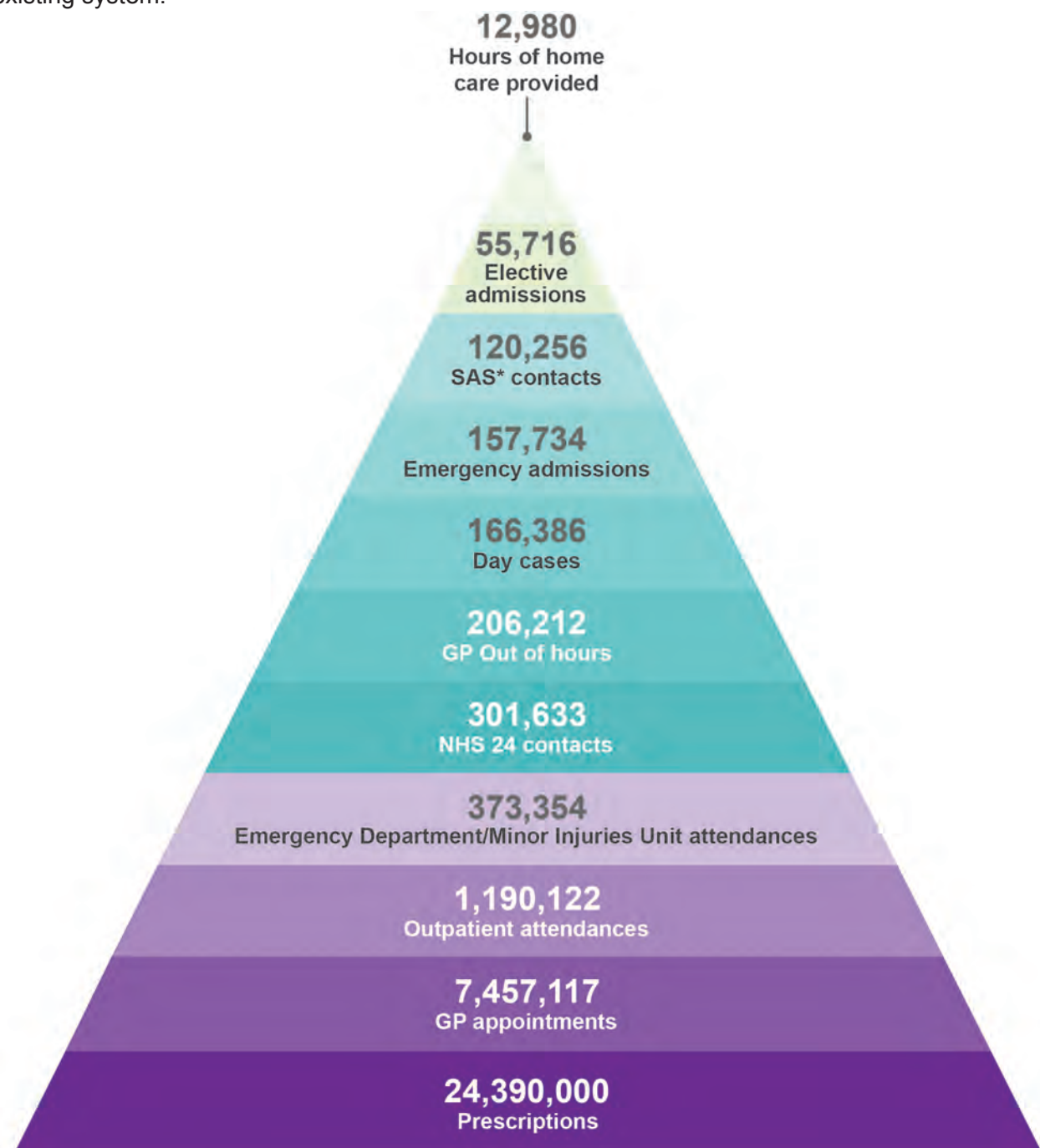
In Moving Forward Together we should embrace and encourage creative approaches to precision medicine, supporting clinical trials which will ultimately build the evidence base needed to transform clinical practice.

Our Tiered Approach

In Moving Forward Together we have adopted a methodology which builds a tiered network approach across health and social care spanning a local and community-based element which can then escalate care as required into specialist or hospital-based care. The ethos across this network being focussed on delivery of anticipatory care and early intervention to enable care is delivered as locally and as early as possible.

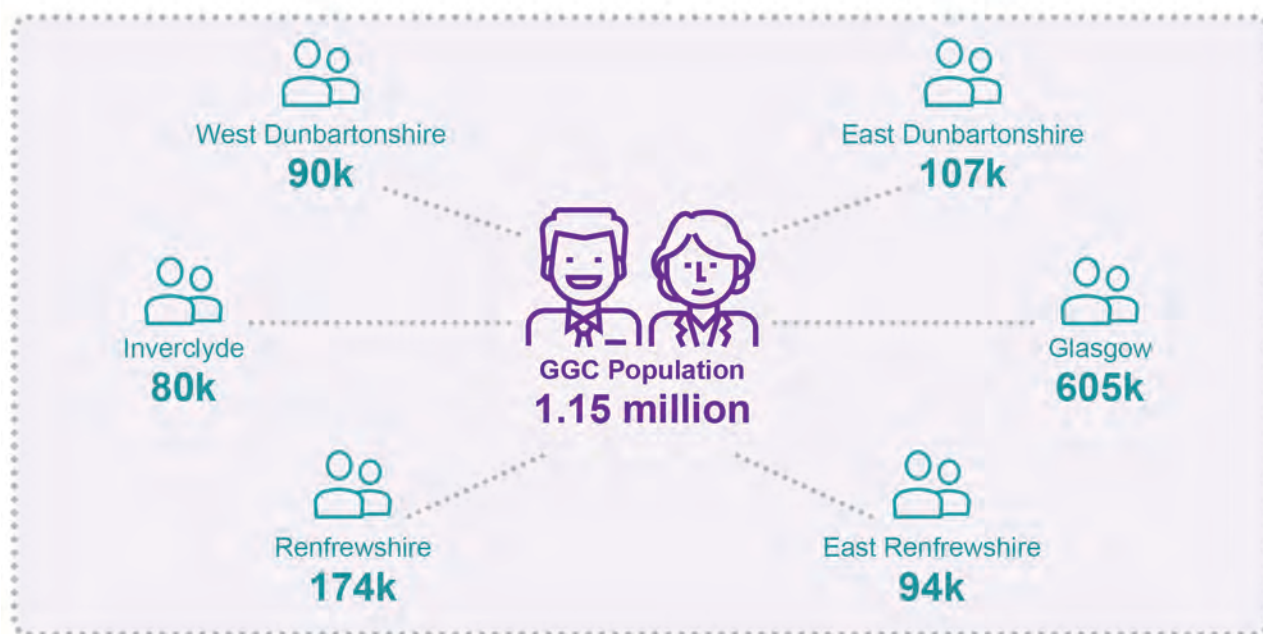
Our tiered network of care delivery seeks to provide access as locally as possible with access to increasingly specialist care provided for a geographical sector or indeed for the whole of GGC or sometimes for the West of Scotland.

The majority of our care is already delivered in our communities and we would seek to build on this. The diagram below shows the volume of activity delivered in GGC in 2016/17 across our existing system.



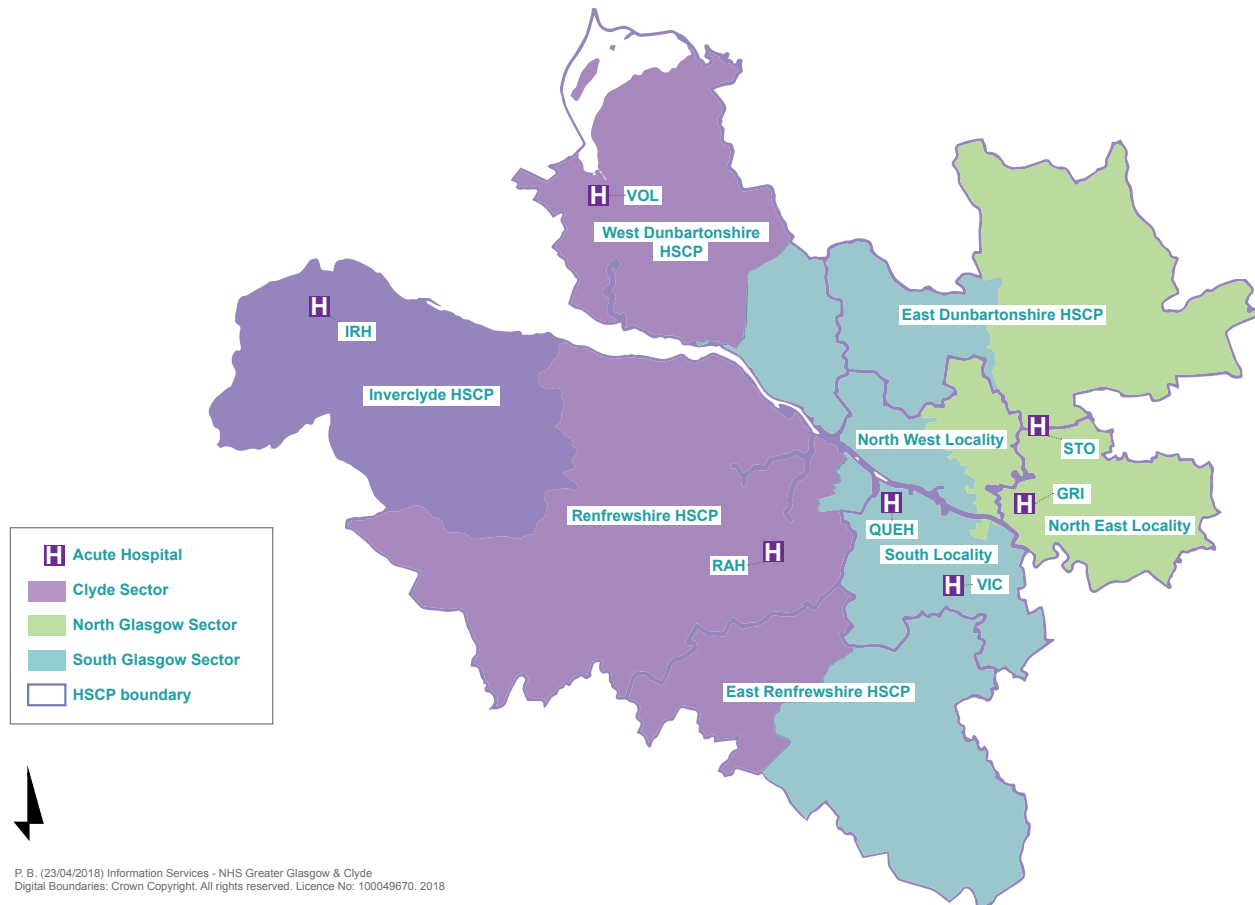
*Scottish Ambulance Service

Greater Glasgow and Clyde has six Health and Social Partnerships with allocated populations. These populations vary in size across the partnerships:



When we consider hospital catchments based on where our population currently attend for emergency care we can describe our population as:

South Glasgow (Queen Elizabeth University Hospital and New Victoria Hospital)	510k
North Glasgow (Glasgow Royal Infirmary and New Stobhill Hospital)	322k
Clyde (Royal Alexandra (196k), Inverclyde Royal (76k) and Vale of Leven (46k))	318k
Total	1.15m



This allows us to describe the delivery of care across our tiers as either local access, access within a geographical sector for more specialist care, or for highly specialist care access from across GGC.

Care which is provided via **Local Access**, at one or more locations within a geographical sector covering a population of around 100-150k, includes:

- GP and enhanced team
- GP cluster
- Community network
 - Virtual or physical hub and spokes model
- Out of hours urgent care network
- Community mental health services
- Intermediate care services
- Local unscheduled care network
- Outpatient consultation
- Routine diagnostic testing
- Day and short stay treatment
- Access to minor injuries

Care which is provided via **Geographical Sector** based access includes:

- Specialist community-based services
- Trauma Unit with full Emergency Department
- More specialist outpatient consultation
- Full range of diagnostic testing
- Non specialist inpatient treatments
- Critical care facilities
- Lower complexity cancer care

Care which is provided via access from across GGC includes:

- Highly specialist community-based services
- Major Trauma Centre
- Highly specialist outpatient consultation
- Specialist diagnostic testing
- Specialist inpatient treatments
- Specialist critical care facilities
- Specialist cancer care

Summary

Our Moving Forward Together vision for the future of health and social care in Greater Glasgow and Clyde recognises that:

- **Demographic changes drive an increase in demand** of around 10% across health and social care services by 2025
- **Doing nothing different would lead to a need for more hospital-based care** to meet this demand
- **Focus on delivering sustainable high quality services** with our available workforce
- **Delivery of the new models of care are expected to lead to more care in communities** and a reduction in hospital-based care
- In the long term, prevention and self care initiatives have the **potential to mitigate the rising demand**
- In the long term this is expected to **lead to less reliance on the hospital-based infrastructure**
- The focus of future **investment should be on the community-based network** to deliver our vision
- **Ongoing investment will also be required** to maintain the quality of our hospital services.

Moving Forward Together is our approach to fundamentally redesign our services to meet the future needs of our population in partnership with our public, staff and the other providers of health and social care.

2: Case for Change

Background

The key factors which drive our strategic context and case for change are reflected in the national strategic direction set by Scottish Government in the 2020 Vision, the Health and Social Care Delivery Plan (HSCDP) and the National Clinical Strategy (NCS).

The HSCDP commits to delivering a whole system of health and social care predicated on seamless care for everyone who needs it dependent on assessed need and delivered within an integrated system. This was set out in legislation and enacted in 2016 through the establishment of Integration Joint Boards who are responsible for planning and commissioning a wide range of primary and community care as well as some acute hospital care.

The Moving Forward Together Programme is not an end in itself, rather it is the beginning of what is an ongoing, evolutionary plan to transform not only the delivery of health and social care services for the people of Greater Glasgow and Clyde but importantly also the health and wellbeing of our population. It is that improvement that will empower individuals and communities by supporting people to fully participate as partners in their health and social care choices, taking responsibility for their own health and their own health and social care needs.

National Strategic Context

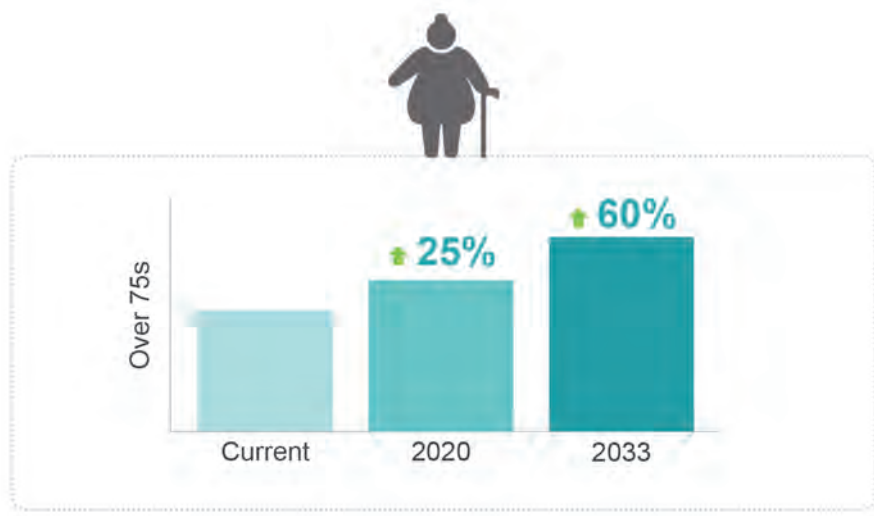
The strategic landscape set for health and social care services in Scotland in which GGC must operate provides an agreed and supported direction of travel which is founded on evidence based good practice and sound principles. Audit Scotland in their report on health and social care highlighted both the imperative to continue to pursue this direction of travel, but also recognised the challenges to be faced and overcome in delivering the changes which are required to move these services forward together.

It is to be celebrated that our people are generally living longer and healthier lives owing to the range and quality of past and present prevention programmes and the health and social care services that the NHS and Local Authorities in Scotland have delivered and are continuing to deliver.

It is also recognised that these positive changes place increasing demands on health and social care services, who have to work within their resources to provide the care needed for local residents. This has resulted in the need to look at the future needs of our population and to develop and support the changes needed to keep pace with demand now and over the coming years. Modern health and social care practice is developing through the growing evidence base which describes what best meets those future needs through new and developing technological advances, but also in terms of what our population expect of their health and social care services in the modern world.

Scottish Government studies predicted that by **2020** the proportion of **over 75s in Scotland's population** – who are the highest users of NHS services – **will increase by over 25%**.

By **2033** the number of **people over 75** is likely to have **increased by almost 60%**.



It was predicted that there will be a continuing shift in the pattern of disease towards long term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia.

These studies concluded that without major transformational change over the next 20 years the changes in demography alone could increase expenditure on health and social care by over 70%.

While these predictions are for the whole of Scotland, they equally apply for the population of the West of Scotland and in the Moving Forward Together context, the Greater Glasgow and Clyde population.

Phase One of the Moving Forward Together Programme updated the predictions on population changes for GGC and each of our HSCP partnerships to enable the development of a projected demand picture up to 2025.

The **Scottish Government 2020 Vision** remains the cornerstone of NHSScotland Health and Social Care policy and it continues to be our strategic goal beyond 2020. The vision sees a state where everyone is able to live longer, healthier lives at home, or in a homely setting and that we will have a care system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self management
- When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

The Quality Strategy

The Quality Strategy published in 2010 is the approach and shared focus for all work to realise the 2020 Vision. It aims to deliver the highest quality health and social care to the people of Scotland, to ensure that the NHS, Local Authorities and the Third Sector work together and with patients, carers and the public, towards a shared goal of world leading healthcare.

The Quality Strategy is based on the Institute of Medicine's six dimensions of Quality.

It is also shaped by the patient engagement feedback received from the people of Scotland when asked what they wanted from their healthcare system. This is summarised as a system which is caring and compassionate and has good communication and collaboration. A system where care is delivered in a clean environment and that gives continuity of care and achieves clinical excellence.

Out of these criteria three Quality Ambitions were developed and agreed:



Integration and the National Health and Social Care Outcomes

Legislation requiring the integration of health and social care came into effect in April 2016 and the new Integration Joint Boards now have responsibility for over £8 billion of funding across Scotland for the planning and commissioning of a wide range of primary and community care, as well as some acute hospital care. The Scottish Government considers this to be the most significant change to the way care is provided for people in their communities since the creation of the NHS 70 years ago.

In addition to the Public Bodies (Joint Working) Act, health and social care services are required to develop in response to other legislation, including:

- **The Social Care (Self Directed Support) Act 2013**, which makes legislative provisions relating to the arranging of care and support, community care services and children's services to provide a range of choices to people for how they are provided with support
- **The Children and Young People (Scotland) Act 2014**, which reinforces the United Nations Convention on the Rights of the Child and the principles of Getting It Right For Every Child
- **The Community Empowerment (Scotland) Act 2015**, which provides a legal framework that promotes and encourages community empowerment and participation and outlines how public bodies will work together and with the local community to plan for, resource and provide services which improve outcomes in the local authority area
- **The Carers (Scotland) Act 2016**, which aims to ensure better and more consistent support for both adult and young carers so that they can continue to care in better health and to have a life alongside caring.

The measure of success in integration is making the necessary changes which put people at the centre of decisions about their care and improves and seamlessly networks the range of services available to make them more responsive and effective for the people who use them.

Hospitals should provide clinical care that cannot be provided anywhere else, but most people need care that can be provided in settings other than hospitals which are more appropriate to the specific individual needs and are better placed to support health and wellbeing. This thinking meets the expectation that people would rather receive support and care at home or in a homely setting when they do not require the level of acute care that can only be delivered in a hospital.

Integration aims to provide care built around the needs of the person, which can support them to remain at home or closer to home, connected to their families and their communities. At a strategic level the benefits of integration are founded on delivery of nine outcomes which are monitored through a range of measurable indicators.

These are:

Outcome

- 1 People are able to look after and improve their own health and wellbeing and live in good health for longer
- 2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- 3 People who use health and social care services have positive experiences of those services, and have their dignity respected
- 4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- 5 Health and social care services contribute to reducing health inequalities
- 6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- 7 People using health and social care services are safe from harm
- 8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- 9 Resources are used effectively and efficiently in the provision of health and social care services

The National Clinical Strategy

The National Clinical Strategy (NCS) is an evidence based strategy which sets out the drivers for the required transformational change in the delivery of clinical services to ensure services are able to meet the changing demands and take advantage of technological advances both now and for the future.

The strategy looks across the whole patient pathway from primary care and community care, to secondary and tertiary care and includes palliative and end of life care and the approach to Realistic Medicine. It uses the known projections and predictions in terms of changes in demographic profile, technological advances and projected available resource to consider the wider implications of those changes for NHSScotland for the next 10 to 15 years and beyond.

The NCS uses national and worldwide evidence of successful change to indicate the potential impact of such changes in terms of improved outcomes and better experiences for individuals.

The drivers for change described in the NCS which equally apply in GGC are:

- Demographic changes in Scotland's population
- The changing patterns of illness and disability
- The relatively poor health of the population and persisting inequalities in health
- The need to balance health and social care according to need
- Workforce challenges
- Financial considerations
- Changes in the range of possible medical treatments
- Remote and rural challenges to high quality healthcare
- Opportunities from increasing information technology (eHealth)
- A need to reduce waste, harm and variation in treatment
- Increasing need for support for an ageing population with increasing levels of multimorbidity
- Multimorbidity arising approximately a decade earlier in areas of deprivation.

The NCS recognises the current challenges to the delivery of these changes in NHSScotland. These challenges are reflective of those currently facing GGC and drive a need to:

- **Improve care and outcomes** via an expanded, multi-disciplinary and integrated primary and community care sector, despite current workforce constraints
- **Increase co-production with patients and carers**, create high quality anticipatory care plans and support people in health improvement and self management
- **Embrace the changes required for effective integration of health and social care** and ensure that it makes a transformational change in the management of patients despite the current demand and supply challenges also faced by social services
- **Reduce the avoidable admission of patients to hospital** whenever alternatives could provide better outcomes and experiences
- **Dramatically reduce the problem of discharge delay** and thereby the risk of avoidable harm and adverse impact on the maintenance, or re-establishment of independent living
- **Make better use of information** and make better informed decisions about both individual and collective care

- **Ensure that services become sustainable** in the face of considerable workforce and financial constraints by giving careful consideration to planning of more highly specialist provision
- **Provide healthcare that is proportionate to people's needs** and where possible their preferences, avoiding over-treatment and over-medicalisation and at the same time prevent under-treatment and improving access to services in others
- **Provide services of greater individual value** to patients
- **Move to sustainable expenditure** so that we maintain high quality services and can also avail ourselves of medical advances as they arise
- **Integrate the use of technology** into service redesign and to consider how IT could transform service delivery and help meet future challenges.

The potential impact for the delivery of health and social care services provided by GGC will be considered across the whole range of services from primary through community, hospital and specialist care and beyond. Moving Forward Together is aimed at defining and supporting the future development and delivery of the transformational changes that will be required to meet the assessed future needs of our people. This is being achieved by taking a whole system approach across all care sectors and boundaries within the GGC area.

In looking to deliver the Health and Social Care Delivery Plan, the principles of service planning are changing in terms of both the 'Once for Scotland' approach and also the changes in planning regionally for populations, across board and geographical boundaries.

In planning regionally for the West of Scotland population of 2.7 million people this is likely to lead to changes in the organisation of services provided in our hospitals. There will be a need in future to work as joined up networks providing the full range of planned care needed across specialist services, linking to and working alongside, primary care clusters and community care services to ensure a coordinated, seamless experience for those individuals who cannot be cared for at home or in a homely setting.

The Health and Social Care Delivery Plan

The Health and Social Care Delivery Plan focuses on three areas, which are referred to as the 'Triple Aim':



Within GGC, a fourth aim, of Better Workplace, has been added recognising the importance of our workforce.

Primary Care Outcomes

The national Primary Care Outcomes Framework sets out a clear vision for the future of primary care as being at the heart of the healthcare system, linking to the 2020 Vision, Health and Social Care Integration, the National Clinical Strategy and the Health and Social Care Delivery Plan.

This vision applies across the four primary care contractor groups and the wider multi-disciplinary team working in primary care. General practices are central to this vision for primary care with Scotland's GPs as the Expert Medical Generalist in the community; focussed on complex care, undifferentiated presentation and local clinical leadership. The new GP contract is now in place and this, alongside additional focus and investment in the wider context of primary care, is expected to achieve a move towards that vision and the creation of extended multi-disciplinary teams in every locality.

National Outcomes

Our children have the best start in life and are ready to succeed	We live longer, healthier lives	Our people are able to maintain their independence as they get older	Our public services are high quality, continually improving, efficient and responsive
We start well	We live well	We age well	We die well

Primary Care Vision

Our vision is of general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multi-disciplinary teams will deliver care in communities and be involved in the strategic planning of our services.

HSCP Outcomes

People can look after own health	Live at home or homely setting	Positive experience of services	Services improve quality of life	
Services mitigate inequalities	Carers supported to improve health	People using services safe from harm	Engaged workforce improving care	Efficient resource use

Primary Care Outcomes

We are more informed and empowered when using primary care	Our primary care services better contribute to improving population health	Our experience as patients in primary care is enhanced
Our primary care workforce is expanded, more integrated and co-ordinated with community and secondary care	Our primary care infrastructure – physical and digital – is improved	Primary care better addresses health inequalities

The **National Review of Out of Hours Primary Care Services** was published in November 2015. It recommends a whole system approach to enable a safe, sustainable, person centred service model for out of hours and urgent care in the community that is clinician-led but delivered by a multi-disciplinary team. This will enable patients to be seen by the most appropriate professional to meet their individual needs, within an integrated service.

The vision for **Pharmaceutical services** in Scotland includes a commitment to increasing access to community pharmacy as the first port of call for managing self limiting illnesses and supporting self management of stable long term conditions, in and out of hours, and to increasing access to GP practice-based pharmacy, integrating pharmacists with advanced clinical skills and pharmacy technicians in GP practices to improve pharmaceutical care and contribute to the multi-disciplinary team.

The **Community Eyecare Services Review** sets out a clear role for community optometrists in the transformation of primary care and ongoing development of community-based care; ensuring that patients see the most appropriate professional and further developing eye care in the community.

The **Oral Health Improvement Plan** sets the direction of travel for oral health improvement and NHS dentistry for the next generation. The plan has a strong focus on preventing oral health disease, meeting the needs of the ageing population and reducing oral health inequalities.

Mental Health

The Scottish Government published a 10 year strategy for mental health in March 2017. It is wide ranging and cross cutting across sectors, including education, prison, secure care, children, young people and adults and also measurement and data requirements to fulfil the 40 actions set out. It will be reviewed at the halfway stage – in 2022 – to assess its delivery and impact.

Maternity and Neonatal Services

The Review of Maternity and Neonatal Services in Scotland published by Scottish Government in January 2017 aims to ensure that every mother and baby continues to get the best possible care from Scotland's health service, giving all children the best start in life. The Review examined choice, quality and safety of maternity and neonatal services, in consultation with the workforce, NHS Boards and service users. In summary, its recommendations are:

- **Continuity of carer:** all women will have continuity of carer from a primary midwife, and midwives and obstetric teams will be aligned with a caseload of women and colocated for the provision of community and hospital-based services
- **Mother and baby at the centre of care:** Maternity and neonatal care should be co-designed with women and families from the outset, and put mother and baby together at the centre of service planning and delivery as one entity
- **Multi-professional working:** Improved and seamless multi-professional working
- **Safe, high quality, accessible care,** including local delivery of services, availability of choice, high quality postnatal care, colocation of specialist maternity and neonatal care, services for vulnerable women and perinatal mental health services
- **Neonatal services:** proposes a move to a new model of neonatal intensive care services in Scotland in the short and long term
- **Supporting the service changes:** recommendations about transport services, remote and rural care, telehealth and telemedicine, workforce, education and training, quality improvement and data and IT.

As is the case with mental health services, Moving Forward Together will bring forward options for appropriate actions to address any changes required in line with the national requirements both in terms of the women and babies within GGC but also as required across West of Scotland as well as any actions taken so far and their impact.

Major Trauma Services

In January 2017 a new National Trauma Network was launched which sees four major trauma centres backed up by a range of co-ordinated trauma units across Scotland. One of these major trauma centres is based in Glasgow, at the Queen Elizabeth University Hospital. The national trauma network is commissioned and run by National Services Division while the local configuration of hospitals and, vitally, the clinical pathways for people suffering trauma are determined regionally and locally to best support and meet need. NHSGGC and West of Scotland planning leads are working together to ensure the most appropriate configuration of trauma units along with Scottish Ambulance Service and NHS 24, among others, to see necessary changes made so as to save more lives.

This work is continuing to be driven by the Major Trauma Network and associated partners, however Moving Forward Together is ensuring that the clinical needs of people with trauma are taken into account in determining the future patterns and pathways of care across GGC.

Cancer Services

The Scottish Government's cancer strategy – Beating Cancer: Ambition and Action – published in 2016, is now being implemented across the country accompanied by additional investment of up to £100m over the period to 2021. The burden of cancer is significant and, in some types of cancer, particularly so for the people across GGC. There have also been tremendous improvements in survival and individual outcomes but the strategic direction is clear – an emphasis on prevention, better (faster) diagnosis and treatment, research (trials), and improving services and data quality.

Within the GGC context there is a strong regional commitment as the Beatson West of Scotland Cancer Centre delivers comprehensive complex chemotherapy and radiotherapy services for all of the population and supports access to nationally delivered services in England where, for example in ophthalmic cancers, there is no Scottish service as numbers are too small and the expertise is concentrated elsewhere.

As with other diseases, cancer is largely (but not exclusively) associated with ageing and the predicted incidence increases are significant, placing additional needs on these services, both for those that largely for safety reasons can only be delivered in the Beatson, such as radiotherapy and brachytherapy, but also on those chemotherapy services delivered on an outreach basis across the whole of the West of Scotland.

Work is continuing to assess the most appropriate configuration of cancer services across the West of Scotland for the future, informed by the Moving Forward Together Programme clinical groups and assessments.

West of Scotland Regional Vision

As Moving Forward Together has been developing a vision for GGC there has been a complementary process to develop a regional design proposition for transforming health and social care across the West of Scotland. In May 2016 a position statement was published on behalf of the West of Scotland Programme which is entirely in keeping with the principles and approach taken forward in Moving Forward Together.

From this a shared vision for the West of Scotland has been coproduced across partner organisations – including NHS Greater Glasgow and Clyde – and articulated as follows.

Our priority is that you will get the care you need in the right place, at the right time, every time. You will:

- **Be at the heart of decisions that affect you**
We will tailor our approach so that we provide integrated care organised around your needs and the needs of your carer
- **Be empowered and responsible for your own health and wellbeing**
We will provide support that enables you to take greater responsibility for your own health and wellbeing. This will include innovative ways of working to help you live a healthy life in your own home
- **Receive safe and high quality care**
Wherever you receive your care and whoever is providing it, we will ensure services are safe and effective
- **Receive care in the most appropriate place for you**
We will provide care that is both convenient and of a high quality. We will do this by reducing unnecessary trips to health centres and hospitals and ensuring you get the most out of the visits you make
- **Experience compassionate care no matter where you live**
Wherever possible, care will be provided as close to your home as possible and reflect your care needs and personal circumstances.

Summary of the National and Regional Strategic Context

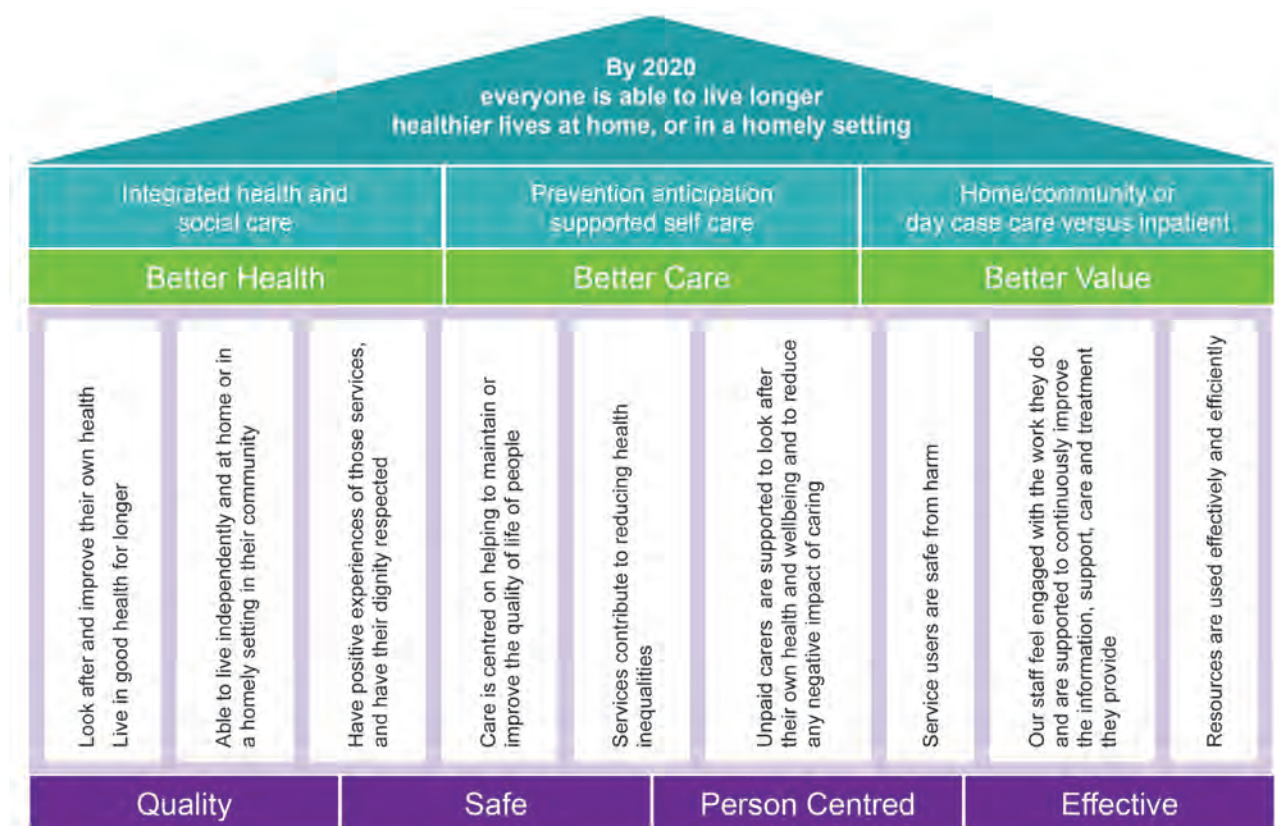
As highlighted in this section there are a number of national and regional policies, strategies and influences which have shaped and will continue to shape the Moving Forward Together Programme and the future of services delivered within GGC. There is a coherent and clear direction set out across all the national, regional and GGC documents.

Scottish Government predictions are clear, providing in turn a clear imperative for change if health and social care services are to continue to be able to meet the assessed needs of the population, young and old, rich or poor, no matter where they live across the GGC area.

The 2020 Vision sets the context of our strategic framework. Its delivery for our population rests on the triple aim and the success of the integration agenda which is supported by the nine pillars of the National Health and Social Care outcomes and the Primary Care outcomes. Everything is underpinned by the Quality Strategy.

Clinical services are being, and will continue to be, developed in line with the National Clinical Strategy and other relevant Scottish Government strategies.

Pictorially we are presenting this as a ‘Cathedral of Care’ – set out below – which is not only an aide mémoire of all that Moving Forward Together represents but supports consistent assessment against all of the principles and outcomes throughout our whole system planning for each and every service.



Our Case for Change

The 2015 NHSGGC Clinical Services Strategy provides the local framework within which NHSGGC plans and delivers health and social care.

Although it predates the National Clinical Strategy the two documents are coherent in terms of the overall principles and the direction of travel across primary, secondary and tertiary care and the shift in care from an emphasis on hospital care towards care provided at home or in a homely setting via primary and community care planned and delivered via health and social care partnerships and, for example, clusters of GP practices working cohesively as a multi-disciplinary team to meet the needs of patients.

The Clinical Services Strategy Case for Change

As with the National Clinical Strategy, the Clinical Services Strategy first identified the case for change based on an evidential review and predictions of our future population needs.

The summary of the final case for change is described by nine key themes shown below.

- The health needs of our population are significant and changing
- We need to do more to support people to manage their own health and prevent crisis
- Our services are not always organised in the best way for patients
- We need to do more to make sure that care is always provided in the most appropriate setting
- There is growing pressure on primary care and community services
- We need to provide the highest quality specialist care
- Increasing specialisation needs to be balanced with the need for coordinated care which takes an overview of the patient
- Healthcare is changing and we need to keep pace with best practice and standards
- We need to support our workforce to meet future changes.

Clinical Services Strategy System Wide Challenge

The Clinical Services Strategy recognised the challenging demand pressures across a system in which 'hospital' and 'community' services were largely seen as separate, with often poor communication and lack of joint planning across the system. It was recognised that the future demand pressures could not be met by continuing to work in that way.

The Clinical Services Strategy proposed a new system of care focusing on providing care where it is most appropriate for the patient. This was based on strengthened 24/7 community services, hospital services focussed on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to hospital visits.

The Clinical Services Strategy proposed working differently at the interface between community and hospital which may involve new services, extending existing services, creating new ways of working through inreach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

Enablers

The Clinical Services Strategy identified that changing the system at scale would require a series of enabling changes to support delivery of the new healthcare system:

- **Supported leadership** and strong clinical engagement across the system to develop and implement the new models
- **Building on the clinical portal** to enable shared IT systems and records which are accessible to different professionals across the care system
- **Jointly agreed protocols** and care pathways, supported by IT tools
- **Stratification of the patient population** to ensure that care is targeted at the appropriate level with supporting anticipatory care plans in place
- **Ensuring that access arrangements enable all patients** to access and benefit from services
- **Increasing the education and information shared with patients** and the public to support people to take more responsibility for their own care
- **Involvement of patients and carers** in care planning and self management
- **Shared learning and education** across primary, community and acute services
- **Governance and performance systems** which support new ways of working
- **Information systems** which enable us to gather the information we need to monitor whether the changes are working, including disaggregated data on activity and outcomes for equality groups
- **Integrated planning** of services and resources
- **Ensuring that contractual arrangements** with independent contractors support the changes required.

Clinical Services Strategy Projected Benefits

It was anticipated that the successful achievement of the new system of healthcare would result in:

- **Patients being in control of their care** and empowered to share decisions about it
- **A system of care** which is easier to navigate for patients and professionals
- **Clinicians and other staff at all stages having the necessary information** about the patient with care better tailored to the patient
- **Better patient experience and patient safety**, and improved health outcomes with a particular improvement for patients with multimorbidity
- **A reduction in health inequalities** as the most vulnerable patients receive better access to holistic person centred care
- **Care which is provided in the most appropriate setting**, relative to the patients' needs
- **More cost effective use of resources** with care focussed on early intervention, better management of complex multimorbidity and a reduction in duplication of care.

The Clinical Services Strategy Future Health System described a series of key characteristics of clinical services.

These are also key features of the future for NHSScotland and GGC in particular in terms of the national strategic picture. Much of the proposed change in the Clinical Services Strategy remains what needs to be and must be done to deliver sustainable high quality health and social care which meets the future needs of our population.

However, if GGC is to continue to meet the needs of our population, Moving Forward Together needs to take the Clinical Services Strategy principles and the national context requirements on to transformational service delivery in the context of integration and bring together health and social care to deliver a new integrated system that not only provides the best quality of care possible but also supports people to manage their own care where appropriate, through maximising the use of digital technology and community support to improve access for advice and support, such as through community pharmacists, optometrists and more appropriate use of GPs and out of hours services.

The actions to deliver for the future needs of our population will:

- Support and empower people to improve their own health
- Support people to live independently at home for longer
- Empower and support people to manage their own long term conditions
- Enable people to stay in their communities accessing the care they need
- Enable people to access high quality primary and community care services close to home
- Provide access to high quality hospital-based care when the required level of care or treatment cannot be provided in the community
- Deliver hospital care on an ambulatory or day case basis whenever possible
- Provide highly specialist hospital services for the people of Greater Glasgow and Clyde and for some services, people across the West of Scotland and nationally.

What Does the Future Look Like?

Subsequent chapters set out the vision for the delivery of health and social care services which are optimised to meet the changing needs of our population.

We describe a whole system approach to planning and delivery of primary, community and specialist care whether that care is delivered on an unscheduled or planned basis.

We also describe the key enablers to achieve the changes described in our vision including new workforce roles, eHealth requirements and other key enablers.

3: Programme Structure

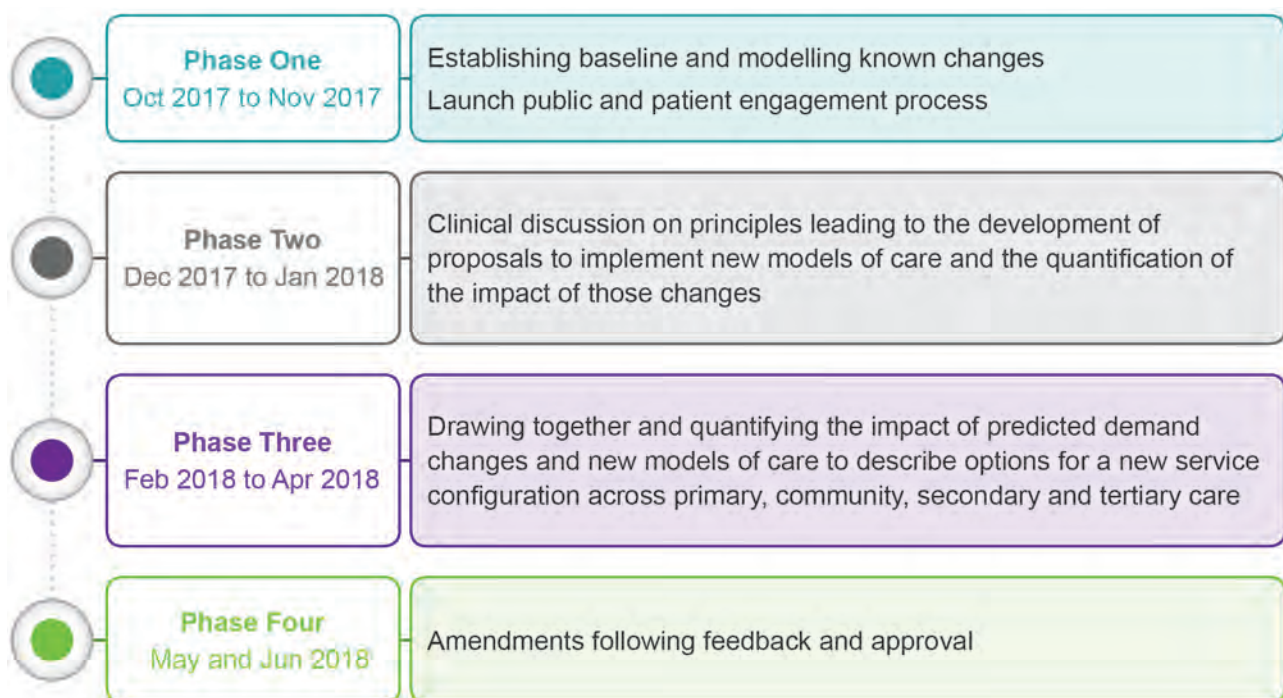
Programme Structure

The key principles on which the Moving Forward Together Programme has been based are as follows:

- Aligned to national strategic direction
- Consistent with West of Scotland Programme
- A whole system programme across health and social care
- Using the knowledge and experience of our wide network of expert service delivery and management teams
- Involving our services users, patients and carers from the outset
- Engaging with, and listening to, our staff and working in partnership
- Embracing technology and the opportunities of eHealth
- Affordable and sustainable.

From the initial scoping of the Moving Forward Together Programme it was decided that the Programme would be conducted as four separate consecutive phases which would allow the work to develop against a clearly defined timeline which was targeted at producing the final proposed strategic document for the NHSGGC Board meeting in June 2018. The phasing of the Programme and the consequential timeline have been strictly adhered to throughout the Programme with all phases being delivered to time.

The four phases of the Programme which were proposed to, and approved by, the NHSGGC Board in October 2017 and subsequently endorsed by the Integration Joint Boards, were defined as follows.



To deliver the Programme on behalf of the NHSGGC Health Board and six Integration Joint Boards a short life programme structure was created. This structure comprised of a Programme Board chaired by the NHSGGC Chief Executive with membership at Corporate Director level across the Health Board, HSCP Chief Officers, partnership and clinical forum representatives and also other key stakeholders such as the West of Scotland Regional Planning Group and Scottish Ambulance Service.

The Programme Board has the following agreed responsibilities:

- **Providing support and guidance** to the Medical Director as Programme Executive and the Programme Core Team
- **Facilitating change** and championing the work of the Programme with internal and external stakeholders
- **Monitoring** the overall progress of the Programme
- **Sponsoring the resource** and expertise required to deliver the Programme
- **Giving direction** on the conduct of the Programme
- **Acting as the coordinating body** for the range of health and social care service changes underway in parallel to the Programme
- **Providing alignment** with other key programmes across health and social care
- **Approving the submission of programme papers** for NHSGGC Board and Integration Joint Boards
- **Discussing and resolving** any conflicts escalated by the Programme Executive.

Following the guidance of the Programme Board is the central Moving Forward Together Core Team who have dedicated time each week to take forward the work of the Programme. The Core Team is composed of senior managers and clinicians from across the HSCPs and the Acute Division and has a nominated Clinical and Managerial lead.

The Core Team members reach back to their base networks to ensure engagement and to use the knowledge and experience base of those networks.

The team was established on 7 September 2017 with representation covering the following areas:

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Policy • Public health • Health economist • Business intelligence and data analysis • General practice • Primary care management • HSCP planning • Pharmacy • Social work | | <ul style="list-style-type: none"> • Mental health • Nursing and allied health professionals • Acute consultant body • eHealth consultant • eHealth management • Acute planning • Corporate communications • Patient and public engagement and involvement |
|---|--|--|

The team meets formally once a week and operates a hub and spoke arrangement with each member taking forward agreed tasks out with the meetings.

The team reports to and takes guidance from the NHSGGC Medical Director as Programme Executive at the end of each week who then engages with the Corporate Directors at their weekly meeting to ensure the Programme direction is coherent and has timely direction.

Each phase of the Programme had specific deliverables which were outlined in the original proposal in October 2017.

Programme Phases

Phase One – October to November 2017

Phase One had a series of key deliverables which are described below.

- **Review the current range of relevant national and regional strategic documents;**
 - Including the National Clinical Strategy, Health and Social Care Delivery Plan (2016) Cancer and Mental Health Strategies
- **Review the outputs of the NHSGGC Clinical Services Strategy** for comparison with national and regional guidance to create an amalgamated set of principles on which Transformation Strategy will be based
- **Update the predictions on population changes** to develop a demand picture up to 2025
 - Using the same methodology as West of Scotland work with ISD to ensure alignment
 - Work at a specialty and condition level using population-based approach
 - Include primary and community care demand
- **Review and quantify the impact of the delivery** of the Integration Joint Board strategic plans and commissioning intentions
- **Carry out a stakeholder analysis** and develop engagement plan
- **Highlight the gaps** where further work should be commissioned.

Review of National Strategies

A comprehensive review of the extant national and regional strategic landscape was conducted in the early weeks of the Programme. Each of the extant policies and strategies were discussed at length by the Core Team. The coherence of each strategy was checked and a process undergone which distilled the key messages from each strategy to enable their presentation as an agreed and understandable framework within which the Programme should operate. This work formed a major part of the approved October Board paper and is summarised into the Cathedral of Care which the Programme uses as a check that thinking is aligned to the expressed national outcomes.

Population Needs Assessment and Modelling

Public health and business intelligence worked together with health economics and the library service to build a detailed prediction of the future health and social care needs of our population. This involved modelling the future demographic projections to 2025 and beyond and applying these changes onto the current activity profile across health and social care services. The profiles were grouped against conditions or specialty pathways ready to support the service modelling sessions.

The second part of this process was a global search for literature on new and innovative service models which are delivering better care. These examples were collated by condition or specialty for discussion with our teams to challenge current thinking and foster a culture of transformational improvement.

There was also an underpinning examination of primary and community care which was seen as relevant to all conditions and specialties.

Stock Take of Progress Against Clinical Services Strategy

A full review was conducted by the Core Team and outreach teams of the progress made against the Board's extant Clinical Services Strategy, published in January 2015.

This process examined areas where the Clinical Services Strategy recommendations had been fully or partially implemented but also areas where it was considered that the Clinical Services Strategy recommendations no longer fully represented what was thought to be the optimal service model.

IJB Review of Strategic Plans

A review of the current Strategic and Commissioning Plans published by the six Integration Joint Boards was completed.

This process allowed the common themes to be compiled and coherence against the national outcomes checked. It also highlighted areas of local priority based on the differing needs of the HSCP populations.

The Population-based Planning Approach

One of the key themes of the National Clinical Strategy was the provision of services as locally as possible but with more complex services being provided at fewer locations across a population. One of the foundation pieces of work which is central to the Programme has been the work done on developing a tiered approach to service delivery for our population. This approach is based on similar work in England and across other health and social care systems as far afield as New Zealand. We have developed a tiered approach to service delivery for our population across the spectrum of health and social care services, covering planned and unscheduled care, cancer care, mental health, older peoples care and primary and community care.

We discussed this approach with the Clinical Leads in the West of Scotland Programme and then used this framework as the basis for discussing future service models with our service delivery teams.

Stakeholder Engagement

A comprehensive and inclusive stakeholder engagement process was seen as essential to the success of the Programme.

A comprehensive stakeholder engagement plan was developed and delivered which not only identified the range of our stakeholders but also described the specific mechanisms and channels through which we ensured each stakeholder group was appropriately informed and engaged.

One of the most important elements of this work was the establishment of our Stakeholder Reference Group (SRG).

Invitations to participate on the SRG were sent to a broad range of individuals and organisations from across Greater Glasgow and Clyde. This included the six Health and Social Care Partnerships, Managed Clinical Networks, Carers Centres and Voluntary Sector organisations with an interest in health and social care.

We aimed to get as wide a geographic and patient, service user and carer perspective hence asked each Integration Joint Board for a representative and contacted Public Partners who had been or were working with us on the Patient and Carer Experience Agenda. We also wrote to charities that represent patients, service users and carers that use health and social care services in larger numbers.

In addition we invited participants from:

- Alzheimer's Scotland
- Beatson Cancer Charity
- British Lung Foundation
- Cancer Support Scotland
- East Dunbartonshire Carers Centre
- East Renfrewshire Carers Centre
- Glasgow North East Carers Centre
- Glasgow North West Carers Centre
- Glasgow South East Carers Centre
- Glasgow South West Carers Centre
- Glasgow West Carers Centre
- Heart MCN
- Inverclyde Carers Centre
- Macmillan Cancer Support
- Maggie's Cancer Charity
- Renfrewshire Carers Centre
- Respiratory MCN
- Stroke MCN
- West Dunbartonshire Carers Centre

A total of 21 people agreed to work with us and regularly attended meetings, received correspondence and provided feedback.

Mr Ian Ritchie, NHSGGC Board Non Executive member was invited to act as the SRG chair.

The SRG met nine times as part of the process with each meeting focusing on a specific element of care delivery.

SRG-1: Background and Context

SRG-2: eHealth

SRG-3: Primary Care

SRG-4: Mental Health

SRG-5: Tiered Models of Care

SRG-6: Surgical Services and a Cross System Approach to Care

SRG-7: Integration Joint Boards and Community Care

SRG-8: Approach to Wider Public Engagement

SRG-9: Programme Update and Next Steps.

Early engagement with the wide range of key staff, partnership and professional forums also took place with members of the Core Team attending meetings to share the key messages of the Programme.

Service Engagement and Modelling Process

The majority of the work in Phase One was designed to enable the transformational conversations with our service delivery teams in Phase Two to be based on constructive challenge to our current models taking examples of good practice from across the globe.

The Phase One projects were fully developed and then shared with our teams ahead of the Phase Two meetings. Each group received a preparatory information pack to support the engagement consisting of a series of documents which included:

- The October 2017 Launch Board Paper
- Detailed demographic and activity projections
- Global literature search for best practice: specialty and primary/community care
- eHealth briefing
- Tiered approach briefing.

Also in order to prepare the teams for the new model development meetings a structured survey was sent out before the meetings which asked team members to consider the future challenges and opportunities set out and also to consider their work in our tiered approach.

Phase Two – December 2017 to February 2018

Phase Two had a series of key deliverables which are described below.

- **Take forward the Phase One principles framework**, case for change, care stratification model and evidence base to enable a structured discussion with small clinical groups from and then across primary, community, secondary and tertiary care
- **Commission specialty groups to review Phase One** predicted service demand and produce proposals for future service requirements, the impact of which could be modelled
- **With clinical groups produce a matrix of stratified clinical interdependencies for each service** which will inform options development and a plan for enabling changes and/or supporting services which are required to sustain the new service models.

The delivery of Phase Two outcomes was through a multilayered mechanism with a complementary top-down and a bottom-up approach.

- **Step One** – Top-down approach
 - With wide clinical engagement
 - Sharing tiered approach with service modelling groups
- **Step Two** – Bottom-up approach
 - Working tiers used as a basis for primary care, community service, social work and acute specialty level engagement to develop tier stratified services.

The process carried out has involved a series of short life groups being established.

In total there were 31 groups established.

These have been virtual groups brought together for a single physical meeting in this phase. The groups have had cross system membership including:

- Acute clinicians, nurses and allied health professionals
- GPs
- Community nurses and allied health professionals
- HSCP Heads of Service
- Acute and HSCP Planning
- Public Health
- eHealth.

Clinicians and managers from other West of Scotland health boards and the Golden Jubilee Foundation have played a part in the short life working groups.

In addition to the specialty and condition-based groups each of the six HSCPs has established locality groups to discuss primary, community and cross cutting issues.

The diagram below shows the groups which were established during Phase Two.

Phase Two Service Modelling Groups

- | | |
|------------------------|----------------------------------|
| 1. Cardiology | 17. Urological cancer |
| 2. Endocrine/diabetes | 18. Gynaecological cancer |
| 3. ENT | 19. Upper GI cancer |
| 4. Gastroenterology | 20. West Dunbartonshire HSCP |
| 5. General surgery | 21. Renfrewshire HSCP |
| 6. Older people's care | 22. ACH out of hours model group |
| 7. Respiratory | 23. East Dunbartonshire HSCP |
| 8. Rheumatology | 24. East Renfrewshire HSCP |
| 9. Orthopaedics | 25. Inverclyde HSCP |
| 10. Urology | 26. Colorectal cancer |
| 11. Haemato-oncology | 27. Lung cancer |
| 12. Breast cancer | 28. Head and neck cancer |
| 13. Dermatology | 29. Critical care |
| 14. Glasgow HSCP | 30. Palliative care |
| 15. Vascular | 31. Tier 3/4 unscheduled care |
| 16. Diagnostics | |

Development of a Tiered Approach Across Acute Primary and Community, Health and Social Care

The principles of having a system where care or support is delivered at the most appropriate tier for the needs of the person and where seamless processes and practices are in place to support care to be escalated up and flexed down to a more appropriate tier to match the care required as the person's needs change is a fundamental aspect of the tiered approach.

Central to this concept is the ability to provide care at the appropriate tier, have a robust monitoring and governance programme to identify early when the needs of a person are changing and to be able to adapt care by early intervention or escalation and/or transfer to another tier of care.

In each specialty service group there has been recognition of the potential to deliver a proportion of care in a more appropriate setting.

Structured Discussion on Care Stratification and Development of a Matrix of Colocations and Interdependencies

Across the 31 different service modelling groups the Programme established a network of over 400 health and social care professionals who formed the readily accessible knowledge and opinion network for the Programme.

Initially the discussion with the groups in the network was focussed on a detailed review and assessment of their particular condition or specialty against the tiered framework. This was then developed into a series of required colocations and codependencies which highlighted the requirements for each service delivery area in terms of relationships with other areas or support facilities. This enabled the production of a comprehensive matrix which described the relationships and requirements of the optimal tiered service delivery model.

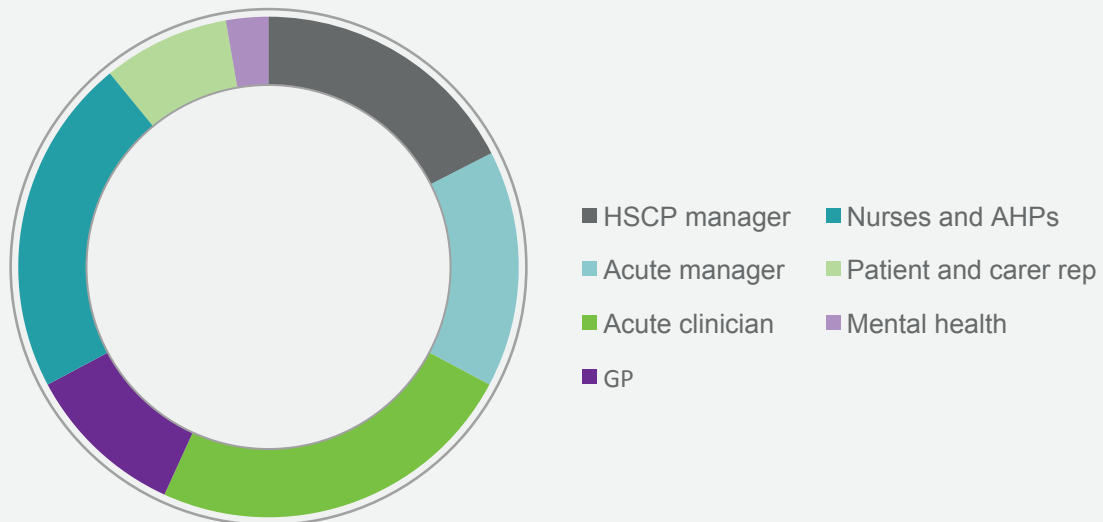
Whole System Event

On 30 January the Core Team hosted the first whole system Moving Forward Together event which took place in the City Chambers in George Square.

The event was co-chaired by Dr Jennifer Armstrong (Medical Director, NHSGGC) David Williams (Chief Officer, Glasgow City HSCP) and Jane Grant (Chief Executive, NHSGGC).

The event was attended by over 270 participants from across GGC health and social care and also enjoyed representation from the West of Scotland Planning Group.

The diagram on page 37 illustrates the diversity across health and social care of participants taking part in the event, which also included 18 patient and carer representatives.



The event was a balance of formal presentations with speakers from across health and social care teams followed by table discussions of the themes presented.

Presentations and table discussion were based on:

- Health and social care integration successes
- Transformation of mental health services
- Cross system approach to care delivery
- Enhancing future primary care service delivery
- The future of surgical services
- eHealth and technology enabled transformation.

The discussion from the 25 tables has been written up and shared with the delegates and across the 31 service modelling groups.

Ongoing Engagement

The Stakeholder Reference Group continued to meet during Phase Two and members attended the Whole System Event.

The Workforce Reference Group, including trade unions and Human Resources staff, was established in Phase Two and met regularly with a programme of meeting dates throughout 2018.

The group planned and coproduced staff engagement events across all acute and HSCPs which would take place in Phase Three to provide the opportunity for health and social care staff to learn more about the Programme and feedback their thoughts and views. These events were communicated widely and all staff were encouraged to attend.

To support wide communication with staff and other key stakeholders including the general public and media a number of resources were developed to communicate the Programme and the drivers for change.

These included a core script which set out the background and drivers for change and a dedicated website: www.movingforwardtogetherggc.org

The website hosts all information on the Programme including case studies and videos showcasing examples of transformation in practice and short animation videos which explain the Programme in layman's terms for use in public meetings and in wider staff engagement. A coordinated approach was taken to ensure that key messages for staff and the public are consistent and, to this end, the Corporate Communications Team continue to work closely with colleagues delivering public and staff engagement.

Phase Three – March to April 2018

The agreed outcomes for Phase Three were:

- **Working with West of Scotland planning and clinical leads, review current West of Scotland plans** and other health board strategic intentions and assess the impact on GGC options
- **Review all the work of Phase One and Two** and adjacent relevant work streams to develop a description of possible new service models across health and social care. Describe the required changes, supporting and enabling work to support future outline delivery plans with options where relevant for new models of care for service configuration across primary, community, secondary and tertiary care
- **Use this basis to prepare an outline of the strategic plan** to be discussed during the wider clinical and public engagement programme through an open and transparent effective dialogue process supported by a series of wide ranging conversations.

The Programme took forward work towards these outcomes through a series of focussed development sessions with the Core Team and key managerial and clinical stakeholders from across health and social care.

Sessions also took place with the senior leadership cadre, including the Acute Operational Directors, the HSCP Chief Officers, the Programme Board, Clinical Senate and Corporate Management Team.

From the review of the extensive discussions both virtually by email and physically in a meeting room of the 31 groups that have been established, the discussion on the 30 January at the whole system event and the ongoing stakeholder engagement work stream, the Programme had collected a vast database of opinion, ideas and innovations and patients and carer representatives that could support transformation. This information and opinion had been gathered from the full range of staff stakeholders across health and social care.

The central task of Phase Three was to consider these inputs against the context of designing a whole system approach to health and social care services for our population, taking forward these transformational views to produce a strategy that delivers the Programme Aim of developing a transformational change programme, aligned to national and regional policies and strategies that describes GGC's delivery plan across the health and social care services provided by our staff, which is optimised for safe, effective, person centred, accessible and sustainable care to meet the current and future needs of our population.

The approach to Phase Three was based around a series of intensive workshops, internally known as the 'Think Tanks'.

There was a programme of these workshops throughout Phase Three. These workshops were delivered by the Programme Core Team along with different groups of key stakeholders who brought expertise and opinion to allow the forming of the emergent vision for the various aspects of health and social care.

Phase Four – May to June 2018

The outcomes of the engagement process during Phase Three were used to test and validate the principles set out for inclusion in this strategy.

A series of meetings were held with a large number of stakeholders including:

- Members of the public
- Acute Operational Directors
- Chief Officers
- Chief residents
- The Clinical Senate
- Full time officers
- Corporate Management Team
- Local councillors
- MPs/MSPs
- Area Partnership Forum
- The Board's advisory structures for staff and clinical governance.

External Programme Assurance

During Phases Two and Three of the Programme, Price Waterhouse Cooper conducted fieldwork to examine the Programme management and governance of Moving forward Together and concluded that the Programme has appropriate programme management arrangements in place and that these are operating effectively.

Summary

The Moving Forward Together Programme is GGC's transformational programme to deliver the National Clinical Strategy, Health and Social Care Delivery Plan and other associated National Strategies.

The Programme describes a new health and social care system that is optimised for safe, effective, accessible, person centred and sustainable care to meet the current and future needs of our population.

The Programme was developed in cooperation and cohesion with the developing work in the West of Scotland for planning on a regional basis.

The Programme provides an overarching framework for change across primary, community and secondary care both in the short term during the conduct of the Programme and thereafter as a result of recommendations.

The Programme supports the subsequent development of delivery plans for the developed new models of care, which describe the required changes in workforce, capital infrastructure and procedures and processes which ensure the intended and projected benefits are realised.

4: Engagement Process

Our Engagement – Overview

Key Issues

- The Moving Forward Together process of engagement has allowed us involve a wide range of stakeholders, both public and staff
- We have involved representatives of the public from the outset
- We have ensured staff were not only kept informed but have been involved and engaged in the whole system process of planning for the future
- We have worked in partnership with the West of Scotland Planning process
- We have worked across all our six HSCPs and included their network of local partners
- We have established a series of relationships which will support our next steps.

Key Considerations

In planning for our next steps we should:

- Continue to involve our public, patient, carers, advocates and third sector colleagues in planning and developing proposals for change
- Continue to involve our staff across GGC in planning and developing proposals for change
- Utilise our communication channels, meetings and structures in place in HSCPs, IJBs and with LA Chief Executives and Council Leaders to ensure we sustain best possible engagement and involvement
- Continue to involve wider community planning networks
- Continue engagement with West of Scotland Regional Planning and Scottish Government Health and Social Care Directorates
- Engage with MSPs and MPs across GGC.

A Shared Vision Developed Through Engagement

In this chapter we describe how we engaged with our population, our staff and other key stakeholders to develop, coproduce and refine our shared vision for an integrated health and social care system. In this context we use “people” as a term for all health and social care service users, patients, members of the public, carers, volunteers and the voluntary organisations which represent them.

We recognised the absolute need to engage with our people and our staff to ensure they felt involved in shaping our vision for a new system of care and that their experience and feedback is critical in how we plan future services.

Only by engaging with people can we develop a system that puts the person at the centre of care. By hearing and understanding the needs of people and treating them as individuals we can improve their experience of services and empower them to be more involved in, and make better informed decisions about, their health and wellbeing and any care that they might need.

We understand the need to effectively inform and engage with people to transform their expectations of modern care. It is through this that we will create knowledge of and trust in alternatives to general practice and hospital-based care and support people to access services within, and feel connected to, their community. This is so that they can improve their health and wellbeing or independently self-manage their physical and mental health.

Critical to realising this is engagement with all our staff to use their knowledge and expertise and hear their ideas about how we might develop new models of care. Our staff are continually striving to deliver improvements in care and outcomes for everyone and we want them to be fully engaged in the work that they do and feel supported to provide the best possible care now and in the future.

To enable us to develop our vision alongside our people and our staff would require us to initiate engagement early and a decision was made to take a different approach that would see us plan and communicate openly in as near real time as possible so that their feedback could influence and shape our thinking.

This early involvement of people and staff would provide the Programme with guidance and direction for the development of our key themes, and the methods to communicate these to inform a wider audience, to encourage participation and actively seek feedback now and beyond into any implementation about how we might deliver our vision.

Our inclusive and early approach to engagement was welcomed and defines our ongoing commitment to put our people and our staff at the centre of everything we do.



I am excited to be taking part in such an innovative programme where, as a stakeholder, I have an opportunity to help influence and shape the delivery of health and social care for 21st century. As someone who is proud of the NHS I want to make it work better for all - patients and staff.”

Stakeholder Reference Group Member



Good that we are being involved early on instead of once all decisions are made and finalised.”

Member of Public – East Renfrewshire

How we Engaged with Our People

The Community Empowerment (Scotland) Act states that Public Body representatives have a duty to engage and involve people and hear their voices in the planning and delivery of services. In addition the Patients Rights (Scotland) Act, designed to help meet the ambition of an NHS which respects the rights of patients and staff, also describes a set of principles that align with our vision to provide services that deliver the most benefit by:

- Taking account of people's circumstances and preferences
- Encouraging them to take part in decisions about their health and wellbeing
- Providing them with information and support to do so.

Our legislative duties aside, we acknowledge the need to continually involve and have open dialogue with people and our staff that enables us to develop plans through inclusive and transparent routine communication. To create a shared vision we wanted to go a step further and work with people and our staff from the outset and an early priority was to develop and agree a Stakeholder Engagement Involvement and Communications Plan to set out how we would do this.

This Plan described how we wanted to engage with people, staff and other stakeholders to provide them with opportunities to have early conversations and hear their feedback so that they could influence our thinking about how we might develop our new system of care.

This early engagement was viewed as crucial to ensuring that our models for new ways of working across an integrated system of care were optimised as safe, effective and sustainable, whilst being person centred and focussed on meeting the current and future needs of our population.

We carried out a stakeholder analysis of all those potentially involved or affected by the Programme and designed a process for communicating and engaging with them. To achieve meaningful communication and engagement we strategically planned how we would;

- Develop and use insights to shape our narrative
- Plan and test content
- Target our activity; measure and evaluate our reach
- Capture and report on all feedback we heard.

To this end, the Stakeholder Engagement Involvement and Communications Plan was intended to be flexible and adaptive so that we could work with our stakeholders, staff and partners to refine our approach and materials based on their advice to maximise our potential reach to widely inform people about the Programme and provide opportunities to hear their feedback.

Understanding our Audiences

We identified key stakeholders together with proposed methods and channels of communication appropriate to the varying roles they would have in the delivery of the Programme. Communication with them was tailored to their differing needs and insights were used to shape the products we would use to do this.

Our stakeholders included our service users, patients and carers, the Board and the six Health and Social Care Partnerships, Scottish Government and our staff, as well as the wider communities, general media and politicians.

Engagement with people was informed by a Stakeholder Reference Group that provided insights and contributed to the coproduction of content and materials. They supported the development of insights by hearing our concepts and working with us to shape and review draft materials and recommend preferred methods of how we might communicate with the wider public.

For staff, this was mirrored by the creation of a Workforce Reference Group with the trade unions and other staff representatives. Together with the Area Partnership Forum and the Acute Partnership Forum, the Workforce Reference Group helped shape the approach for staff engagement and communication, supporting the planning, preparation and review of draft communications for the Programme.

To effectively and meaningfully engage with people firstly requires fit-for-purpose content that describes key concepts in a way that people can understand. This content then needs to be communicated widely using channels and methods to maximise our reach into communities.

To enable this a hub and spoke model was developed and central to this was the formation of a discreet Stakeholder Reference Group to inform locally owned engagement driven via the existing mechanisms and resources of the Health Board and each Health and Social Care Partnership.

Stakeholder Reference Group

The Stakeholder Reference Group was established to support and guide us on how to engage and communicate with people and was composed of Public Partners – service users, patients and carers, representatives from patients' and carers' groups, or community groups that have an interest in this area.

Invites to participate in the Group and represent people were sent to a broad range of individuals and organisations from across Greater Glasgow and Clyde. This included the Integration Joint Boards, Carers Centres and Third Sector organisations representing service users, patients and carers. Twenty one people agreed to work with us and regularly attended meetings, received correspondence and provided feedback. The Group was also chaired by a non executive member of the NHSGGC Board.



The Stakeholder Reference Group has had nine meetings during which the Group was provided with high quality accessible information on the key concepts and relevant data driving the individual components and overall development of the Strategy. Feedback from participants was largely positive with the rationale for and aims of the Programme widely accepted.

The Stakeholder Reference Group's feedback also provided insights for the content of key messages, shaped the type of information materials that were developed and the approach used for wider public engagement. The themes that emerged from the Group often shaped future presentations and mirrored the overall aims and direction of the Programme.

The Group welcomed their early involvement and encouraged the need to have ongoing open conversations about how we might deliver services to meet current and future demand. Evaluation of their participation demonstrated that they felt listened to, that their feedback was valued and had an impact on the shape of the Programme and engagement on it.

The details of the Group including their terms of reference, membership, the content of each presentation and a Group agreed commentary of each meeting were made available online on the Moving Forward Together website.

The Group also agreed to play an integral role in wider communication about their purpose, how they were involved and their thoughts and comments about the Programme's aims and direction of travel by working with us to create videos and articles.

Working Collaboratively

To maximise our reach into communities NHS Greater Glasgow and Clyde and the Health and Social Care Partnerships worked collaboratively to jointly deliver engagement on the Programme using a coordinated approach to communications to share content, amplify messages and most importantly listen effectively.

Working in partnership with Health and Social Care Partnership leads and officers helped shape the approach and the resources required for wider public engagement. Their reach into, expertise, knowledge and understanding of their locality, community dynamics and concerns that people have about services are critical to local engagement.

Feedback from Locality Group Stakeholders and the Stakeholder Representative Group led us to change our initial plans that suggested large scale engagement events. They instead said we should focus resources on materials and products that could be shared easily and more widely promoted. They felt it was important to raise awareness and inform people about the Programme, tell them where they could get further information and how they could provide feedback.

Wider Public Engagement

Taking direction from our stakeholders we wanted to extensively connect with people and describe the rationale and purpose for developing a Transformational Strategy and hear their feedback about it. We used the established, well developed and trusted Board and Health and Social Care communication channels to promote content and materials.

These networks allowed material to be distributed to groups representing people across Greater Glasgow and Clyde and a further 20,000 people registered on the Board's Involving People Network.

At the locality level, when materials were disseminated in each Health and Social Care Partnership, any requests for further information sessions from local community and user interest groups were fulfilled by a fully briefed and engaged Local Officer.

Members of the Patient Experience and Public Involvement Team also spent a half day session in each of our eight acute hospital sites engaging with people and handing out information leaflets. Further information on this engagement is provided in Annex C.

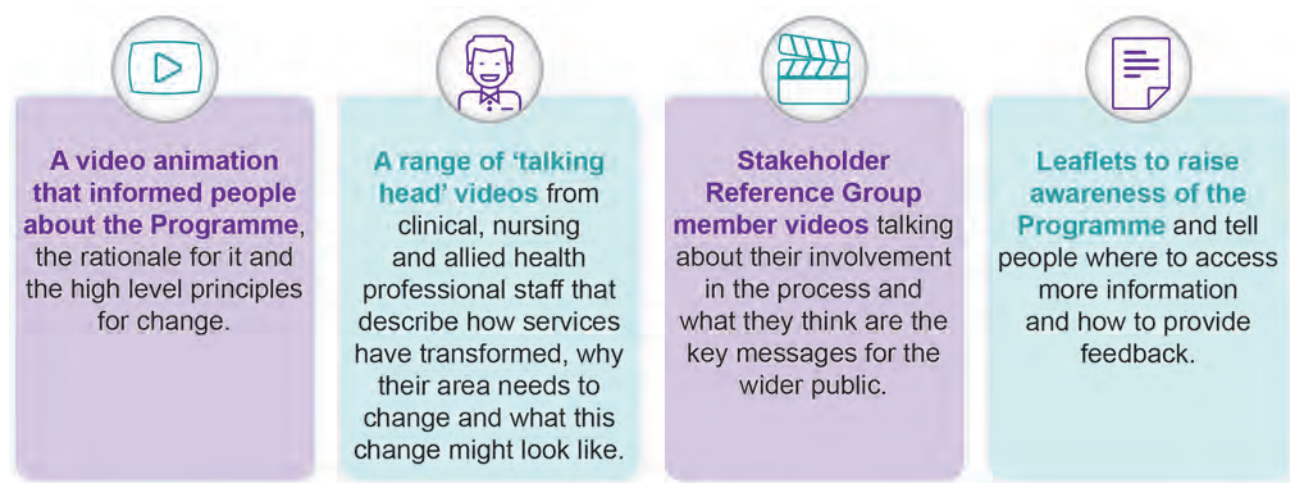
Accessibility and Equalities

All our engagement and communication activities were designed to be fully accessible to all communities. Throughout we used Plain English, presented in easy to understand formats and used the website to host materials to make information accessible to a wider population or those who have difficulty in travelling.

We worked with the Board's Health Equalities and Human Rights Team to develop supplemental materials in alternative languages or formats as required. We also used their established communication channels to offer specific sessions if requested to equalities groups.

The Resources we used to Maximise Reach

The Stakeholder Reference Group was used as a basis for developing core content and helped shape the development of:



A dedicated website was developed to represent the Health Board and six Health and Social Care Partnerships and host all materials about the Programme.

We also promoted a generic email and a freephone telephone number that people could use to request further information or provide feedback.

All our resources were used to promote a process to encourage people to provide feedback about the rationale for the development of the strategy and if people understood and agreed with the proposed direction of travel for new ways of working across health and social care.

How we Engaged with our Staff

Our health and social care workforce and trade unions and professional organisations are major stakeholders in the Moving Forward Together Programme. At the outset of the Programme we considered how best to communicate with our workforce and involved our trade union partners in agreeing an approach to communicate and engage with our 38,000 workforce.

NHS Greater Glasgow and Clyde and our Health and Social Care Partnerships have in place formal structures and arrangements which allow stakeholders to meet and discuss strategy and policies that will impact on the health and social care workforce and to develop shared communication and engagement plans for our workforce. Moving Forward Together has created an exciting opportunity for us to involve our staff in planning and transforming health and social care services and in recognising and building on the good work which staff have led in supporting person centred care, delivered close to home.

Our Approach

NHS Greater Glasgow and Clyde and our six Health and Social Care Partnerships have established Partnership Agreements which recognises trade unions and professional organisations in shaping workforce strategy. In progressing the Moving Forward Together Programme we have built our engagement approach jointly with trade unions and utilised the established structures which create the opportunity for stakeholders to discuss and engage with each other on the Moving Forward Together Programme.

In view of the diversity of the NHS workforce, the Area Partnership Forum includes the following trade union and professional organisations who we have engaged as part of the Moving Forward Together Programme :

- UNISON
- Unite the UNION
- Royal College of Nursing
- British Medical Association
- British Association of Occupational Therapists
- British Dental Association
- British Dietetics Association
- British and Irish Orthoptists Society
- Chartered Society of Physiotherapy
- CDNA
- Federation of Clinical Scientists
- GMB
- Royal College of Midwives
- Society of Chiropractors and Podiatrists
- Society of Radiographers

In addition to the Area Partnership Forum, each of the hospital-based Directorate and Sectors hold local Partnership Forums which provide service management and trade unions the opportunity to meet to discuss local implementation of Board strategies, policies and changes.

Within the Health and Social Care Partnerships, there are individual arrangements for partnership working. These arrangements allow NHS and social care trade union and professional organisations the opportunity to discuss cross cutting employment issues and ensure that staff working across health and social care are included and involved in all issues which impact on the integrated workforce.

The Moving Forward Together Workforce Reference Group

A core group comprised of trade union and Human Resources, workforce planning and organisational development leads for the Board has been established and meets monthly to discuss the Moving Forward Together Programme and workforce issues.

The Workforce Reference Group is mandated to provide consistent advice, support and direction if necessary on areas where matters have been raised from the Programme.

An early objective for the group was to develop a core script and presentation to support a series of staff engagement events which took place across Greater Glasgow and Clyde for health and social care staff.

Existing Communications Structures

Meaningful engagement with our staff, where our staff are our primary audiences, learning first hand about Moving Forward Together as it affects them and in advance of external audiences, is a core principle of this major programme of transformation.

Effective engagement begins with effective communications, founded on the principles of openness and transparency. Throughout the Programme, staff have been advised of progress through a series of communication briefs using trusted and established communication channels within the Board and our Health and Social Care Partnerships. These are summarised below:

- | | |
|--|---|
| <ul style="list-style-type: none"> • Board and committee meetings • IJB committees and briefings • IJB development sessions • Papers and updates to council members • Management meetings • Staff partnership fora • Team Brief (monthly) and monthly cascade • Core Brief (real time) | <ul style="list-style-type: none"> • Staff Newsletter (monthly) print and digital • HRConnect • Intranet and social media • Staff communications portal • Email • Twitter • Facebook |
|--|---|

A key element of our communications and engagement approach has been to bring transformation to life by showcasing some of the examples of where our staff are leading innovation in delivering person centred care in an integrated way. In addition, we have captured key note speakers to provide short films on transformation which provide staff with the opportunity to learn more about how we plan to deliver future services.

Staff Engagement Events

A series of staff events commenced at the end of March 2018 and ran through to the end of May 2018. These sessions allowed staff from health and social care to meet with, and have a structured conversation with, the Programme Team. A total of 20 sessions took place during the period 26 March 2018 to 30 May 2018. To ensure staff working across the Board could attend, events were held in 14 different locations. More than 400 staff attended the sessions and they welcomed the opportunity to engage with the Programme at an early stage of the development phase.

The events aimed to describe the Moving Forward Together Programme, the aims and objectives of the Programme and to provide the context of why NHS Greater Glasgow and Clyde and our Health and Social Care Partnerships need to think and plan differently for future services. The session also created time and space for staff to share their views on what Moving Forward Together means for their service and how our staff can continue to engage with the Programme.

Staff were invited to provide their feedback on:

- The changes proposed in delivering healthcare and if the approach is the right way to proceed
- The impact of the changes on staff members and the services they represent
- How each staff member can help make the changes successful
- The enabling impact of technology and the opportunities that technology and innovation might create.

Our staff presented a range of views in response to the discussions and some of the feedback is outlined below:



Recognition that the current model for healthcare is not sustainable but the changes that are needed are not doom and gloom, the future is exciting and staff want to be a part of it.”

Member of Staff



Ensuring capable IT infrastructure, systems, appropriate hardware, software, licences, in place to enable the real potential of technology in supporting patient care. This will require appropriate investment.”

Member of Staff



IT systems need to ‘talk’ to each other to ensure smooth, secure and swift recording, sharing and accessing of information.”

Member of Staff

Staff Engagement Moving Forward

The journey of transformation is a long term strategy for the future and we will continue to engage with our workforce to ensure staff are aware of, and involved in, all the key stages of its development. We will review the successes of the staff engagement events and consider a programme to involve, engage and support our staff and leaders who are instrumental to the future realisation of our vision through delivery of the Programme.

Other Key Stakeholders

Community Planning and Voluntary Sector partners were engaged with via established communication channels, meetings and structures in place in each Health and Social Care Partnership.

The Board has an established Advisory Structure to enable professional advice on key strategic issues including from our independent contractors. We have engaged with this structure throughout the process with regular updates and membership of key groups. This includes the Area Clinical Forum, Area Medical Committee (and Hospital and GP Sub Committees), Area Nursing and Midwifery Committee, Allied Health Professionals Committee, Area Optometric Committee, Area Dental Committee and Area Pharmaceutical Committee.

Other key stakeholders we engaged with included representatives from the Scottish Government and the Health and Social Care Directorate.

Sessions were held with Local Authority Chief Executives, Council Leaders and key IJB staff.

There have also been discussion sessions with local MSPs and MPs with all those having GGC as part of their constituency receiving an invitation.

5. Our Population

Our Population – Overview

Key Issues

Overall the life expectancy of our population is increasing.

The healthy life expectancy and life experience of our population is influenced by:

- Life lived in ill health through disease
- Deprivation
- Unhealthy behaviours.

Key Considerations

To deliver the improvements envisaged in the health and wellbeing of our people we will seek to:

- Reduce the burden of disease through empowering our people via health improvement programmes and a measurable shift to prevention
- Reduce health inequalities across our system through advocacy and community planning
- Ensure the best start for our children with a focus on early years to prevent ill-health in later life
- Promote and support good mental health and wellbeing at all ages
- Use data better to inform service planning and public health interventions.

In order to deliver improvement we must work across the entire health system.

- We should support our staff to promote better health and improved choices to support good health
- We should work with other key stakeholders to contribute to a reduction in inequalities
- We should listen to, and build relationships with communities, partners and individuals to create a coordinated integrated workforce to address our shared priorities of creating a healthy, more equitable society and more sustainable public services
- We should ensure services provide person centred, accessible and inequalities sensitive care
- We should design and deliver services focussed on prevention and which support health and wellbeing and reduce health inequalities
- The challenges and actions required to make the decisive shift towards prevention will be set out in the forthcoming public health strategy, Turning the Tide Through Prevention.

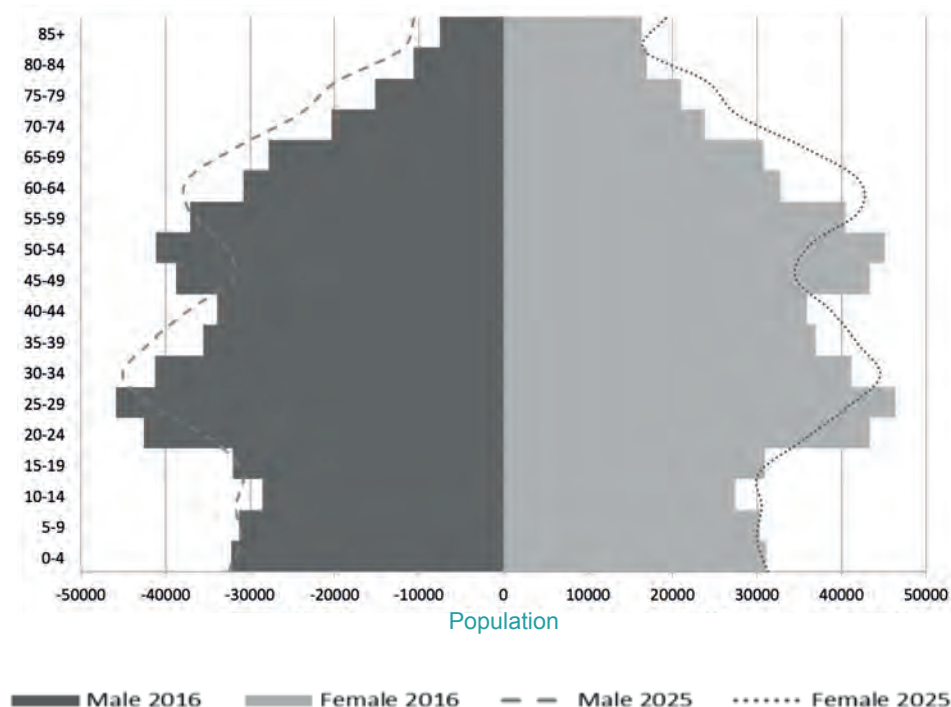
Introduction

In this chapter we discuss the determinants and prevalence of ill health in our population which drive the demand for health and social care services and describe a whole system approach to working in partnership with our population to address these determinants to improve healthy life expectancy and people's life experience. NHSGGC is currently developing a detailed Public Health Strategy.

Understanding Our Population

Projections show that the period 2016 to 2025 will see the population of GGC age significantly. It is expected that the people aged over 65 will increase by 16% overall, with a 17% increase in those over the age of 75 and a 25% increase in those aged 85 years and older.

Population pyramid for GGC residents in 2016 and 2025



This increase in the length of life of our population should be celebrated, but drives us to consider how we support our people and communities to take care of their health and prevent avoidable illness.

There are different age profiles across our different localities and this requires each HSCP to develop approaches tailored to their local needs.

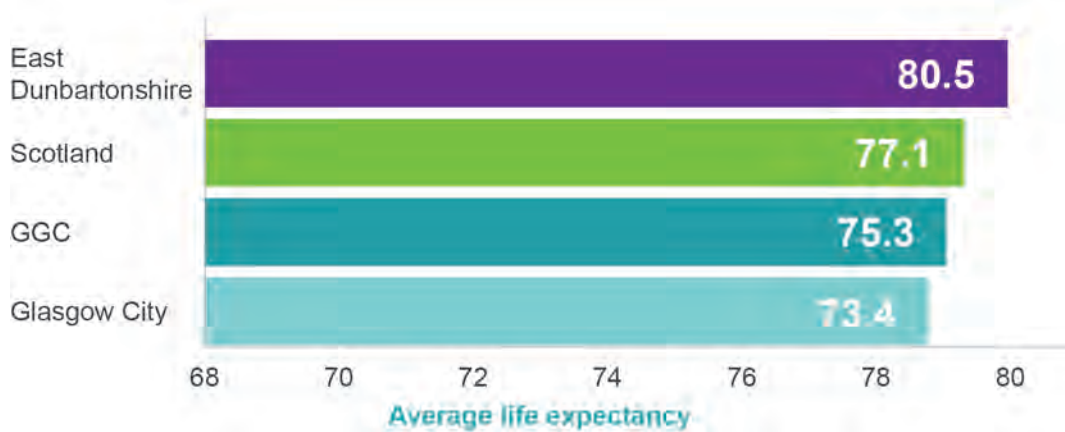
Life Expectancy

Life expectancy is an estimate of the length of time a person born today is expected to live. Gender and socio-economic deprivation are the strongest factors determining this estimate.



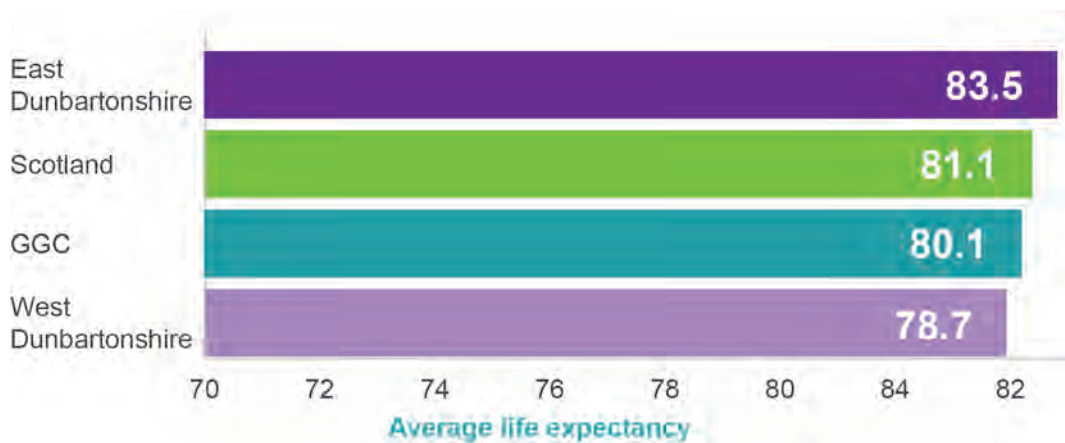
Male

On average males in GGC have shorter life expectancy than the Scottish average. However this varies across the differing localities in GGC by levels of deprivation in each area.



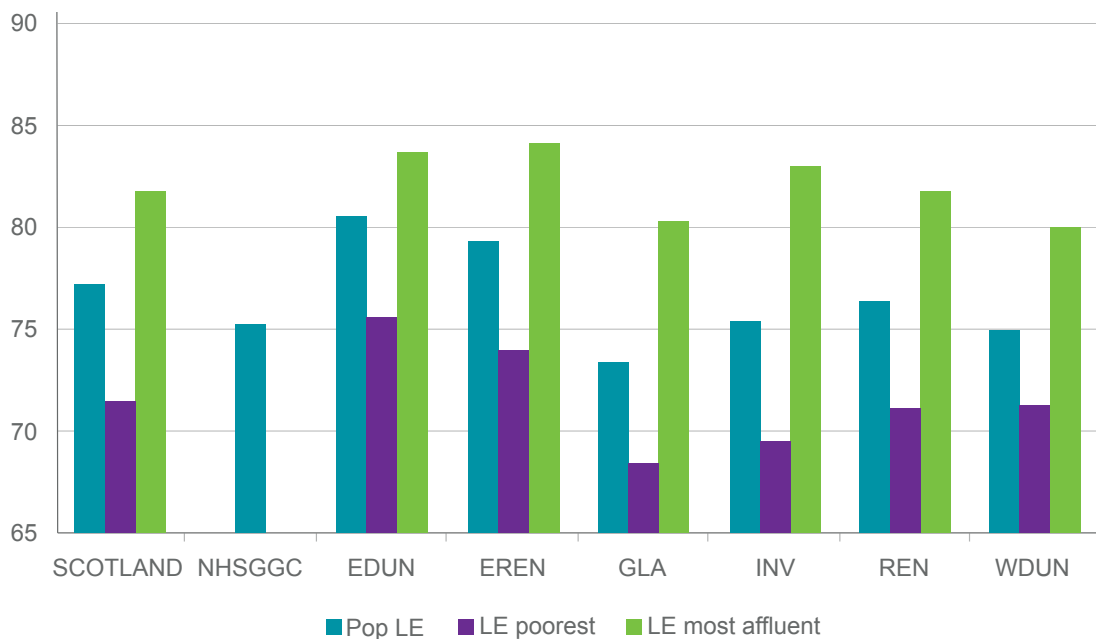
Female

Female life expectancy is higher but there is a similar pattern.

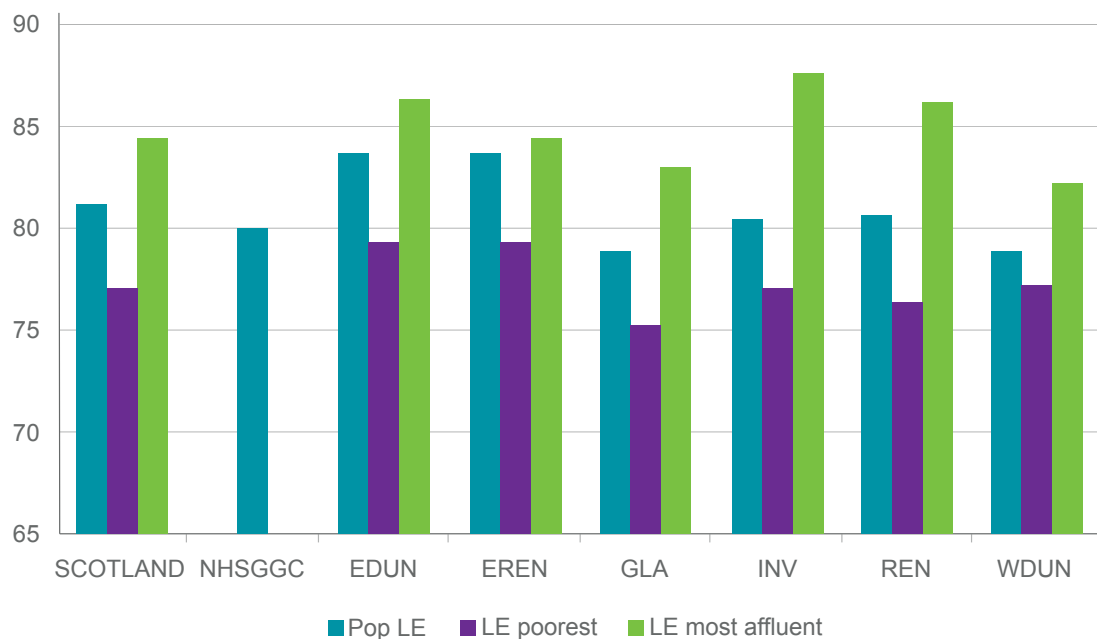


Much of the difference in life expectancy is related to life circumstances, mainly socio-economic factors and is influenced by education, employment, health behaviours and patterns of health and social care use.

Life expectancy (LE) at birth for males for the general population and for the poorest quintile and most affluent quintile for Scotland, GGC and HSCP areas



Life expectancy (LE) at birth for females for the general population and for the poorest quintile and most affluent quintile for Scotland, GGC and HSCP areas



Avoidable Mortality

In Scotland, in 2016, 28.1% of all deaths were considered avoidable. This proportion was higher in males (34.2%) than in females (22.2%). Across the partnership areas, the proportions of avoidable mortality varied from a high of 42% for males in Glasgow City to a lower level of 18% for females in East Dunbartonshire and East Renfrewshire, mirroring issues around poverty levels in the areas. For context, if we could reduce avoidable mortality in the partnerships to the Scottish average, this would have resulted in 327 fewer premature deaths in the population that year. If we could have reduced avoidable mortality to the level seen in East Renfrewshire, this would have resulted in 1,078 fewer deaths that year.

Avoidable deaths can be further broken down as preventable, that is, those premature deaths which could have been avoided through public health action, and amenable mortality, those which could have been avoided through better quality healthcare. 24% of Scottish deaths in 2016 could have been prevented by stronger public health action. This proportion was higher in males where almost a third of premature deaths could have been prevented. In the same year, 14% of deaths could have been avoided through better healthcare. Again, the figure was higher for males. While this data is not yet available at a local level, the finding emphasises that better life expectancy needs both a focus on strengthening public health action, and on improving the impact of high quality healthcare across the whole population.

The Impact of Disease on Life Expectancy and Healthy Life Expectancy

The Scottish Burden of Disease Study (2015) examined the impact of illness on premature death and disability. The study measured the impact of disease on healthy life expectancy. This is measured as Years of Life Lost (YLL) or as Years of Life lived with Disability (YLD). The combined impact of these factors is a measure called Disability Adjusted Life Years (DALY).

The study shows that the highest impact diseases in terms of loss of life expectancy through premature death in Scotland were in order:

- Cancers
- Cardiovascular diseases
- Neurological disorders
- Chronic respiratory diseases
- Mental health and substance use disorders
- Diabetes and endocrine disorders.

Rank order of Years of Life Lost (YLL) by disease group and gender for Scotland in 2015 Source Scottish Public Health Observatory

Disease group	Both sexes	Males	Females
Cancers	1	1	1
Cardiovascular diseases	2	2	2
Neurological disorders	3	5	3
Chronic respiratory diseases	4	4	4
Mental health and substance use disorders	5	3	8
Diabetes, urogenital, blood, and endocrine diseases	6	8	5

The study shows that the highest impact diseases in terms of loss of life years before the onset of chronic illness or disability in Scotland were in order:

- Mental health and substance use disorders
- Neurological disorders
- Other non-communicable diseases, such as diabetes, hypertension and osteoporosis
- Cardiovascular diseases
- Chronic respiratory diseases
- Diabetes and endocrine disorders.

Rank order of Years of Life lived with Disability (YLD) by disease group and gender for Scotland in 2015

Source Scottish Public Health Observatory

Disease group	Both sexes	Males	Females
Mental and substance use disorders	1	1	1
Musculoskeletal disorders	2	2	2
Neurological disorders	3	4	3
Other non-communicable diseases	4	3	4
Cardiovascular diseases	5	5	5

When we combine the impact of life limiting illness and chronic illness to assess the impact on overall healthy life expectancy the order of impact was:

- Cancers
- Cardiovascular diseases
- Mental health and substance use disorders
- Musculoskeletal disorders
- Neurological disorders.

Rank order of Disability Adjusted Life Years (DALYs) by disease group and gender for Scotland in 2015

Source Scottish Public Health Observatory

Disease group	Both sexes	Males	Females
Cancers	1	2	1
Cardiovascular diseases	2	1	3
Mental and substance use disorders	3	3	2
Musculoskeletal disorders	4	4	5
Neurological disorders	5	5	4

These conditions shape the life expectancy and life experience of our population and drive our need for health and social care and therefore inform our areas for priority whole system action.

The Impact of Deprivation on Healthy Life Expectancy

As discussed when considering disease, healthy life expectancy is the number of years a person is expected to live without chronic disease or disability.

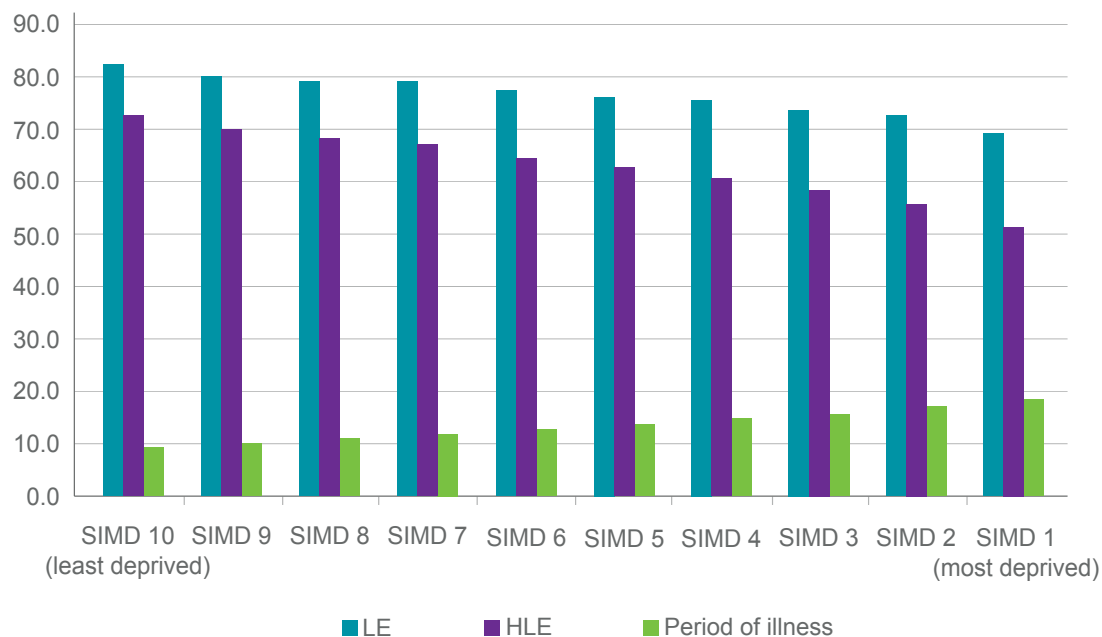
In 2016, life expectancy for Scottish males was 77.0 years but healthy life expectancy was only 59.3 years. In the same year life expectancy for Scottish females was 81.1 years and healthy life expectancy was 59.3 years.

National studies show a very strong link between life expectancy, healthy life expectancy and deprivation.

As deprivation increases, overall life expectancy decreases but also life spent in ill health increases with the overall effect being a marked decrease in healthy life. This is shown in the chart below for males but the impact on females is similar.

Life Expectancy (LE), Healthy Life Expectancy (HLE) and period of life spent with illness for males by decile of socio-economic deprivation across Scotland for the period 2009-2013

Source NRS



In short, a Scottish male living in the poorest area would be expected to live 12.6 years less than his most affluent counterpart and to spend an additional nine years of that shorter life in poor health.

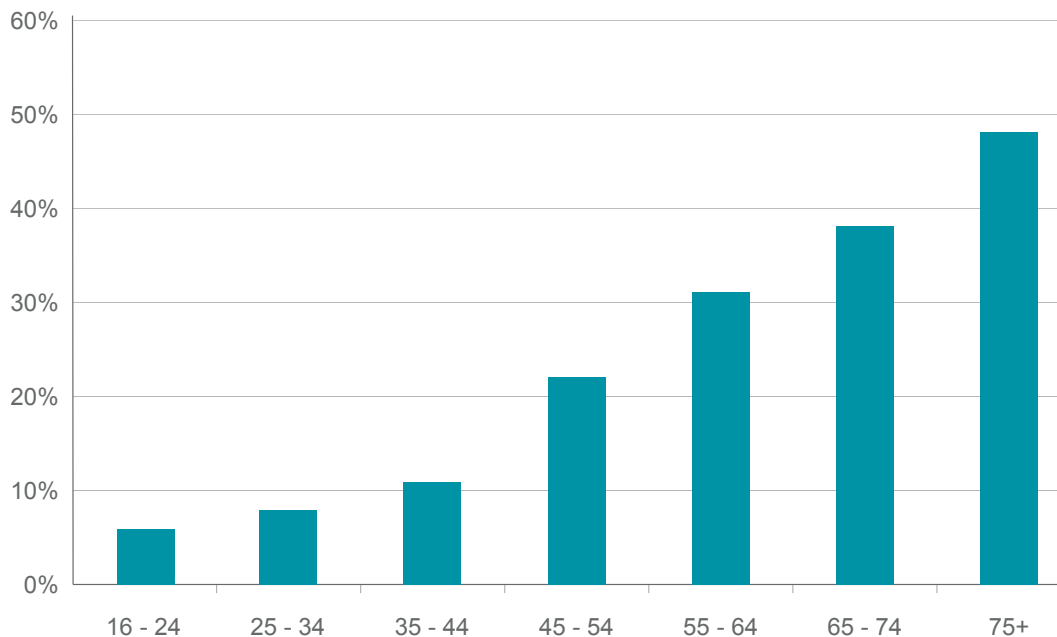
This shapes the demand profile for health and social care across our areas of differing deprivation.

Long Term Conditions

Long term conditions (LTCs) are conditions which, over a prolonged course, may limit functional capacity or cause disability, which cannot be resolved spontaneously but can be managed by medication and other support.

In the most recent GGC Health and Wellbeing Survey (2015) it was shown that the prevalence of LTCs becomes higher as people age and is higher in areas of higher deprivation.

Prevalence of long term conditions by age



With the projected rise in our ageing population we can expect a rise in LTCs.

Multimorbidity

Multimorbidity is the presence of two or more long term conditions. The prevalence of multimorbidity rises with age and requires a multi-professional team approach for people who need to see many different professionals and teams for care.

A person centred coordinated approach which considers environmental factors and health behaviours which underpin the development and progression of LTCs, can be helped by behaviour change interventions such as smoking cessation, nutritional improvements and physical activity, which can improve people's clinical condition, slow disease progression and improve quality of life.

Life Circumstances and Behaviours

Life circumstances are strongly associated with life courses and health outcomes. Those living in more affluent circumstances are more likely to follow trajectories of high educational attainment, employment, health sustaining behaviours around smoking, alcohol, physical activity and diet. Those living in poverty are more likely to follow trajectories of limited school attendance and educational attainment, limited job opportunities and unemployment and are more likely to smoke, consume hazardous or harmful levels of alcohol, have a poor diet and have limited physical activity. These life courses are not inevitable and changing health behaviours is entirely possible and must be our goal.

Smoking

The strong link between smoking and many cancers, cardiovascular disease and chronic respiratory diseases is well known, however smoking remains a significant risk factor for our population. The impact of the Smoking in Public Places Legislation has resulted in improvements in health behaviours and in the health of smokers and non smokers alike however in GGC we have a population with one in four currently smoking.

Smoking rates are higher in men at 29% than in women at 21%, and are highest in young men aged 16-44 at 34%.

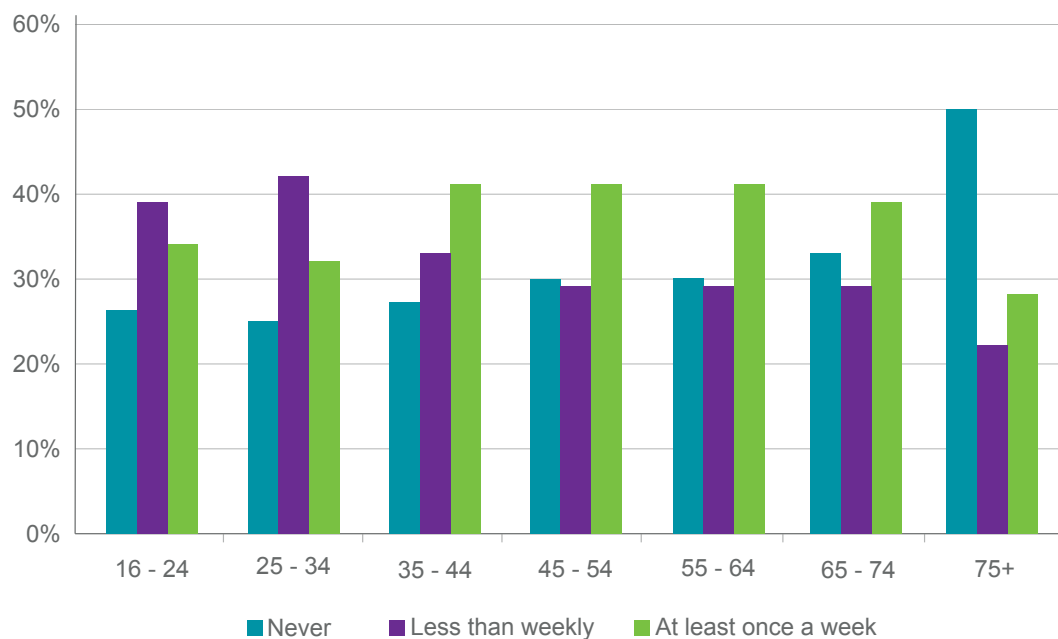
There is a marked variation with deprivation in smoking rates, with those living in the poorest areas being 39% compared with a rate of 19% in the rest of our population and studies also show smokers in deprived areas are also less likely to be actively trying to stop.

Alcohol

Excessive consumption of alcohol is a major cause of illness and premature death as well as causing significant social problems.

The Health and Wellbeing Survey shows alcohol use across our population with only the over 75s showing a minority in regular drinking which is likely to be a contributory factor to their length of life.

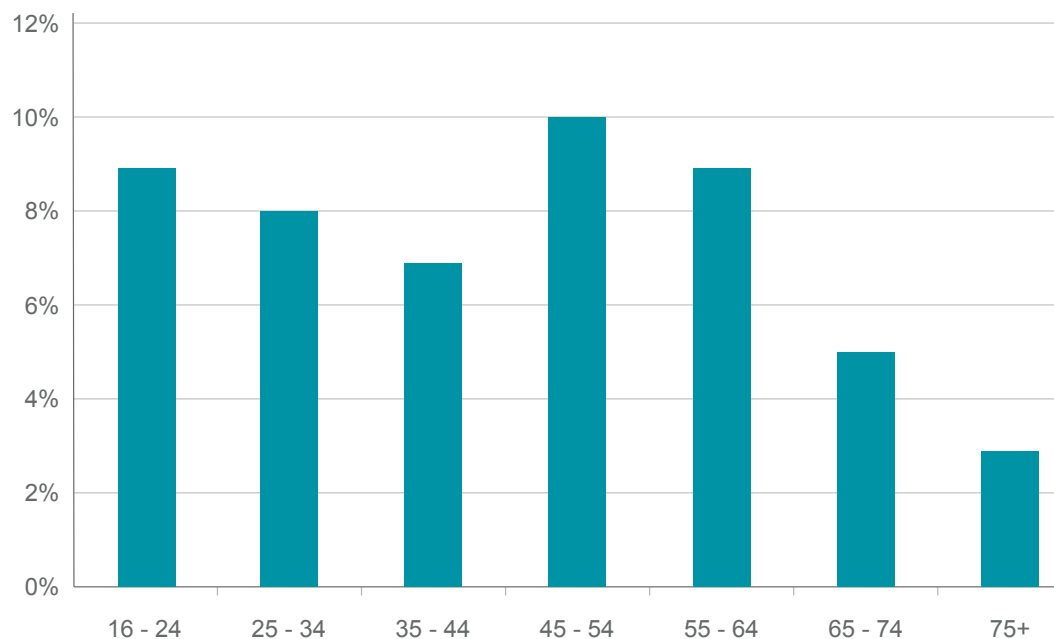
Alcohol intake in GGC residents by age, 2014/15



Males are more likely to drink at least once per week and those living in the poorest areas were no more likely to drink than those living in affluent areas.

Overall 8% of the population were drinking in excess of the recommended alcohol limits and this was higher in men at 12% than in women at 4%. Those in middle age were most likely to be drinking excessively.

Proportion of NHSGGC residents exceeding the recommended limits for alcohol intake, 2014/15



Binge drinking, which is defined as consuming six or more units for women or eight or more units for men on one day in the previous week, was shown to be common. Overall 16% of the population reported binge drinking in the week before the survey, constituting 38% of all drinkers.

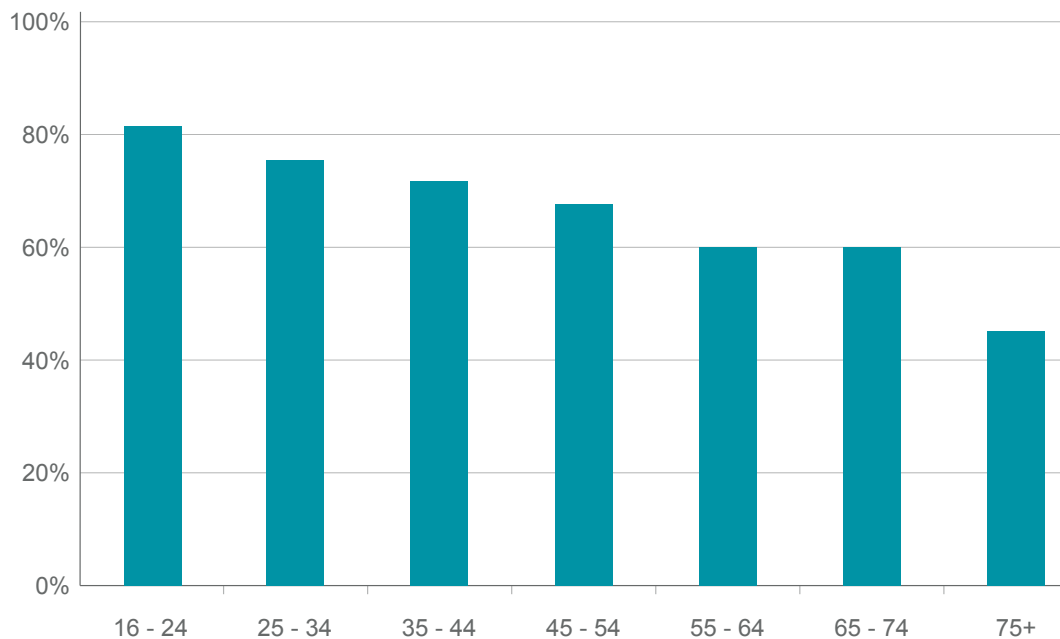
It is hoped that the recently introduced Minimum Unit Pricing for Alcohol will in time have a significant impact on problem drinking however this must be as part of a wider educational message to change behaviour.

Physical Activity

Physical activity is associated with a wide range of health benefits, including cardiovascular fitness, good mental health and improved functional capacity and decreased disease progression in those with chronic illnesses. Conversely, physical inactivity is associated with a significant number of independent risk factors for chronic illness including hypertension, obesity, and poor mental health.

The Health and Wellbeing Survey showed 68% of respondents met the target of at least 150 minutes of physical activity per week.

Proportion of NHSGGC population who met the physical activity target, 2014/15



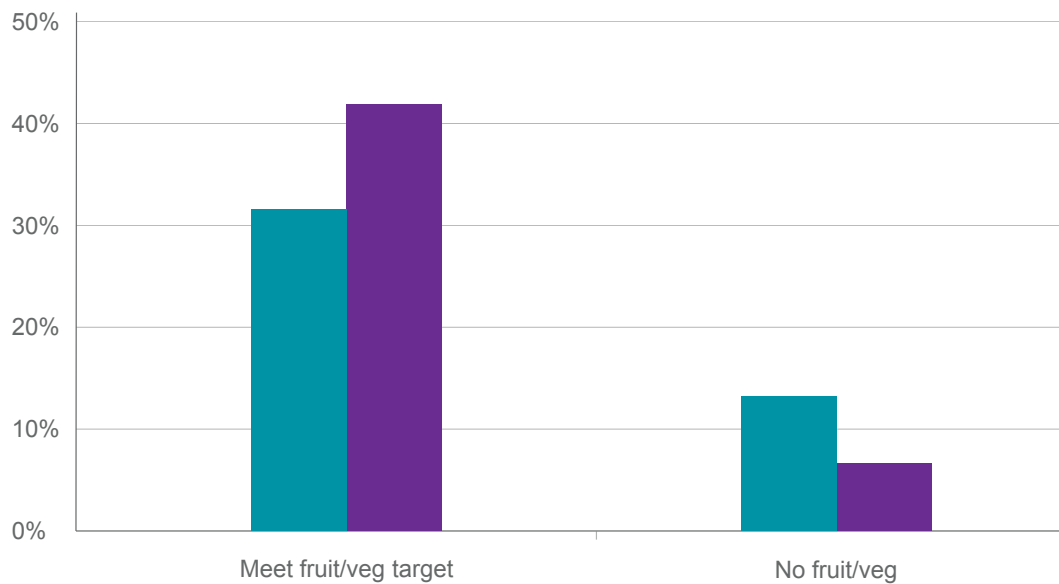
Diet

Poor diet, and in particular one which is high in sugars, starch and fat and low in fruit and vegetables, is strongly associated with a number of diseases, including cardiovascular disease, colorectal cancer and the development of diabetes.

The Health and Wellbeing Survey showed, overall, 39% of the population met the target for fruit and vegetables, but 9% did not eat fruit or vegetables at all.

Those living in the most deprived 15% of areas were significantly less likely to meet the target and significantly more likely to not eat any fruit and vegetables than the rest of the population.

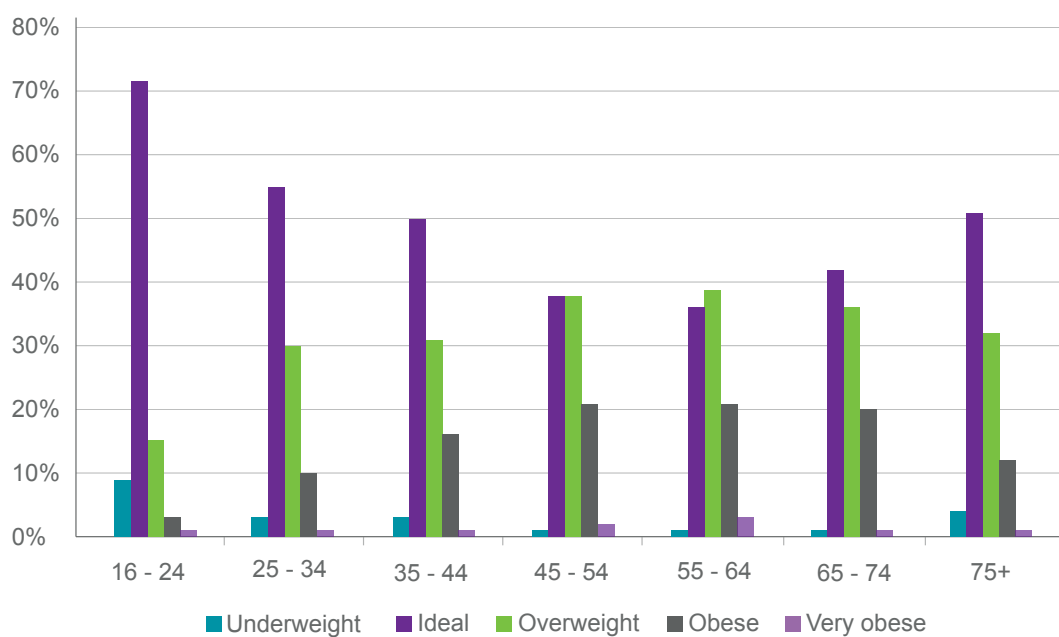
Proportions of the most deprived 15% of the population who met the fruit and veg target or did not eat any fruit and veg in comparison with the rest of the population, 2014/15



Obesity

Overweight and obesity levels are the commonest risk factor for our population. Being overweight or obese is associated with cardiovascular disease, diabetes, cancer and musculoskeletal conditions and they reduce the independence of people with many other chronic conditions. The Health and Wellbeing Survey showed that overall 49% were overweight, obese or very obese in with this percentage rising to 63% for those between 45 and 65. There was no consistent pattern by gender or poverty.

Proportions of the population who were underweight, ideal weight, overweight, obese or very obese by age. 2014/15



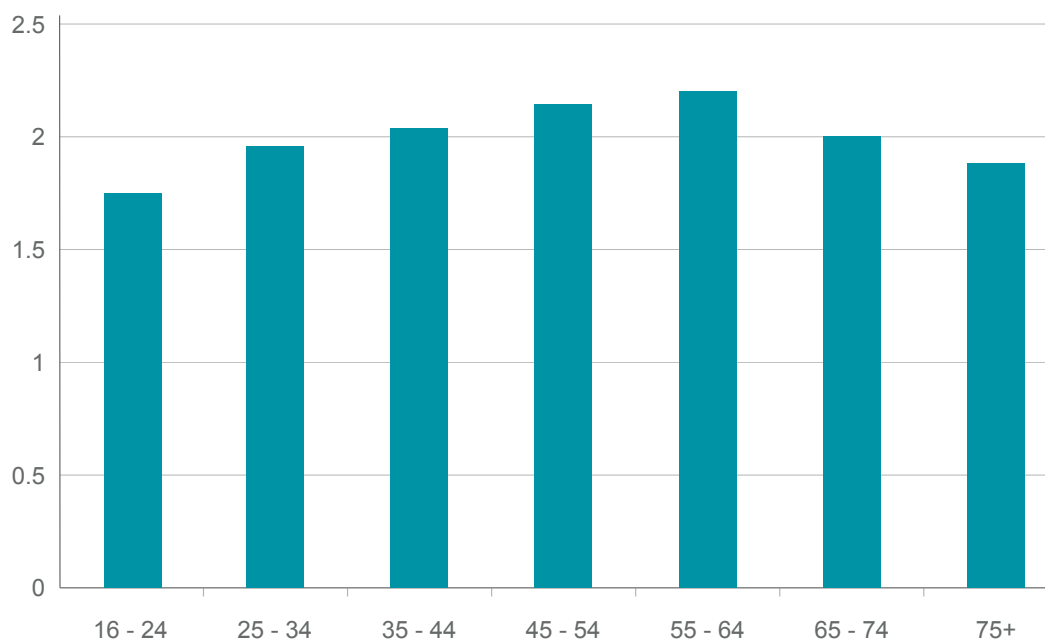
Unhealthy Behaviours

The Health and Wellbeing Survey examined unhealthy behaviours. The five behaviours in question were:

- Smoking
- Being overweight or obese
- Not meeting physical activity guidance
- Not meeting the five a day target for diet
- Binge drinking.

The survey showed unhealthy behaviours most common between 45 and 65.

Average unhealthy behaviour scores by age of respondents, 2014/15



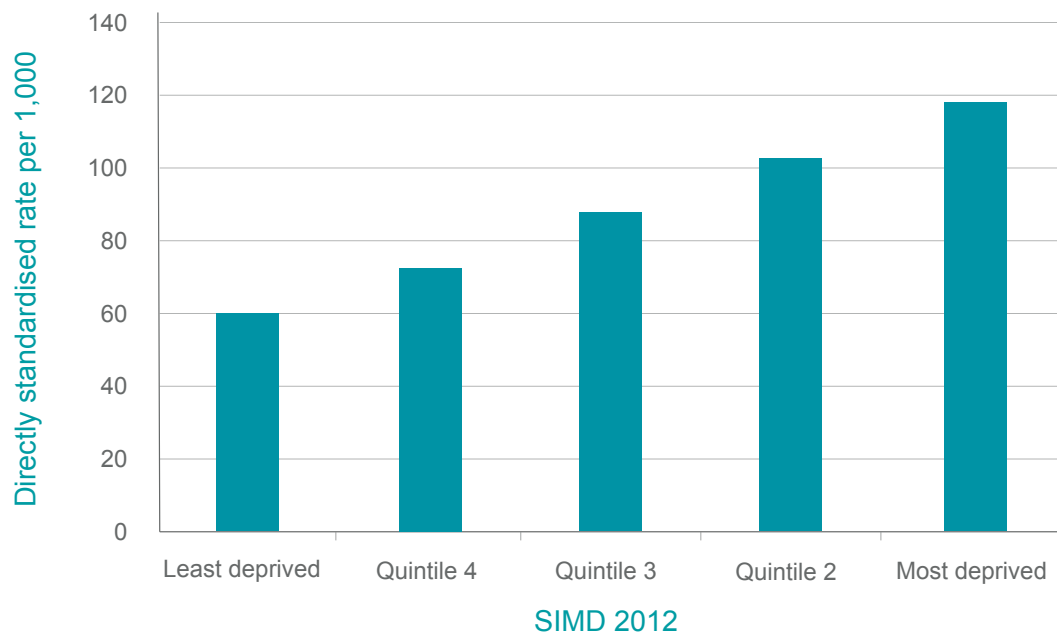
Impact of Deprivation on the Use of Health and Social Care Services

Across GGC different groups of the population generate differing demand for health and social care services, with the greatest drivers being increasing age and poverty.

Poverty is more strongly associated with patterns of urgent care use rather than programmed care with emergency care access twice the rate in the most deprived areas as in the most affluent.

The chart over shows the impact of deprivation on emergency department use.

Directly standardised attendance rates at Emergency Departments, 2013-2015



Source ScotPHO data.

Evidence suggests that deprivation is a major cause of unscheduled care demand and that the demand for out of hours services is greater than the demand in hours.

72% of the variation in urgent care was related to poverty and social factors with only 28% being associated with system and service factors (O’Cathain et al, 2014). Research has demonstrated that deprivation was associated with 18% more in-hours consultations in the GP surgery; 28% more ‘same day’ consultations (emergency appointments) with a GP; but 44% more out of hours contacts with primary care in comparison with more affluent areas (Carlisle et al, 2002).

This pattern is not simply related to access to primary care, but to the culture of using health and social care.

This drives a need to consider deprivation and in assessing how person centred services are, with a need to focus on access, healthcare literacy, and skilled engagement with communities experiencing deprivation as we seek solutions which will ensure this issue is effectively tackled.

Summary

The major drivers that shape the health of our ageing population as discussed are:

- Deprivation
- Disease; including mental and physical health
- Smoking
- Alcohol consumption
- Physical exercise
- Diet
- Obesity
- Access to and quality of health and social care.

There is an opportunity to influence how these factors control our future healthy life expectancy. This can be done through a partnership between our people and our care givers to provide education and support and the opportunity and encouragement to make more healthy life choices, where possible, to minimise the adverse impact of these factors on life expectancy and life experience.

Working for Healthier, Fairer and More Sustainable Health and Services

Self Care, Health Literacy and Person Centred Care

We have shown that people living longer and the impact of deprivation are the main drivers of health and social care demand and that unhealthy behaviours are common in our population.

In order to tackle these drivers, we should work in partnership with our population as a health and social care system. We should collaborate with local and national governments, industry, public services and above all with communities and individuals themselves in order to together tackle poverty and support behaviour change.

As defined by the World Health Organisation, self care is what people do for themselves to establish and maintain health, prevent and deal with illness.

It encompasses:

- Hygiene (general and personal)
- Diet (type and quality of food eaten)
- Lifestyle (sporting activities, leisure etc.)
- Environmental factors (living conditions, social habits, etc.)
- Socioeconomic factors (income level, cultural beliefs, etc.)
- Self-medication.

Health literacy is about people having the knowledge, skills, understanding and confidence to use health information, to be active partners in their care, and to navigate health and social care systems.

Supported self care should be developed across all levels of care and settings and requires the development of:

- Accessible patient information
- Structured patient education programmes
- Disease-specific individualised medicines advice
- Generic self management skills
- Enabled access to wider health, social care and voluntary sector support systems.

Person centred care means working with communities and individuals to tailor interventions to the needs of the individual, taking account of what matters to them. It is based around the five 'must do with me' issues:

- What matters to the individual
- Who matters to them
- What information do they need
- Nothing about me without me
- Personalised contact.

Inequality Sensitive Practice

Person centred care requires the use of inequality sensitive practice (ISP).

ISP is a set of skills which health and social care practitioners develop to support those experiencing inequality to optimise their advice, support and treatment plans and the ways individuals engage with services.

ISP ensures that practitioners have the skills to:

- Understand the impact of inequality
- Build relationships, support the person and raise their aspirations in a sensitive way
- Provide alternative options and act as an advocate when required to do so
- Be proactive in ensuring consistent practice
- Promote equalities and be non discriminatory
- Take a person centred approach.

The concepts of self care, health literacy, person centred care and inequalities sensitive practice must be at the heart of our health and social care system, not only to create an environment through which prevention can take place, but, importantly, to drive and support services that focus on the individual's needs and what matters to them.

The House of Care initiative (HofC) demonstrates an approach to care management and building trust for people living with long term conditions. The approach promotes ways of working for staff and people that supports self care and addresses inequalities and health literacy issues.

The model comprises four independent components with collaborative care and support planning conversation at the centre.



Prevention

Prevention measures can act on the causes and determinants of poor health, detect asymptomatic illness such as screening programmes, or act to reduce or eliminate complications from established disease.

This range of strategies includes interventions intended to prevent or actively manage acute exacerbations of disease as well as longer term work to maintain health and prevent chronic deterioration of an existing long term condition over a period of many years.

Public health services can be part of the solution to the challenge of increasing health and social care demand in both the short and longer terms.

We believe that identifying and preventing risk factors and illness can reduce the demand for services, support resilient communities and increase the number of healthy years lived.

Improving health also means removing barriers to access and delivering services which take account of the social context of people's lives.

The key areas of focus for GGC are:

- To reduce the burden of disease through empowering our people via health improvement programmes and a measurable shift to prevention
- To reduce health inequalities across our system through advocacy and community planning
- To ensure the best start for our children with a focus on early years to prevent ill-health in later life
- To promote and support good mental health and wellbeing at all ages
- To use data better to inform service planning and public health interventions.

A Refreshed Model for Prevention and Supported Self Care

In order to achieve these objectives we should work across the entire health and social care system. We should support our staff to promote better health and improved choices to support good health. We should work with other key stakeholders to contribute to a reduction in inequalities. We should listen to, and build relationships with, communities, partners and individuals to create a coordinated integrated workforce to address our shared priorities of creating a healthy, more equitable society and more sustainable public services.

The key actions for public health in GGC are to:

- Develop and apply evidence to the health and social care system
- Focus on addressing the causes of poor health and inequalities
- Apply a lifecourse approach, starting with an early years focus
- Strengthen the role of services in preventing ill health and promoting wellbeing
- Protect the public's health from environmental, communicable and other health risks
- Ensure services provide person centred, accessible and inequalities sensitive care
- Provide services which are proportionate to need and risk, and at their best where they are needed most and design and deliver services focussed on prevention and which support health and wellbeing and reduce health inequalities.

Across all health and social care environments, we must prioritise prevention, seeing each contact as an opportunity to change an individual's trajectory away from premature illness and death. To achieve this transformation will require a profound change to embrace prevention across our diagnostic and curative services.

In prioritising prevention across the system, we should seek to:

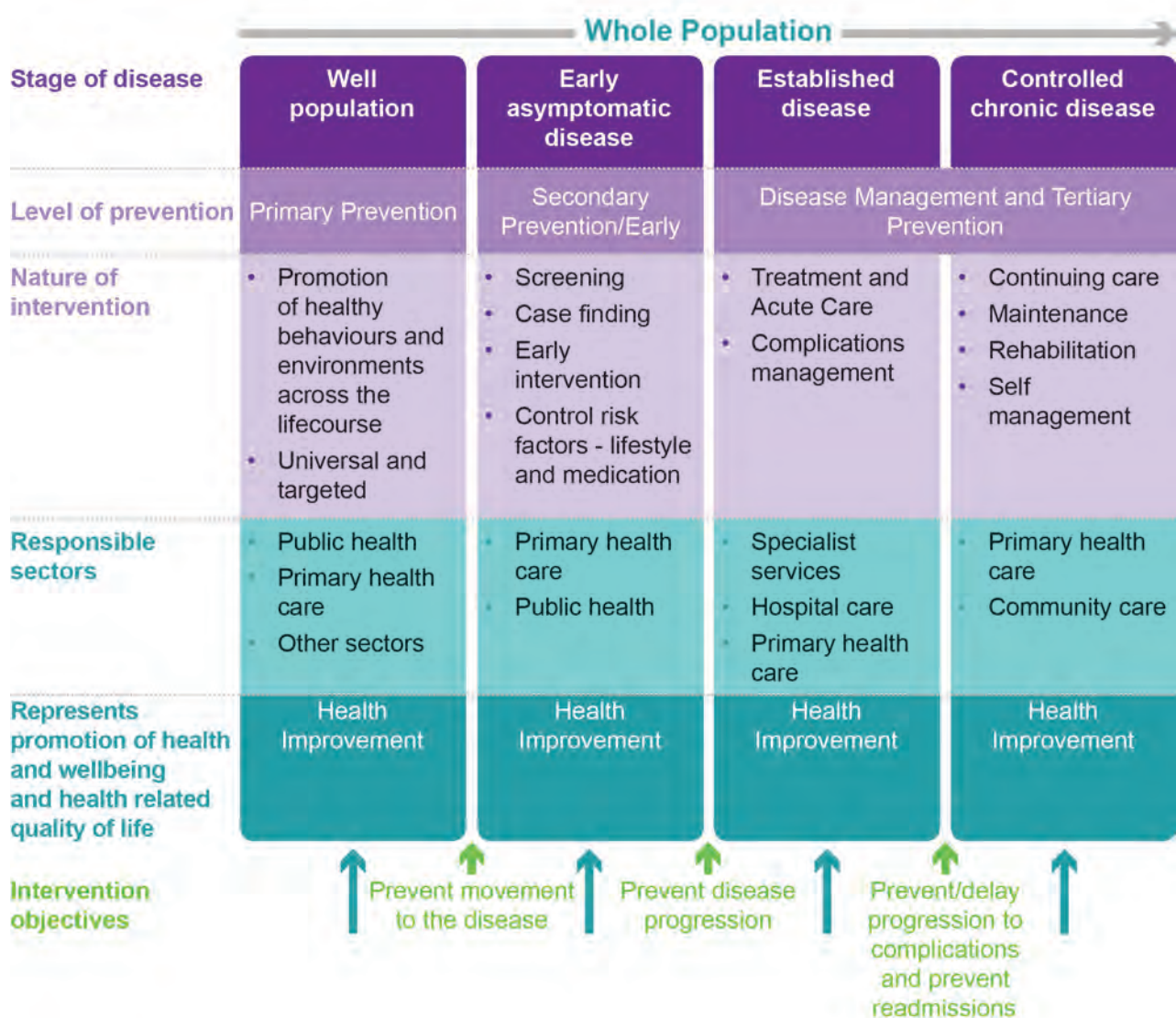
- **Implement national developments and guidance** to existing screening programmes and ensure compliance with standards; enhance uptake for those programmes and population groups where uptake falls short of national standards
- **Maximise the potential of primary care** including the new GP contract to address health inequalities and health improvement
- **Embed routine holistic assessment of individual needs** in care planning to connect people with non-clinical services which can improve their health outcomes
- **Support person centred care** and inequalities sensitive practice particularly in relation to Chronic Disease Management and to support self care
- **Adopt a Health-In-All-Policies approach** to include all sectors that influence health
- **Support quality improvement** across services.

To address prevention, self care and inequality sensitive approaches, we should revise our approach to integrated prevention across the whole population, in particular those people with identified risk factors, social vulnerability or those who demonstrate limited capacity to engage with elective care, and overuse of emergency care.

Whilst there will be an emphasis on self care and health literacy for everyone, we realise that this approach will need to be optimised for those experiencing the greatest inequalities. We need to develop a model which explicitly takes account of social vulnerability and inequalities, using approaches to engagement and prevention in order to tackle those at greatest risk of premature illness and death.

Such a model is outlined in the diagram below which summarises our approach.

Our vision for an integrated prevention and care model



Turning the Tide Through Prevention

The forthcoming public health strategy Turning the Tide Through Prevention will set out the key challenges and actions required across the whole system to make a decisive shift towards prevention.

6. Our Whole System Approach

Whole System Approach – Overview

Key Issues

- Our vision in Moving Forward Together describes a whole system approach in which services are delivered by a network of integrated teams across primary, community and specialist and hospital-based care
- Care is delivered as close to home as possible but where care is highly specialised or complex this will be accessed via fewer dedicated centres
- The focus throughout our system is to anticipate needs and deliver the right care by the right person as locally as appropriate in order to support people to return to independent living at home whenever possible.

Key Considerations

To enable our future whole system planning and delivery to work as a single integrated person centred network we should;

- Understand people's needs and involve them in decision making on their care
- Develop a network of teams delivering health and social care services, who are focussed on meeting people's needs through access to the full range of options available across the network
- Support people to take care of themselves or access services in their community which will allow them to self manage conditions and to live in the best possible health with minimal intervention
- Engage with, and inform, our population so that they know and trust the range of alternatives to hospital-based care, allowing them to present to the most appropriate setting according to their need
- Ensure services are easily understandable and accessible
- Promote a culture of cross system working and develop the technology to make that multi-disciplinary approach
- Design a system that has planned adaptability which ensures people can move across the tiers of care as their needs change. There should be a real focus on de-escalation of care, as and when this is appropriate, to facilitate their early return to healthy independent living and also to ensure specialist capacity is available for people who urgently require that level of care
- Follow the principles of Realistic Medicine to prioritise and manage demand.

Our Principles

It is important to reiterate the key principles on which the Moving Forward Together Programme has been based, as these underpin all of the work and findings set out here and in subsequent chapters.

- Aligned to national strategic direction
- Consistent with West of Scotland Programme
- A whole system programme across health and social care
- Using the knowledge and experience of our wide network of expert service delivery and management teams
- Involving our services users, patients and carers from the outset
- Engaging with, and listening to, our staff and working in partnership
- Embracing technology and the opportunities of eHealth
- Affordable and sustainable.

Our Challenge

The changing demographic will have a considerable impact on the demand for our services.

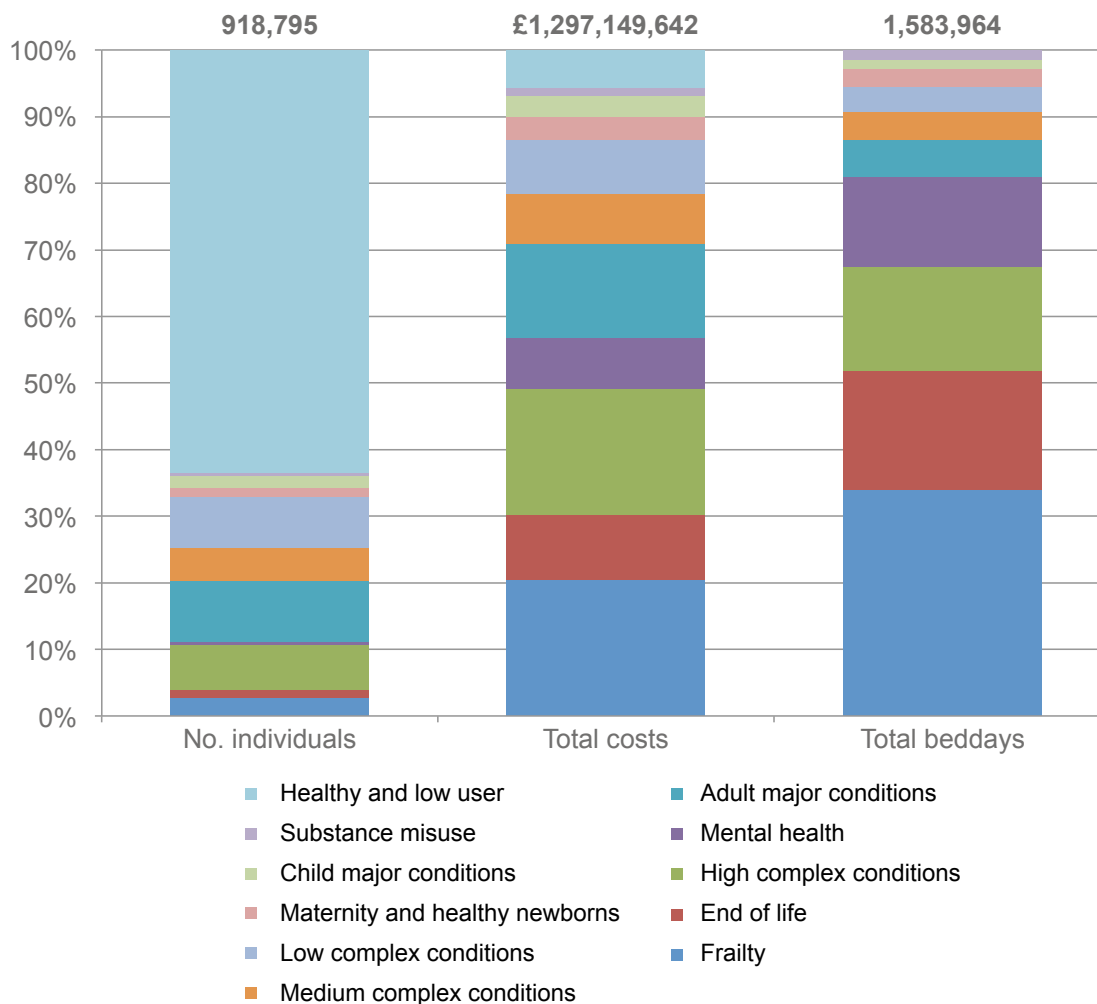
The table below shows the use of hospital beds stratified into clinical groupings. The table shows the number of individuals, the financial resource and the number of bed days used by each grouping in 2016/17.

The high user categories in terms of financial and bed resource are people with frailty, complex or multiple conditions, mental health issues or people at the end of their life.

GGC bed days by group	No. Individuals	Total bed days
All	918,795	1,583,964
Adult major conditions	84,616	87,780
Child major conditions	16,012	22,711
End of life	10,994	282,973
Frailty	24,869	538,864
Healthy and low user	583,479	0
High complex conditions	62,337	245,803
Low complex conditions	68,787	59,088
Maternity and healthy newborns	13,415	41,887
Medium complex conditions	46,205	68,113
Mental health	4,142	215,068
Substance misuse	3,939	21,677

The chart below shows the proportion of total finance and bed resource used by each category.

This shows that the **11%** of individuals in those four groups generate **57%** of the costs and **81%** of the bed days.



If we apply a conservative demographic growth of 10% by 2025 to these four high resource use groups the additional demand generated equates to 128,000 bed days which equates to 413 beds.

Therefore if we do nothing differently we should be planning to open at least an additional 413 hospital beds.

We do not believe this is the right thing to do so we must develop our system to deal with this additional projected demand in a different way by enhancing community services and at the same time, promoting prevention, self care and self management.

A Networked Integrated System

In this chapter we describe our vision for a single integrated health and social care system where people are supported to live independently at home in good physical and mental health but when the need for care arises that is delivered as near to home as possible and with a focus on returning people to independent healthy life at home or as near to that as possible.

Person Centred



There is an absolute need to put the person at the centre of all care delivery. Our system must also recognise the needs of carers and ensure everyone is treated as an individual. We aim to improve individual experience of our services and strive to empower them to be more involved in their health and wellbeing and help them make better informed decisions relating to their care.

The benefits of a healthy lifestyle in preventing ill health are well known. Tobacco smoking, alcohol consumption, diet and lack of physical activity (and often a combination of several of these) significantly increase the risk of premature death and number of years spent in ill health.

The determinants of health are well documented and many of them lie outside the direct influence of the NHS such as relieving poverty, improving housing or education. The way we work with community planning partners and with Scottish and UK governments and the effectiveness of our influence on factors determining people's health, are crucial elements of improving health. Our health and social care system can also affect the social determinants of health through the design and delivery of services and has a role in directly delivering health improvement programmes. The evidence for the cost effectiveness of many lifestyle changes e.g. stopping smoking, losing weight or being more physically active is strong. They can all reduce use of the NHS and other public services as well as prolonging healthy life. However it can be impossible to encourage people to adopt healthy lifestyles without first improving the circumstances in which they live and work, changing environments to support healthy choices and involving people in decisions about their health.

NHSGGC's work on equality and human rights aims to ensure equitable access to our services and to improve outcomes where we have identified that we need to make a significant difference for patients from particular equality groups. NHSGGC has a published A Fairer NHS 2016-20 which includes mainstreaming actions and equality outcomes for all the groups covered by the legislation.

Human rights are the fundamental freedoms and rights to which everyone is entitled. They are built on universal values such as dignity, equality, freedom, autonomy and respect, first set down in the Universal Declaration of Human Rights 65 years ago. Scots contributed to the development of the modern understanding of human rights, which resonates with our deeply held values of fairness and responsibility to the community.

Human rights also link closely with the aims and values of the NHS to deliver person centred services which are free from discrimination and meet people's needs.

Our system must continue to recognise and take account of the importance of carers, recognising the caring that is done by partners, spouses, friends and families and supporting those carers to look after their own health and wellbeing as well as providing care.

We need to welcome and integrate the important role played in care delivery by the third sector and other partners.

As part of the wider public sector we should aim to contribute to health and wellbeing through being able to develop influence on housing and other community planning programmes to join up communities.

We will seek to anticipate care needs by working with our population, as individuals, carers and families with the aim of preventing crises and providing support to people before or just as the need arises.

Seamless Care Across Boundaries

Our system will seek to make the current boundaries between the various elements of health and social care delivery invisible to the person receiving care and imperceptible to the teams delivering that care.

This care will be delivered by a network of teams seamlessly integrated across primary, community and hospital-based services. The teams will take a holistic view of the whole person and shall view their wider needs rather than take a condition specific view to care. The team will have an anticipatory focus, endeavouring to ensure that care when needed is delivered as early as possible and prevents unnecessary escalation or hospitalisation.

The teams across the network will be connected using technology, so that timely decisions can be made by considering the widest possible range of professional advice. This will ensure that the person receiving the care has access to the most appropriate options and that they will have an informed view on what care they receive and how that care is delivered.

Early identification of arising need is essential if we are to deliver early intervention and avoid unnecessary escalation. We need to develop a whole system culture where the person is at the centre of the care network but each team involved in the network views the person as being the focus of all the teams across the network. This is vital in ensuring that the specific needs of the person are matched to the appropriate services or support of the relevant team from across that network.

Enabled by Shared Information and Communication

Central to this concept is the availability of a single comprehensive person record which would enable the teams across the network to view the appropriate sections of the same information about the person they are supporting and enable coordinated decision making to take place across the network.

As a complementary part of this record we would wish to have a comprehensive person care plan which is developed in partnership with the person and describes the current and anticipated care needs of the person that are relevant at that time and are updated with changing need. This should be accessible to all the teams across the network and also agreed with the person as a reflection of their needs and wishes.

The final enabling technology is an easily accessible and timely mechanism for joining up the various elements across the network so that each team can access support and opinion from each different part of the network to enhance person centred decision making which focuses on deciding on and then accessing the most appropriate level of care for that person at that time.

The Tiers of Care – Community Services

Organisationally the approach we have taken is to describe a tiered approach across the entire health and social care system.

These tiers of care begin in the person's home and move out to universal local community delivered services through locally delivered hospital-based services and more specialist community delivered services and onto specialist hospital delivered care which may be to access a service which serves the population of not only Greater Glasgow and Clyde but the wider population of the West of Scotland.

Throughout this tiered system the focus must be on delivering the care a person needs as locally as possible whenever possible but having a system that ensures safe, effective and timely access to high quality specialist services when required although recognising as complexity and specialisation rise these may not be delivered locally.



These tiers should not be visible to the person receiving the care and the network should appear as a continuous system of care in which the person's needs are met by the appropriate team in the appropriate setting, adapting to the changing needs of the person but always with the focus on returning people to independent healthy life at home or as near to that as possible.

In our system we will seek to maximise the number of people who do not need any care services. Through the promotion of healthy lifestyle choices and access to supported self management we shall promote and support independent living at home in good mental and physical health for as long as possible in a person's life time.

When a person is at risk of experiencing a period of poor physical or mental health we shall seek to deliver support as early as possible that would enable them to quickly return to good health with the provision of anticipatory or early interventions.

In the most local tiers of care this would be from services delivered in or close to the person's home. Access to the community teams in the local network would provide services based around the local GP practice and the extended team attached to that practice but also include the local community pharmacy, dentist and optometrist, home care and a wide range of other social care services.

The GP practice is at the heart of the community and we will aim to join up the practice extended team into a wider network of community assets with easy access into, out of and across services and ability to share information and care planning.

In the wider community network there will be access to other service teams delivering the full range of health and social care services. Some of these services will be aligned to clusters of GP practices and some may be aligned to a community hub such as a health or health and care centre.

The bringing together of the various teams across health and social care so that the care needs of individuals from our population is delivered by an integrated team is seen as essential. This joining together of delivery teams across the normal budgetary and managerial boundaries and centred on individuals and their needs will allow better person centred care. The network will operate across the tiers and ensure changing needs can be met by the appropriate team at the right time and in the right place.

The tiered approach across our community network will include a comprehensive range of teams which will include but not be limited to:



Some community delivered services will be highly specialised and as such may be delivered by one team for an HSCP or indeed, for very specialised services, may be delivered by one team for the whole of Greater Glasgow and Clyde.

In our communities to meet the needs of our population there will be specialist and hospital-based services. Access to hospital and other specialist care should be an extension of the care delivered in the community or in a person's home. In our seamless integrated system the provision of hospital care should, whenever possible, be anticipated and be part of a process of care which seeks to enable to person to return to independent healthy living at home or near to home as soon as practicable.

Our system needs to be able to meet the needs of people with a single condition or need and those who have a complex array or multiple needs and to support the management of people with multiple needs as they have less ability to self manage. Our system has to support carers where they exist and provide care where they do not.

When a person's social, physical and mental care needs change unexpectedly our system needs to be ready to quickly and safely escalate the level of care for that person to the appropriate level whether that is in working hours or out of hours.

Again our system for unscheduled care should have a tiered approach where the majority of care can be appropriately delivered within a local community by a network of service teams, with access to emergency hospital or specialist community-based services for those whose needs cannot be safely met within the community.

The Tiers of Care – Hospital-based and Specialist Care

Our hospital services will also be arranged in a tiered network which is an extension of the community-based network. Hospital services will provide local access to services wherever possible. When care delivery requires access to very specialist equipment or very highly trained specialist staff those services may be delivered by a single team or from a single location for an area, for the whole of Greater Glasgow and Clyde or even for the West of Scotland. For example, in unscheduled care, the Queen Elizabeth University Hospital has been designated as the Regional Trauma Centre which means it is the centre which will deliver emergency services for those patients with multiple life threatening injuries for the whole of the West of Scotland. These patients may often arrive by helicopter and will require the coordinated care of a number of specialist teams which can only be delivered at the Queen Elizabeth University Hospital. At a geographical sector level there will be trauma units which will provide emergency care for the Clyde and North Glasgow populations where that level of care does not require the number of specialist teams that would mean treatment could only be delivered at the Queen Elizabeth University Hospital.

We recognise the importance of transport networks in a networked system whether that is public transport, people's own personal transport or transport provided by partners such as the Scottish Ambulance Service.

The benefits of our networked tiered approach are many. The creation of specialist centres of excellence has been proven to maximise the best possible clinical outcomes. By layering services we are improving sustainability of service delivery in the face of workforce and capacity challenges. Networking makes the best possible use of specialised equipment and facilities which are only required by a small proportion of our population. We can provide an appropriate balance between local access for routine or lower complexity care packages while giving access to highly specialist and complex care when necessary.

Keys to Success

There are a number of essential elements which will enable our system to work as a single integrated person centred network.

The first element is a comprehensive knowledge of the services available across the care network and a clear understanding of when each service is appropriate to meet a person's needs. This element applies to the service teams delivering care. Each team should be supported to access the full range of options available to meet the person's needs across the network. They should know how to direct to and/or access those services so that each appropriate option for the person's care is easily accessible.

This element applies also to our population. We need to engage and inform our population so that they know and trust alternatives to hospital-based care, allowing them to present to the most appropriate setting according to their need. We also need to support people to take care of themselves or access services in their community which will allow them to self manage conditions and to live in the best possible health with minimal intervention.

The second element is ease of access. Our population should have a system where access to the appropriate service is not a challenge. Where there are services which have access criteria these should be transparent and fair. Where access requires a waiting period due to capacity limitations the reason for and implications of this wait should be explained to the population. This will promote an honest conversation and allow service providers and service users to have a common expectation and to allow educated and informed decision making on care delivery options.

The third element is communication. This is communication with the population on their priorities, their expectations and their preferences. Only by understanding people's needs can we deliver person centred care. This is also communication across our networks. Modern technology presents opportunities to connect service delivery teams across different geographical locations and allow team working without the need for colocation. The advent of a culture of cross system working and the technology to make that multi-disciplinary approach a practical proposition will allow the quality of person centred decisions to greatly improve. Decisions should not be based on a lack of information or an inability to seek specialist advice to support decision making. Joined up decision making, in near real-time, improves the appropriateness of the subsequent care delivery and also the flow through the system and supports an earlier return to good health and independent living.

The necessary adoption of a tiered but networked approach to service configuration means that not every service is available at every tier and that some services are only accessible in certain locations or are delivered by certain suitably trained teams.

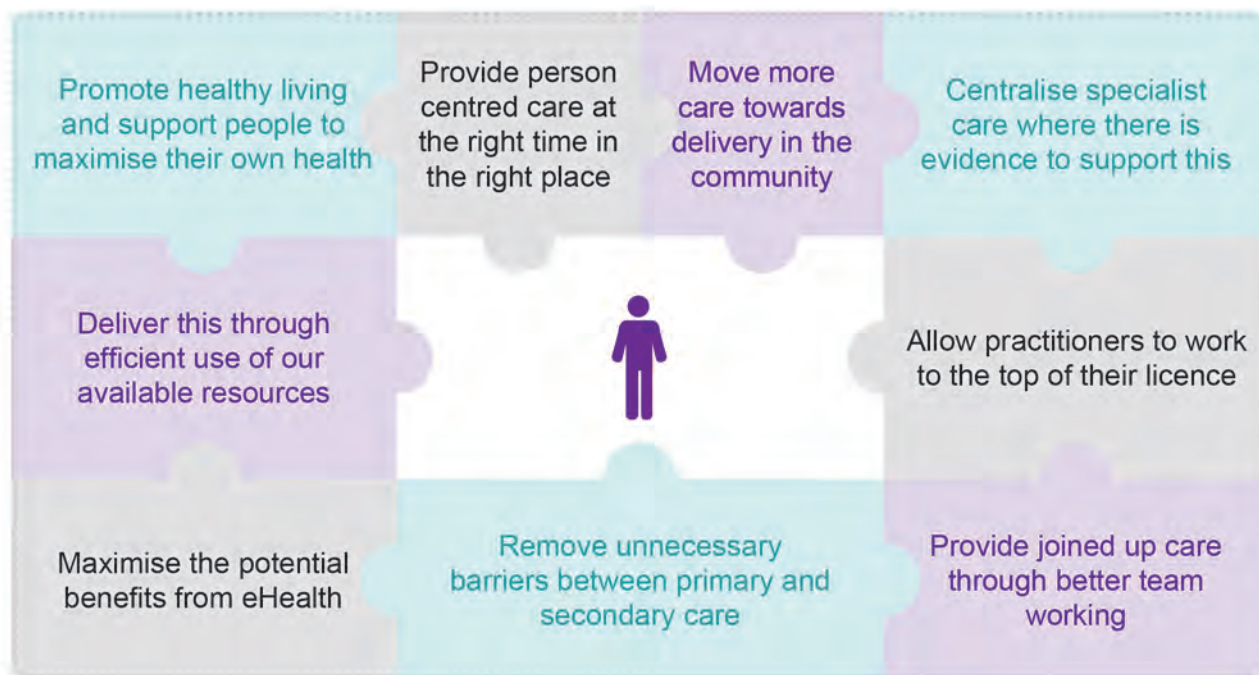
In order to make this configuration safe the system must have a planned adaptability which ensures people can move across tiers as their care needs change. This requires service delivery teams to be trained in the identification of changing needs, particularly in people whose health is deteriorating requiring them to be escalated to more specialist care. The system must have a robust mechanism for the timely delivery of the required escalation in care whether that is in moving the person or in mobilising a specialist response to the person. The definition of a timely escalation will depend on the nature of and pace of the changing need but the system must be capable of ensuring a safe escalation of care in any eventuality.

Finally the system must have a real focus on de-escalation of care as and when this is appropriate. The moving of people back down tiers of care as soon as appropriate will facilitate their early return to healthy independent living and will also ensure specialist capacity is available for people who urgently require that level of care.

It must be as easy to step down through levels of care as it is to step up and this must be seen as a normal mechanism as people regain physical and mental health and are given the appropriate care and support rather than a withdrawal or downgrading of care.

Our Vision

In summary we will seek to deliver a system which will:



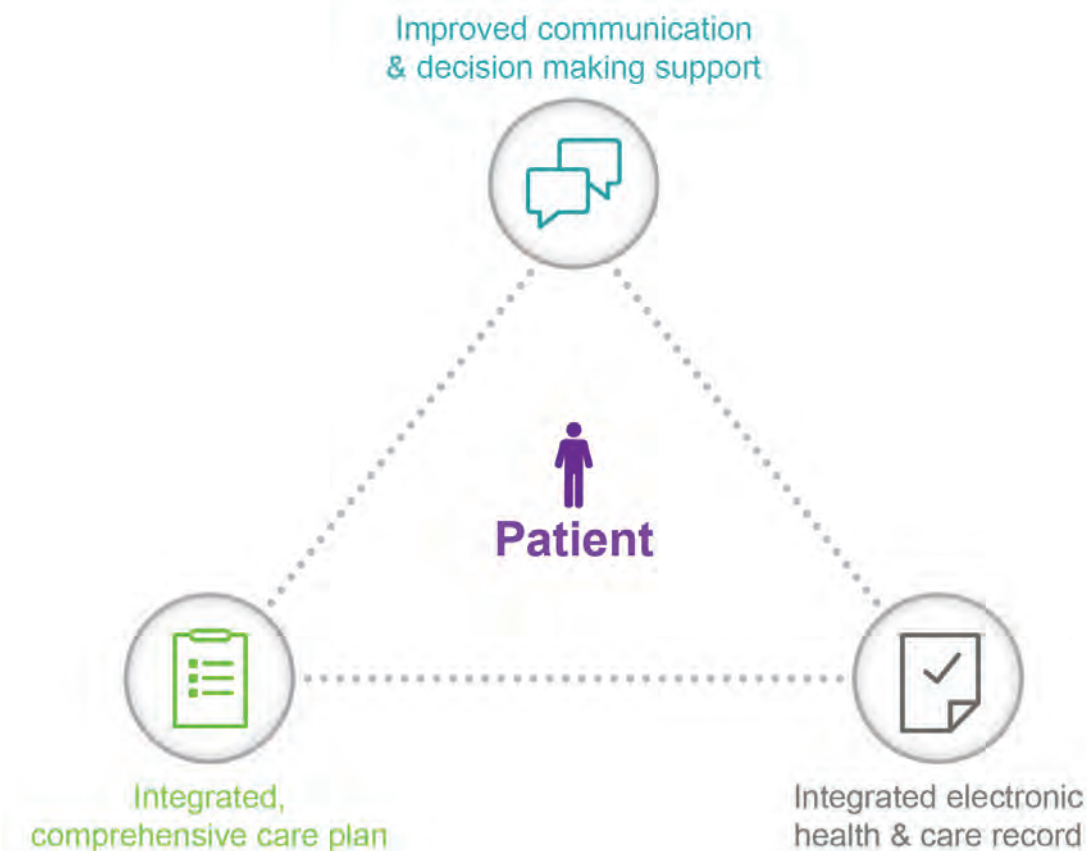
7. eHealth

Introduction

Increasingly we live in an 'information society' with almost every aspect of our daily lives touched by technology – whether this is in our homes, in our wider communities or in our working lives. How we book holidays, how we read the news, and how we keep in touch with our families and friends have all been revolutionised. People expect to use technology in all areas of their lives and health and social care should be no exception.

What is eHealth?

eHealth means different things to different people but essentially it is about how we use information to facilitate healthcare. The World Health Organisation describes eHealth as 'the use of information and communication technologies for health'. Most people will think about computers and the internet when they think about eHealth, but it encompasses how we present and use health information using these and other technologies. From a practical point of view, eHealth includes all the computer systems that are used to view, record and transact with the Health & Care Record (previously the Electronic Patient Record), along with the numerous specialty clinical systems and the hardware and processes that surround all of these.



What Sort of Information?

Information in eHealth can range from directly relevant information to the person such as the results of blood tests or a letter from a clinic to large volumes of data about a population. Data concerning scheduling of healthcare, the person's contact details and their wishes would all also be relevant data that could play an important part in delivering the best care for them. Other information may not relate to the specific person but may still provide the care team with advice on conditions and treatments that allow them to make the best decision for their care – this is called **Clinical Decision Support**.

How Do Health and Social Care Workers Access this Data?

It is important that the care team looking after the person is able to access the relevant information at the right time. It should be easy for them to find the information and nothing important should be missing. This is one of the challenges for Moving Forward Together, to make the person's record as complete as possible and easily available for the care team working in different disciplines and geographical locations. The care team need to have access to these records on secure computers and mobile devices from wherever they are providing care, and all care teams will be able to contribute to a shared care record. Moving towards a single or shared care record will allow the development of shared care pathways for people with certain conditions where the person and the care team follow a pathway designed to deliver best practice. eHealth systems should incorporate effective clinical communication channels between care teams so that the appropriate expertise is always available for the person.

Why is eHealth Important to Deliver Safe and Effective Care?

Doctors, nurses, AHPs and the extended care teams need to have access to the right information to make the best clinical decisions. eHealth can help by providing this information in an easily accessible format. Furthermore, eHealth systems could be used to pull together important information for a clinical service to form dashboards that can highlight vulnerable people and trigger interventions. Key safety areas such as prescribing could be made entirely electronic to support safe use of medicines, highlight medicine interactions and allergies, and encourage use of locally-agreed prescribing guides. There is currently research ongoing to see whether artificial intelligence could be used to interpret health data and predict which people require treatments and what treatments would be best for them. Care teams are constantly trying to improve the quality of their service and to do this they require information about how they are performing. Obtaining, interpreting and acting on this information are part of **clinical informatics and quality improvement**.

Artificial Intelligence or 'AI' describes the intelligence of machines or computers in healthcare. AI can support our workers when they need to process large amounts of information.

What Interaction do People Have with eHealth Systems?

People will have increasing access to their own information in the future, after all they are at the centre of it. A Health & Social Care Portal is proposed which would give people secure access to their information such as care appointments, documents and test results. Interactivity would be developed such as accepting/rejecting appointment times, filling in questionnaires about their current wellbeing, and communicating with their care team. It is envisaged that key information such as medicines and Anticipatory Care Plans, could be held in such a Portal and will form part of the electronic care record. **Technology-enabled care** describes the use of electronic devices in the home, such as blood pressure or activity monitors. These could feed data into the Care Record so that advice or adjustments to treatment could be made remotely.

Is all this Information Kept Safely?

Keeping information safe is paramount in designing any of these eHealth developments. There must be appropriate safeguards to protect against inappropriate access or use of people's information, but on the other hand these safeguards must not create barriers to appropriate data-sharing. For the whole system to work, it is essential that a degree of information sharing goes on and that this sharing is 'seamless' wherever possible. People should understand that this is essential to the 'whole system' functioning, and high level data sharing agreements should facilitate this.

Strategic Context

The significant opportunities for digital technologies to transform the way health and social care is provided is recognised and it will be essential that we harness the potential of technology and innovation in order to sustain and develop new models of health and social care and to empower people to actively engage with and manage their own health and wellbeing.

People expect to have access to the digital tools to support their health and social care and that those providing these services also have the access and tools that they need.

Our workforce expect to be supported with modern technology to enable them to view the appropriate information about the person they are caring for, make decisions and communicate effectively across the integrated team.

Scotland's Digital Health & Care Strategy states:



The issue is not whether digital technology has a role to play in addressing the challenges we face in health and social care and in improving health and wellbeing: the issue is that it must be central, integral and underpin the necessary transformational change in services in order to improve outcomes for citizens. Over the next decade digital services will become not only the first point of contact with health and care services for many people, but also they how choose to engage with health and care services on an ongoing basis.”

The Moving Forward Together Programme recognises that digital technology will be central to delivering the transformational change that is necessary in order to support integrated health and social care teams in delivering new models of care.

The existing Clinical Portal is now used by 12,000 front line staff each week with more than 25,000 staff having access across the organisation including acute care, mental health, primary care, GP surgeries, community nursing and a number of social care settings. Portal is an essential system for clinical staff within GGC, where clinical information and resources can be accessed quickly and easily. Health and social care staff use the Clinical Portal to access the electronic health and care record which holds a range of key information including hospital care correspondence, referrals, diagnostic results, health service encounter history and a mental health summary. Work has commenced to integrate a range of data from social care systems, starting the journey to an integrated shared record.

Cancer Specialist Story

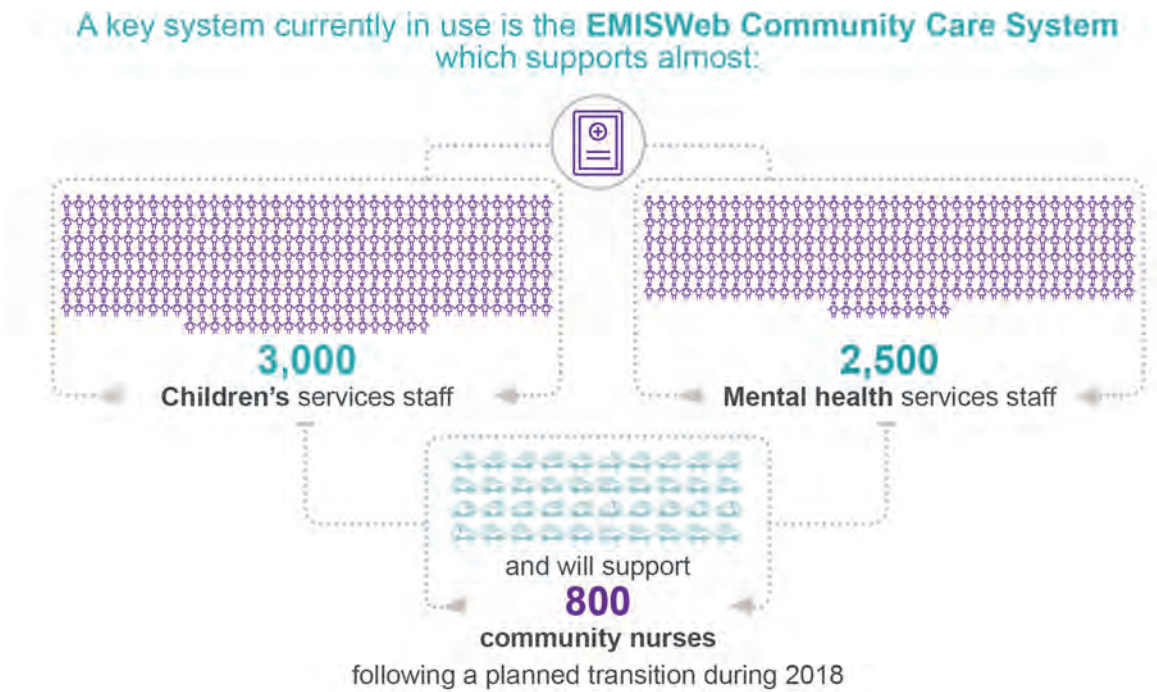
“As a cancer specialist, I work within a regional service, and between 55 and 60 per cent of our patients do not reside within the Greater Glasgow and Clyde catchment area,” he says.

“They come from surrounding health boards and, occasionally, if they have a very rare cancer, from other parts of Scotland. We could find some information for them by going into the national information repositories for the individual health boards.

“But the big advantages of the West of Scotland portal to portal are that you don’t have to manage so many passwords and you can find additional information, such as clinical correspondence. It really is useful.

“If I am seeing a new patient, or a follow-up patient who has had investigations done, or a patient on chemotherapy, then I want to see their test results, and their scan results, and their treatment log. Now, I can do that from within one system, which is a huge benefit.”

A key system currently in use is the EMISWeb Community Care System which supports almost 3,000 children's services staff, 2,500 mental health services staff, and will support 800 community nurses following a planned transition during 2018. Due to an organisation wide approach EMISWeb provides access to case records across services, handling referrals and scheduling of appointments and is one of a number of health and social care systems which feed the shared record which is accessed and viewed from the Clinical Portal.



The vision for an integrated health and social care system will rely on technology to support new ways of working and to provide health and social care teams with the information and tools that they need. This will also be the main drive for the five year NHSGGC Digital Strategy.

Integrated care will become the norm, whereby people are supported by a total care package across acute, community and primary care services. Joining up these services can be complex, given that separate systems and processes currently exist. eHealth technology offers the toolkit to transform these areas, providing a truly integrated and modern care service.

The vision of an integrated health and social care system where people are supported to live independently at home or, when the need arises, as near to home as possible can be made possible with the support of technology.

Utilising technology, the following strategic goals have been identified in order to deliver the vision set out in the Moving Forward Together Programme:

Improved Communication and Decision Making Support

GP to hospital referral, outpatient processes and inpatient workflow are now almost completely digitally driven. The aim will be to extend this to allow all necessary care transitions to be digitally managed and tracked across the teams within the network.

Already remote consultations give greater choice and convenience for people that would ordinarily have to travel long distances for routine check-ups and help alleviate administration across our services. Pilots of video conferencing technology such as 'Attend Anywhere' which provides people

with access to online video conferencing facilities from any location including a home environment have concluded and will be implemented in services to support remote, virtual clinics where a video call is necessary. In addition the use of telephone, email dialogue and online web chat with people will be promoted for virtual clinics in addition to the provision of guidance to services on how to set up and record virtual clinics within the Patient Management System in order to support future expansion across the Board and the West of Scotland region.

People will participate in this communication utilising technology to access options about their care, enabling people to take a more proactive role in their own health and social care. Building on our successful initial pilot of a Health & Social Care Portal – a “Digital Front Door” to health and social care services people told us,

““ The concept of this Portal is fantastic, a long time coming in my opinion””

““ This portal would put patients firmly in control of their healthcare, and that can only be a good thing””

““ ... for the majority of patients across Scotland, I expect this would be a success.””

Specific areas of focus will include:

- **Access to Clinical Portal with extended sharing of information** available to clinical and social care practitioners. This will enable the care network to view the same information, have online discussions across the team, including the patient if necessary
- **A Health & Social Care Portal** with access to appointments, correspondence and investigations, linked to an explanation of their condition and better ways of engaging digitally with the health service and their care providers
- **Advice referrals and clinical dialogue** enabling co-ordinated decision making and the ability to anticipate people’s needs as early as possible. Specialists will be able to provide advice and information regarding tests or examinations which can be carried out before a person is referred into a hospital or to another practitioner
- **Electronic referrals viewable by the integrated team** will be available. We will explore artificial intelligence (AI) support for routing referrals to reduce the time taken to make decisions
- **Community nursing teams** will make more use of predictive data to aid planning and help them target their visits to people who most need them
- **Clinicians will be supported with advanced analytical tools**, visualisation and better decision support to aid real time working
- **Cohort registries and better results management tools** will support moves to ‘safety-netting’ and alerts to review rather than bringing people back routinely for appointments just to make sure something has happened
- **Quality improvement** will focus more on patient-related outcomes
- **Further development** of the HSCP data sharing framework to include all relevant aspects of social care information.

It will be necessary to review information sharing and governance to ensure that information is available to those who need it at the appropriate time. It will be important to ensure that this aligns and reconciles both citizen and care provider demands, ideally with a move to person centred control and reduces impact of organisational silos.

Shared Record

In order to ensure that people are at the centre of their integrated healthcare, a comprehensive electronic health and social care record is essential. This shared care record will be accessible for those health and social care professionals involved in the person's care. This will ensure that the total care package can act with common purpose, based on a rich and reliable digital record.

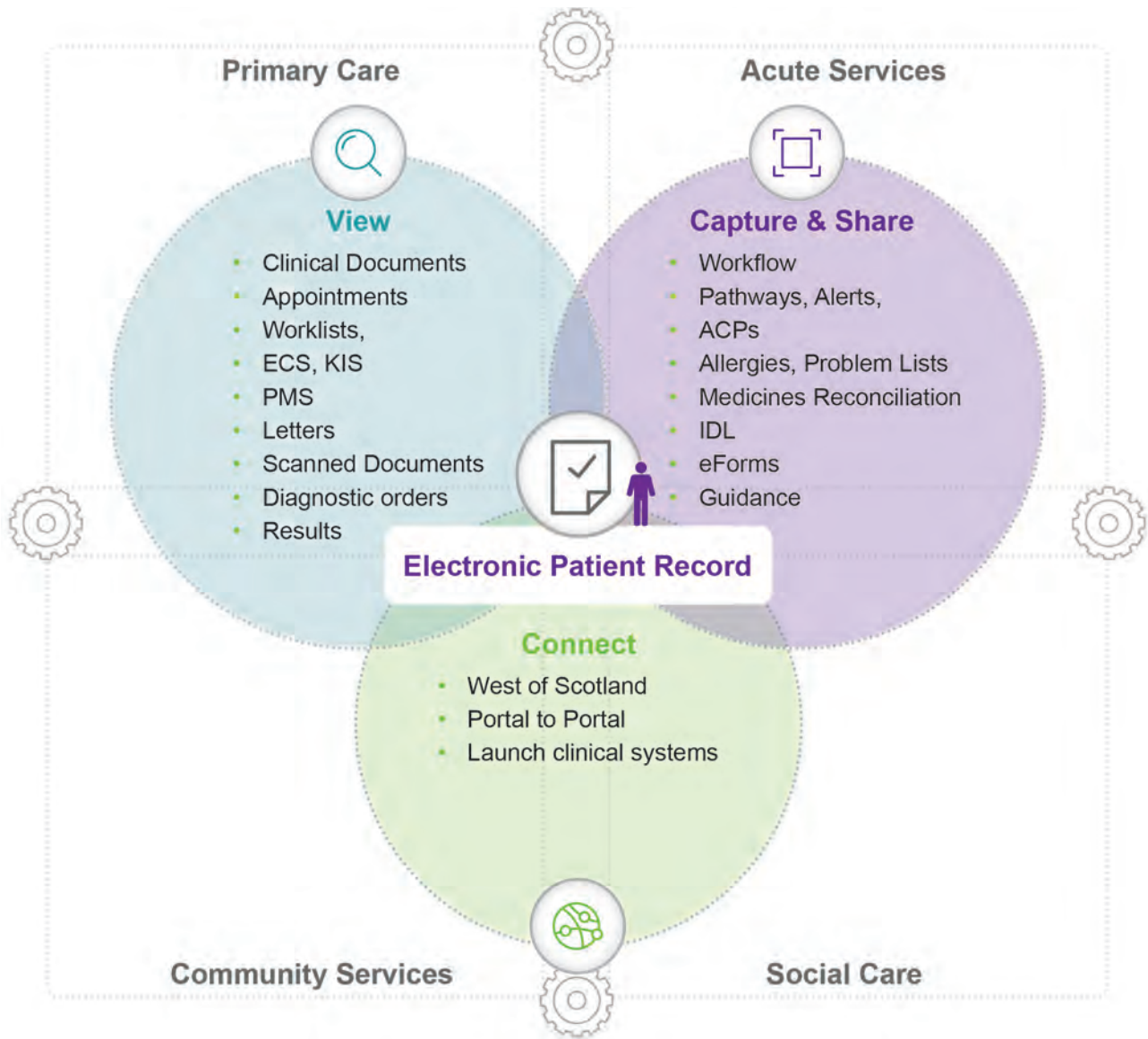
Building on and developing the cornerstone systems currently in use, the shared record will include all of the relevant information from the hospital, community, primary care and social care. This will improve real time communication and collaboration across the care network, enabling multi-disciplinary teams to collaborate at their convenience using the most accurate information available, allowing them to understand the complete care context to aid decision making.

Health and care records from multiple sources and systems will be joined up with active input from multiple sources to deliver a truly integrated, digital record which will help to reduce or remove unnecessary duplication, interference or gaps in information. In time systems will be integrated in order to support integrated care transition without the need to join up records.

This shared health and care record will provide a comprehensive and ongoing record and one which people will also have access to and will be an integrated reference point to align people, departments, processes and systems around the active and ongoing needs of the person.

People will have access to their own digital records and will actively contribute and transact with services in this way. Recent pilots of the National Health and Social Care Portal have demonstrated that it is possible for people to accept, decline or change their appointments digitally and that this can then be actioned on patient management systems and that people want to use this type of technology to access their health and care records and to engage with services.

Electronic forms will be able to be completed by people before they attend and sent directly into the NHS clinical systems for clinicians to view, respond to and contribute to. This then forms part for the person's integrated Health & Social Care Portal record. This capability will also enable administrative processes to be streamlined across tiers and networks of care teams.



Integrated Comprehensive Care Plan

The health and social care teams will rely on an integrated care plan to support patient pathways and established workflows. The use of technology to provide this will enable a single care plan using digital forms and communication tools to support the pathway. The care plan will be accessible to all those who need to see it including the person receiving care and will be included and viewable within the shared record.

Thousands of electronic forms (eForms) already capture information and cornerstone systems are configured to support workflow of a person's pathways and across teams. Major further development of eForms and their associated pathways will drive additional workflow efficiencies and will underpin and enable transformational changes for service redesign across networks and regardless of organisational boundaries. This technology will enable the management of a person to take place remotely and regardless of where the clinician or person is based.

A range of capabilities will be provided including:

- Where appropriate **the use of digital technology** will enable the management of people's care to take place remotely and regardless of where the health and social care team or the person is based, whereby consultations are increasingly conducted using smart phone app, telephone, email, video conference or online portals

- **Dynamic electronic forms** and pathways based on agreed clinical workflow will be developed
- **Integrated anticipatory care plans and notes** will be accessible within the care plan and recorded in the shared record. People will be able to view and contribute to their care plan
- **Problem lists recording diagnosis**, procedures and allergies will be included in the care plan
- **A shareable list of current medication** to reduce medication errors at care transition will be available
- **Alerts and scoring** which will flag at risk, vulnerable people to the integrated team will be included and communication tools will be available to allow the health and social care team to discuss and update the care plans.

Person Centred Technology

Whilst seeking to take full advantage of the opportunities that technology has to offer both healthcare providers and our population, we must still provide person centred care for those members of our population who do not wish to or cannot access this technology. We must support these individuals so that they are not disadvantaged by any care system changes and that these changes take account of the needs and preferences of every member of our population.

Innovation

Innovation in digital healthcare provides a real opportunity to evolve and enhance relationships with people receiving care, where telecare and telehealth, virtual clinics using video and people accessing and contributing to their integrated health and care record allows greater empowerment of self care.

In order to support clinical and care teams a number of new application systems will also be delivered including a new Ophthalmology clinical system, a new GP IT system and extensive implementation of the existing community system into new service areas.

There will be opportunities to explore and trial the use of artificial intelligence (AI) in relation to increased processing capability for electronic triage and referrals.

Increasingly person held data from wearables, apps and technology enable care systems will form part of the Electronic Health and Care Record. People will be able to access services through different channels including online through the internet and via mobile phone apps. A range of capabilities will be available through the use of innovative new technologies:

- **Virtual consultations**, reducing the need for people to travel, improving the management of long term conditions and maximising clinic utilisation and efficiency. Technology such as online video calls, web chat and online assessment forms will be available and will be recorded in the shared record and care plan
- **Technology enabled care** such as home health monitoring and which deliver benefits to people and services at scale will be a key focus with the integration of this information into the care plan, supporting self management of health and wellbeing with a focus on digital products and services
- **Mobile and wearable technologies** provide significant opportunity to people and their health and social care team to use individualised healthcare information and analytics. In the future this data will be viewable by the team providing care and can be used to determine early warning and preventative processes.

- **Promotion of digital tools** which support people to access their digital health and care record, transact digitally with the health and social care team, access relevant information for their condition, including signposting, enabling them to actively participate in their health and social care
- **The development of a clinical informatics programme** utilising data and harnessing the capabilities of rules based informatics provide a wealth of opportunity to deliver finely tuned alerting for specified people, pathways and/or conditions. Examples include deteriorating conditions or changes to conditions that exceed (or are close to) pre-defined thresholds based on risk scores, results outside of an acceptable range or based on an increase in pain score; which would trigger an alert or activate a process.

Martin's Story

Martin has been living with HIV infection for 22 years. Over the years he has been careful to take all his medication, but has been feeling more tired than normal. He has recently had some backache, not been sleeping well and has been taking lots of painkillers bought over the counter. He receives a notification via his phone's health app that it is now six months since his last test. He is quick to respond and he searches and books for his routine annual blood checks at his nearest community phlebotomy clinic.

It is great that this works with his phone map software as he had not realised a new site had opened nearer to his home. This saves the need to travel to the hospital. The appointment to get his bloods goes smoothly – sad they still need to take blood – and he shows the barcode on his phone to make sure the staff allocate the blood checks to the right clinician. The staff check his weight and give him a blood pressure monitoring device to use for 24 hours as this hasn't been checked for a year anywhere in the health system.

A day later his phone notifies him that results are ready for collection. He logs into the site and sees straight away that his kidney function is reduced below normal. There is a useful 'help' link to follow and he realises that the painkillers may have contributed to the problems. He logs into his patient records and adds the painkillers to his medicines list and checks that the rest of the listed medicines are correct. Back at the hospital his consultant sees this result at the top of the pile of results awaiting review as it is unexpected, so the system support has marked this for priority. Fortunately she can see that Martin is already aware of the issue and has seen the result as well. The consultant can also see the blood pressure is raised and along with the updated medicines list it is becoming clear what the problem is. They arrange a short video consultation just so the consultant can see how well Martin really is and make sure that communication is as good as it can be.

Martin agrees to come off the painkillers and self refer to the back pain physio service in his local council gym, which he manages easily. The automated ordering system has already prepared a prescription for his HIV medicine to collect which will be released as soon as his viral load result returns as normal. It is much easier now he has opted for collection from his local community pharmacy. He has asked to repeat his home blood pressure and books to repeat his renal function next week at the nearby blood test centre. Later that day he checks in and sees the reassuring result that in spite of all this drama his virus remains fully controlled.

Chapter 8: Planned Care

Planned Care – Overview

Key Issues

- Applying population-based planning to the delivery of health and social care services across a whole system network with tiered care providing appropriate services accessible in the right place at the right time to meet people's needs
- A focus on self management, self care and supporting people to live independently in their own communities
- Alignment with the National Clinical Strategy in terms of changes to the ways in which services are planned and delivered so that care is provided as locally as possible but making the best use of specialist skills and equipment through networks
- Planned care should be community-centred and the majority of it should be community delivered whether that is by GPs, the extended practice team, the wider community network or on an ambulatory or outpatient basis at a local hospital
- Evidence supports the delivery of clinically proven better outcomes through increased volumes, better use of new technology and a more sustainable workforce.

Key Considerations

To enable our vision for planned care we should bring together the different elements of care into a seamless delivery system. We should develop a system where:

- Each local community population will have access to GP services
- GP practices will be part of a cluster and will be part of an enhanced team
- Communities will have access to an integrated community model
- Community services will be arranged as a hub and spokes in some areas the hub will be a physical location such as a health and care centre whilst in other areas this may be a virtual hub with teams being connected via technology rather than colocated in a building
- There is access to intermediate care services for people who do not need to be cared for in a hospital setting whether this is to avoid admission to hospital or to enable discharge from hospital after treatment
- As defined in the whole system chapter, each local community will have access to a wide range of outpatient services within their local geographical sector. They will also have access to a wide range of day case and short stay treatments available within their local geographical sector
- Each geographical sector will have a hospital that offers access to routine inpatient surgery and other treatments of medium complexity which do not require highly specialist teams or equipment. That facility will have on-site critical care facilities and the necessary diagnostic support
- Highly specialist planned care such as complex cancer treatment or highly complex surgery services will only be delivered from selected sites across GGC which have the necessary highly trained staff and specialist equipment to be considered as centres of excellence. These centres are designated to deliver services for the whole of GGC or in some cases the West of Scotland or even the whole of Scotland

- Cancer Care is delivered as part of the West of Scotland region. Cancer treatment will be delivered as locally as possible whenever that is safe and clinically appropriate and more complex care will be delivered to the highest standard in fewer units or in the regional Cancer Centre
- Diagnostic facilities and screening programmes will be provided as locally as possible except where the diagnostic processes require specialist teams or equipment when the provision may be better delivered from fewer units.

Our Approach

Our approach to planned care follows our framework of developing a whole system network or tiered care providing the level of care appropriate to the needs of our people in the right place and at the right time with a focus on self management, self care and supporting people to live independently in their own communities.

The National Clinical Strategy describes the need to make changes to the processes of care and structural changes to the way in which services are planned. It advocates services being delivered locally wherever possible but when these services require specialist skills or equipment it advocates a population approach to planning which would see the creation of a fewer number of centres of excellence where the bringing together of skills and equipment into selected locations providing services across a geographical region would provide:

- Clinically proven better outcomes through increased volumes
- Better use of new technology
- A more sustainable workforce.

The GGC tiered network approach describes planned care as a local and community-based element which can then escalate care as required into a hospital-based network which provides both local planned outpatient and day case procedures for local populations as well as centres of excellence for highly specialised treatments for people from across and out with GGC from only a few facilities or in some cases a single facility.

Planned care should be community centred and the majority of it should be community delivered whether that is by GPs, the extended practice team, the wider community network or on an ambulatory or outpatient basis at a local hospital.

The Planned Care Tiered Network

Across this network we have described a range of tiers which deliver care at differing levels of complexity and generate differing requirements for specialist staff or equipment. As care is escalated through the tiers the need for colocation and co-dependency with other services rises. With this rising complexity comes lower volume as a smaller number of people require this specialist care. Therefore in order to provide the better outcomes described in the National Clinical Strategy we would seek to deliver these services from fewer locations but sustainably and at the very highest possible standard.

Self Management and Care



The most local tier of care is actually to provide an environment in which people are empowered and supported to look after their own health. Healthy lifestyle choices will maximise the time that people live in good health at home and have no need of health or social care services.

As a need arises, whether that be a health or social care need, our anticipatory approach would provide community-based solutions and care options which allow the person to return to good health as quickly as possible without needing to be escalated through the tiers of care.

Community-based Network

There are a range of services to support planned care which are available through the network of community-based services.

There are the services of local **community pharmacists** and **optometrists** and **dentists** who can provide advice, support, treatment or triage onto other services as appropriate to the needs of the person.



The **GP practice** is at the heart of our community network and together with the wider network of community-based services provides access to a comprehensive range of planned care up to and including referral to a hospital-based service.

With the vast majority of planned care being delivered without the need to refer to hospital, the maximisation of community-delivered planned care is essential to meeting the increase in demand.

In the role as an expert medical generalist, the GP has a focus on treating people with complex needs as individuals and this includes assessing their care needs in the context of multiple conditions and discussing any need for specialist planned care with the patient as part of their overall needs. In order to fulfil this role the GP needs support in terms of information and access to timely advice from the providers of specialist care whether they are community or hospital-based and also clear pathways into and out of a wide range of supporting services.

This integrated and seamless network is centred in the community but extends into care facilities such as local hospitals and across into centres of excellence for planned care which provide services for a larger population.

In terms of **hospital-based services** we continue to describe an integrated networked approach which is an extension of the primary and community care services.

Access to the specialist care provided in hospitals and other specialist facilities should be an extension of the care delivered in and for our communities. When a hospital stay is planned this should be for the minimum time appropriate to deliver that care and a timely return to the community should be a focus throughout. In order to enable this there should be community-based support before admission in order to help prepare people for hospital and preparation for discharge to ensure there is no need for an unnecessarily extended hospital stay. In achieving this it is important to consider the projected needs of the person after discharge from hospital during any extended recovery period required which should be in their community whenever possible through the use of intermediate care or support in a person's home.

Extending Community Services

The demographic projections predict rises in the demand for planned care of around 10% over the next ten years, be that for outpatient appointments, day case procedures or inpatient care which may include critical care. Innovation and transformation are required if we are to deliver timely access to planned care in the face of this rising demand.

Hospital-based planned care should be an extension of the community and as such should be locally accessible on an outpatient and ambulatory care or day case basis where possible.

In the acute hospital setting day case has become the norm but there may be potential to take this further by delivering some elements of current and future planned care outwith the hospital setting as part of the community-based network.



There are a number of opportunities which have been put forward during the service modelling process in Phase Two which suggests some activity that is currently done in hospitals which could safely be provided more locally.

- **Increasing acute outreach** into the community network with a wider range of specialist clinics in the community, working as part of a team with primary care and community services
- **Diagnostic services** organised around assessed individual needs
- **Rapid access to specialist opinion** and review as an alternative to emergency admission or to facilitate discharge.

In our specialty-based service modelling groups there were a high number of specific examples of care that could be delivered more appropriately in a local community setting. These include but are not limited to:

- In **cardiology**; a move to community care for heart failure through increased specialist outreach and support to community-based remote device monitoring, blood pressure monitoring and electrocardiogram for heart monitoring
- In **dermatology**; community-based chronic condition management and the use of teledermatology
- In **diagnostics**; the opportunity for community phlebotomy services
- In **ENT**; community-based nasal endoscopy, dizziness and ear wax removal services colocated with audiology services
- In **general surgery**; specialist nurse-led assessment and monitoring
- In **gynaecology**; a move to increased day case care
- In **older people's care**; more community outreach from hospital-based consultants and closer links into GP clusters and care homes
- In **rheumatology**; community delivered care for hypermobility, fibromyalgia and chronic pain
- In **orthopaedics**; community AHP-delivered musculoskeletal assessment and treatment
- In **urology**; community delivered catheter maintenance
- In **vascular**: claudication services and a focus on community-based education, lifestyle advice and exercise classes.

It is recognised that these changes will require development of new services and enhancement of the network of community and local services.

Across many specialties there was an enthusiasm to embrace technological opportunities where advice and opinion is provided without the need for the person to attend hospital.

Focus on Specialty Outreach

The three specialties where a community-based network of services supported specialist outreach from hospital were already proving to be effective or there was the greatest opportunity to make benefits from this model of working were in the provision of respiratory, diabetes and gastroenterology care services.

Gastroenterology

In the work of the Gastroenterology group there were proposals for a range of care services that could be appropriately based in the community network with suitable support from hospital outreach including:

- Hepatitis B care
- Hepatitis C care
- Diagnostic investigation for chronic liver disease with ultrasound
- Community phlebotomy
- Coeliac disease.

It was considered that **coeliac disease** lends itself well to a community network based annual review with access to condition monitoring and result interpretation with the option when required to escalate via referral back to hospital care.

Chronic diseases of **liver** and inflammatory bowel disease are currently mainly hospital-led, however there are opportunities for self management and community-based eHealth supported models to allow for local phlebotomy and stool testing which are triggered after analysis of self reported telemedicine results from patients.

Hepatitis C treatment is increasingly delivered in the community and this service model can be further enhanced by the networking of services across hospital-based and community services by the intelligent use of technology and information sharing systems, particularly a single shared record between social care, addictions and medicine.

Haemochromatosis - venesection is another area for development into a community-based service. There is an opportunity to use an algorithm to interpret results of community taken tests which would generate a referral for venesection or guidance for further monitoring.

Hepatitis B patients in the non-inflammatory phase of infection could be managed in the community and have blood test results reviewed at a virtual clinic.

People referred with probable **non-alcoholic fatty liver disease** could have a community-based blood test, automated risk score calculation, fibroscan if indicated and medical history obtained at nurse-led clinic which could then be reviewed in a consultant virtual clinic and results and advice communicated to the person and the community network team.

To support this model it was seen as vital to enhance clinical dialogue and support to GPs from specialists.

It was highlighted that colocation with or close relations with community addictions teams would enhance this service.

Diabetes

In the diabetes group there was a description of a person centred hub and spoke model of care. This model would see the majority of **Type 2 diabetes** monitoring being managed in the community network supported by specialist-led cluster multi-disciplinary team meetings. The majority of **Type 1 diabetes** care would be delivered by specialist teams which could be as an outreach service into the community. It was envisaged that diabetes hubs deliver complex diabetes scheduled care including facilities for delivering structured education for self management and links to other key services such as paediatric and transition services.

This view of diabetes services is seen as a wider network of community-based health and wellbeing hubs. These hubs, whether physical in a centre or virtual through a technologically connected hub of community teams, could undertake most of chronic disease surveillance.

In relation to diabetes this could also include retinal, foot and microalbumin screening. These hubs would therefore provide the care processes with the results of these investigations being shared via digital portals such as My Diabetes My Way. This would support person centred care with joint goal setting and support specialist staff in maximising the effective use of their specialist skills.

People's Stories

John's Story Today:

John has Type 2 diabetes and as such he has to attend several different appointments to have various different processes of care performed such as eye and foot screening. He finds this challenging as he does not drive and depends on public transport which can be very costly given the number of appointments he attends. He also attends appointments with his healthcare team where he has other tests performed such as blood and urine tests. John feels that a lot of time is spent having things done to him with little time to discuss the issues that really matter to him such as his diabetes, health in general and how his illness impacts on his everyday life. John finds it very frustrating that the results of tests are not available at the time of review and therefore discussions are based around possible rather than actual results and this leaves him uncertain as to what should happen next. He sometimes receives letters following his appointment but finds it difficult to understand some of the medical terms and does not want to bother the doctors or nurses to highlight this as he knows they are very busy.

Once or twice John has attended a clinic where they have been able to provide 'real time' HbA1c results which highlights his overall diabetes control. These are provided by the healthcare professional at clinic and he does not have time to consider the result, what it means and what he may want to discuss during the consultation to improve his health and wellbeing. John often feels judged during consultations as this result seems to be the main focus of the discussion and he feels he is being told what to do rather than discussing the things he might like to think about to help improve his health. John has heard about person centred care which offers genuine partnership working, shared goal setting and decision making but he does not feel the current system allows this to happen. He does not think this is anyone's fault simply that the services he attends are not set up to offer this.

John's Story Tomorrow

John has Type 2 diabetes and he is delighted that in his local area they have recently opened a new community health and wellbeing hub where he can attend to have all his eye, foot and urine screening performed. He can also have his blood tests, blood pressure and weight checked. He finds this particularly useful as he does not drive and this cuts down the number of appointments he has to attend and this saves him a significant amount of money. John has also found that the other services offered within the health and wellbeing hub have been very useful. He has managed to stop smoking as the first time he attended he noticed that smoking cessation services were also based there and they were able to help him quit. One of the best things about the hub was the fact they also had services that could help with his finances and as a result of their help he has been able to get additional benefits that he never realised that he was entitled to. John has used this money to buy more fruit and vegetables and as such is eating more healthily which has helped him lose weight and improve his diabetes. He also found the fact that it was located near a pharmacy helpful as it was easier for him to pick up his prescription and get advice on all the medicines he needs to take. The last time he was there Diabetes Scotland were also there and he was able to speak to them about his diabetes and he found the peer support very helpful.

John has also been set up on My Diabetes My Way which he can access via his smartphone. He is now able to see the results of all the tests and screening that has been performed as well as tips and advice on how he can improve his health and wellbeing. John has found this very useful as he has discussed these results with his family and they have been able to work together to think about some of the questions he might like to ask about his health.

Two weeks after his visit to the health and wellbeing hub he has an appointment at his practice. He is delighted that both the healthcare professional and himself can have a discussion about his results 'real time' and they are able to spend time answering the questions he has brought as well as agreeing a plan on how to improve things. This makes him feel much more motivated and he genuinely feels that the consultation has been about him trying to maximising his health and wellbeing. At his last visit the practice also discussed with him the possibility of having a virtual follow up consultation via his phone and he thought this would be very helpful to ensure he would put in place all the things he planned to do following his last visit.



Respiratory

The respiratory service has moved forward by taking the opportunity to develop improved working across professional and organisational boundaries. There has been a great deal of progress but there is an enthusiasm and scope for respiratory services to be further transformed to meet the needs of the population by further developing the Community Respiratory Team.

There are additional benefits from increasing the model of allied health professionals and nursing colleagues delivering care in the community via outreach nurse or allied health professional delivered community clinics.

The principle of developing efficient, cost effective, comprehensive and holistic respiratory services which optimise existing resources and staff skills is achievable by integrating care delivery and by creating a culture that puts needs of people at the centre of care delivery and enable people to be supported to make shared decisions.

Hospital-based, consultant-led, multi-disciplinary team working can support allied health professional and nurse-led clinics and other community services to manage many aspects of respiratory disease in the community.

This model of consultant oversight and accessibility for advice and support but care delivery being in the community by non-consultant staff groups has been shown to be highly successful. This model has benefits to people in terms of having their care delivered locally but also in terms of allowing specialist staff to make the most of their specialist training by working to the top of their licence.

The establishment of rapid assessment clinics for **chronic obstructive pulmonary disease, asthma, bronchiectasis** and **breathlessness** could be established in community hubs.

This service could be delivered by appropriately skilled and supported allied health professionals and nurses feeding into follow up with consultant-led multi-disciplinary team discussion including physiotherapy, occupational therapy, dietetic and pharmacy input.

This model has been shown to give clear benefits in reducing unnecessary hospital admissions.

Non consultant outreach clinics can enable local care with new patients being triaged in the community by specialist nursing or allied health professional teams. There are successful examples of such working and benefit is gained not only in reducing waiting times and consultant workload but also in delivering more local care. This supports improved education in condition self management and access to early intervention to escalate treatment which can prevent additional unplanned healthcare use.

Empowering Person Centred Care

Empowering people to understand their treatment options and the impact of their choices is a key theme across all specialties moving forward. This requires the community team and GPs to have a greater understanding of these options when initially discussing the possible treatment options with people. This requires better education information sharing and communication links between primary, community and hospital-based care teams. An initiative being trialled in the **orthopaedic service** is that of “opting in” to treatment. This pilot challenges the traditional model of a face-to-face consultation with a hospital-based specialist in order to determine a treatment plan.

A GP referral to acute care traditionally results in a face-to-face appointment with a hospital-based consultant, an allied health professional or a nurse in a particular specialty. The initial attendance is traditionally regarded as critical to the person and their journey through care, as it allows for diagnosis, reassurance and definitive decisions on treatment. The current management and administrative processes are designed to fit this model.

The transformational thinking supporting this orthopaedic “opt in” pilot challenges this model as it is considered that in a face-to-face consultation:

- **Often there is no added clinical value**; the diagnosis will be based on the primary care assessment of the presenting symptoms and examination, with the electronic patient records providing the past history including investigations and relevant scans and test results
- **Collected feedback** suggests that much of the verbal information provided at a face-to-face attendance may not be retained
- **An explanation regarding the musculoskeletal condition** with an advice regarding “self care” is often sufficient for many patients.
- **Many people are increasingly comfortable with “self-service”** models of interaction in everyday life, as technological advances have provided rapid access to information and virtual contact with the appropriate person for many years
- **A phone call with the appropriate person** who has access to all the relevant clinical information is often more convenient and cost effective than a face-to-face attendance.

The need for a face-to-face consultation should be justified and only required when the clinical benefit of a face-to-face consultation is clear.

The pilot is based on principles sponsored by the National Modernising Outpatient Programme and Access Collaborative which are:

- **Patients will receive timely access to advice**, treatment and support
- **Patients will not incur unnecessary inconvenience** when accessing outpatient services
- **Patients will gain access to outpatient review services** when it is clinically necessary and appropriate
- **Patients should not be asked to travel** unless there is a clear clinical benefit, and that any changes should not increase the workload for primary, secondary or social care in an unplanned/unresourced way
- **All referrals should either be vetted by a consultant/senior decision maker** or processed via a system-wide agreed pathway
- **Referral pathways (including self management) should be clear** and published for all to see
- **Each hospital and referral system should have a joint and clear understanding of demand** and capacity

- **Each local system should have a clear understanding of access to diagnostics** as part of pathway management
- **Improved and published metrics** including how we record and measure virtual/telehealth/technology enabled care.

In this pilot virtual triage is carried out by an experienced extended scope practitioner using agreed protocols to review the referral and the person's record as well as all relevant scans and test results. Following this triage process selected patients are sent a leaflet regarding their condition with an option to either telephone a clinical helpline number for further information and advice, or to opt in for a face-to-face appointment using person focussed booking.

Hospital-based Services

Within hospital-based services we continue to describe a tiering of services which balances the principle of local access against the better outcomes that are proven when highly specialised services are delivered by dedicated teams in centres of excellence.

New Outpatient Services

The first tier in hospital-based planned care is the outpatient service. Traditionally new referrals for an outpatient consultation are made from the community into a hospital-based specialty and the person is then seen according to the waiting time in place. After the initial consultation a decision is made on whether the person needs specialist treatment and if so what that treatment consists of.

The person will then be placed on another waiting list for a period before receiving their treatment.

From the service modelling groups the suggested enhancements to this traditional process have been focussed on;

- **Better education for our population** on the range of treatments available and the impact of those treatment options
- **Better support for and communication with GPs** to enhance decision making on referrals
- **Treating the person as an individual** where the specialist treatment is seen in the context of the needs of the whole person
- **Alternatives to specialist hospital treatment** such as physiotherapy and exercise
- **Alternatives to face-to-face** consultation
- **Options for condition management** rather than definitive treatment
- **Designing the delivery of complex pathways** around fewer specialist centres so that better outcomes are generated for patients from quicker diagnosis and treatment by dedicated teams.

There is a national programme underway to modernise outpatient services being taken forward in GGC. The national and agreed local objectives are in alignment with the Moving Forward Together principles.

National Objectives

Patients will receive timely access to advice, treatment and support:

- **Increased self management**
- **Access to advice-only services** which are recorded in the patient's notes
- **Increased access for GPs** to diagnostic tests and their results
- **Increased use of standard referral pathways** and guidelines to reduce variation
- **First appointment will be with the most appropriate person**, not necessarily a consultant.

Patients will not incur unnecessary inconvenience when accessing outpatient services:

- **Patient self management** should be the presumption
- **Outpatient follow-up** should only be provided where there is a need for clinical treatment.

Patients will gain access to outpatient services when it is clinically appropriate:

- **Return appointments to deliver negative test results**, or those which require no further hospital care, will no longer be offered; instead, patients will be informed directly (letter, email, text, etc.) or via their GP
- **Fast re-access systems for patients** to self refer for follow-up will be created.

Local Objectives

- **Strengthening knowledge exchange and self management** in the community with the person at the centre
- **Extending decision support**, care planning and care services in the community through integrated care records which allow all health professionals involved in a person's care to have full access to the appropriate information
- **Emphasising competency based roles to support non consultant practitioners** across primary and secondary care to provide first contact for people, reducing the need for new consultant outpatient attendances, allowing consultant resource to be focussed on more complex patients
- **Optimising eHealth and digital opportunities** at the primary/secondary care interface
- **Reducing widespread variation in secondary care** return appointments and review processes wherever clinically appropriate to reduce the number of return appointments of low clinical utility
- **Giving people more control** over their appointment booking and scheduling processes to reduce did not attend rates and improve people's satisfaction
- **Giving people access**, where clinically appropriate, to teleconferencing technologies
- **Giving people access to the National Health and Social Care Patient Portal** to accept, change or decline appointments.

Alternatives to Hospital-based Outpatient Consultation

There are two areas of transformational action being taken forward as alternatives to the traditional hospital outpatient consultation. The first area focuses on using the skills of the community network to provide assessment, diagnosis and treatment in the community and the second is the use of technology to allow people to gain access to advice and clinical decision making without having to visit a hospital site.

An example of the community-based approach being taken forward at the moment is in the redesign of the **orthopaedic pathway** with much greater emphasis being placed on the role of the musculoskeletal (MSK) physiotherapy service. This allows people with orthopaedic conditions to access specialist MSK physiotherapy treatment in the community rather than be placed directly onto a surgical waiting list.

Currently hospital-based consultant orthopaedic outpatient attendances include people who could be managed in the community on a MSK pathway. These people are being seen by both consultants and extended scope practitioners (ESP). In many cases people who are directed to consultants and ESPs are appropriate for care following a community-based MSK pathway rather than a hospital-delivered service. In this pilot selected people have their care delivered on a Primary Care MSK pathway rather than by a hospital-based team. This will enable hospital orthopaedic capacity to be focussed more effectively on people on a surgical pathway.

This approach is being tested on orthopaedic foot and ankle, spinal and then hip and knee pathways.

There are a number of “virtual” clinic models already in place in GGC and there has been an enthusiasm across our specialty service model groups. Telephone consultations have been available but not widely used for a number of years. By using technology solutions such as “attend anywhere” a person can have a face-to-face consultation with a hospital-based specialist without needing to travel to a hospital site. This has advantages for the person in terms of reduced travel time and cost but also for the system in terms of requirements for physical space and also possible gains in efficiency and productivity.

There is also an opportunity for reducing the need for patients to attend hospital multiple times by multi-disciplinary team working where several teams discuss a person’s care needs and the plan for their treatment in coordination but without the need for the patient to be present.

Return Outpatient Services and Follow Up

After planned treatment the requirement for and method of follow up is an area of potential transformation. With access to remote video communications there is no longer a need for every patient to physically attend a hospital for review. The use of software that connects a clinician and patient remotely is available now with technology such as “attend anywhere” and is being used increasingly.

The ability of a non-located team of clinicians to review a patient as a multi-disciplinary team through accessing and discussing their clinical records via portal access enables complex decision making without the need for travel or indeed for the patient to be present.

With the development of an integrated network of tiered service delivery there will be less need for unnecessary hospital-based follow up based on a need to track patients. People will return to their community after treatment with a plan of ongoing care if required and a system of monitoring by the community network which allows escalation back into hospital-based services if required rather than as a routine check.

Due to the increase in long term conditions there is a rise in the number of conditions and treatments which require ongoing monitoring. Wherever possible this should be conducted in the community rather than requiring frequent follow up visits to hospital. This will require further development of services within the extended community network to carry out the monitoring and systems to pass results back to the responsible clinician, who can escalate care where necessary.

Through the increased use of modern technology some of this monitoring will become a process which can be controlled by the person by taking their own readings with a personal device or even having data submitted directly to monitoring teams through the use of wearable devices that send readings electronically.

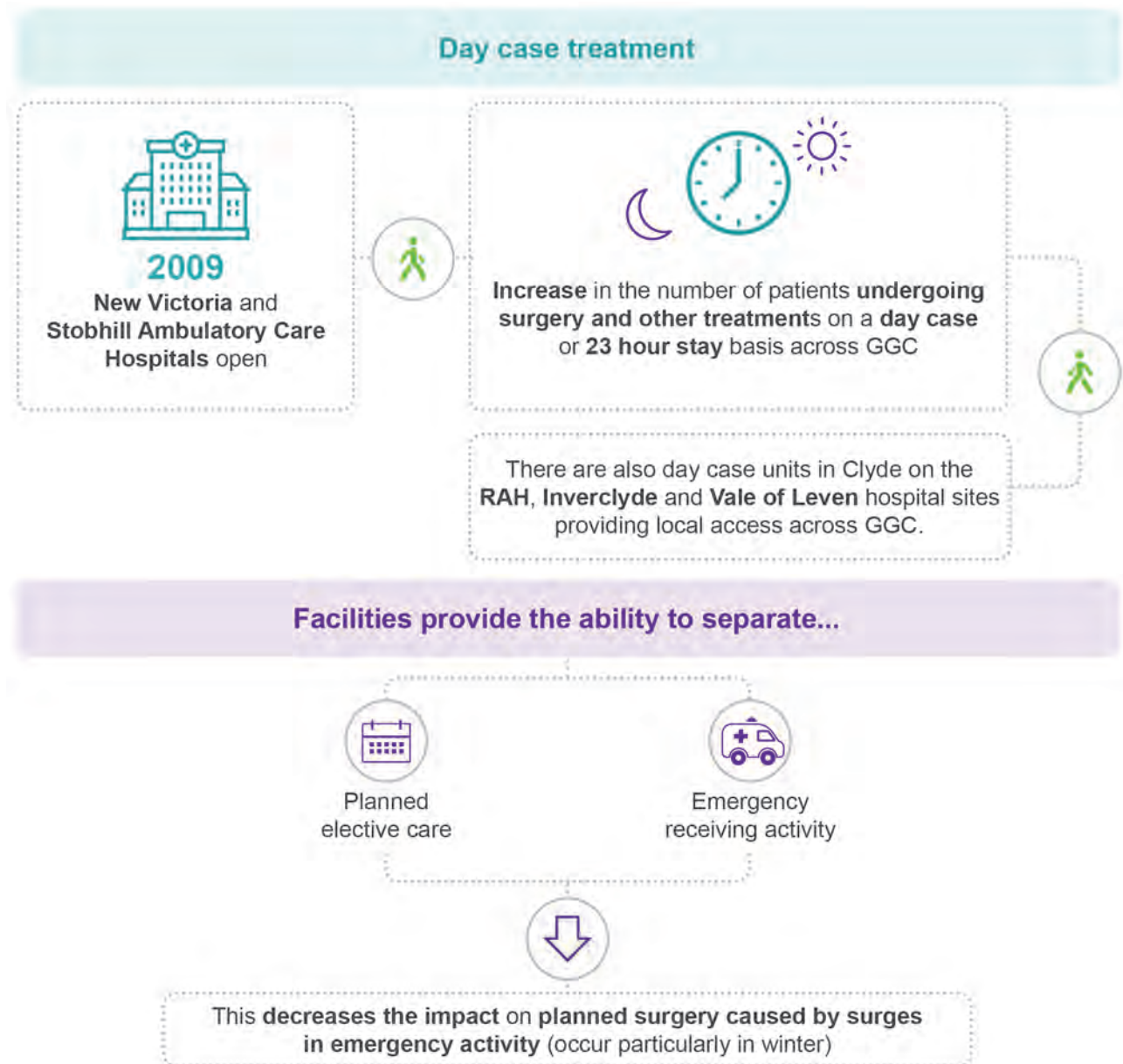
Self management will become the preferred method of managing long term conditions, where people are enabled to monitor and control their own conditions whilst having timely access to community and specialist care if their needs change or other unexpected changes arise.

This process will be enhanced by the creation of the integrated network of better linked community and specialist services, which feature specialist outreach and embedded specialist delivered services in the community.

When outcomes are improved by delivering specialist or complex treatments in a small number of networked centres of excellence these centres should serve a population from across an area or a region.

Day Cases

The Scottish Government 2020 Vision includes the statement that, when hospital treatment is required, day case treatment should be the norm.



Great progress has been made in the last decade in GGC in this regard. Since the opening of the New Victoria and New Stobhill Ambulatory Care Hospitals in 2009 there has been an increase in the number of patients undergoing surgery and other treatments on a day case or 23 hour stay basis across GGC. There are also day case units in Clyde on the Royal Alexandra, Inverclyde Royal and Vale of Leven hospital sites providing local access across GGC.

These facilities have provided the ability to separate planned elective care from emergency receiving activity which decreases the impact on planned surgery of the surges in emergency activity which can occur particularly in winter.

The clinical evidence presented as part of the National Clinical Strategy showed that there are better clinical outcomes when teams are performing higher volumes of cases. This methodology supports models used elsewhere around the world to create high volume centres for procedures such as cataract surgery and orthopaedic joint replacement.

Going forward we will examine the configuration of elective surgical services with a view to maximising both the clinical outcomes and the efficiency of these services.

Central to the maximisation of day case and short stay procedures are three processes which take place while the person is still in their community.

The first of these processes is **pre-operative assessment**. This is a safety based process which assesses a person's suitability for anaesthesia options and whether their underlying health supports treatment as a day case in a facility without on site critical care.

The second process is **pre-admission** which is where a person undergoes the appropriate preparatory actions to ensure that they are fully ready for their procedure on the day they are admitted. These actions vary with each specialty and each procedure and act as a way of personalising the process prior to hospital to the person's individual needs.

The final process which is still in its early stages of becoming widespread is that of **pre-habilitation**. This process is based on the evidence that physical fitness is an important determinant of post-operative outcomes. Less fit patients have higher incidences of morbidity and mortality after major surgery. A focus on physical fitness measures give a good indication of risk during and after operative treatment and an increase in physical fitness is shown to reduce these risks. This focus is on shared decision making with comprehensive provision of information to people and their carers, to inform a decision that is specific to an individual person's condition and context.

These processes are key to linking the community to safe and effective hospital-based care and a successful return to home as soon as possible.

Inpatient Care

If day case or short stay treatment is the norm then inpatient stays of several days with a possible period of critical care are the not uncommon exception.

The requirement for planned care to be conducted on a site where there is access to an emergency theatre and critical care facilities may be driven by either the person's state of health or the complexity and scale of the procedure to be undertaken.

Advances in surgical techniques such as less invasive laparoscopic procedures has done much to reduce the impact of surgery on the patient and to enable a faster recovery but as our population grows older there will continue to be a requirement for planned operations, especially those of a complex nature, to be conducted on a site with inpatient extended stay beds, access to critical care and an emergency theatre should complications develop post-operatively.

When the treatment has a substantial impact on the person's mobility or ability to carry out everyday tasks, the anticipation of these needs in terms of support at home and requirement for care, aids and adapted homes will speed up recovery and a return to independent living.

Follow up plans should be developed across the network with a return to care and monitoring in community the preferred method but with access to specialist opinion and support to allow that to happen.

At the higher end of the complexity spectrum some procedures are so complex and uncommon that they will be provided from a small number or even one single facility serving the whole of GGC, the whole of the West of Scotland or in some cases the entire nation.

Evidence shows that when these highly complex and infrequent procedures are delivered by a small number of highly trained and experienced teams from a small number of sites the extra volume that this centralisation provides leads to better clinical outcomes for the few patients undergoing these procedures.

This is not a new direction of travel but a continuation of a long term trend in surgical provision which has led to improved outcomes from single dedicated centres of excellence serving the whole of GGC.

Maternity and Neonatal Care

'**The Best Start**' – A five year forward plan for Maternity and Neonatal Care in Scotland' was published in January 2017. This set out a vision for the future planning, design and safe delivery of high quality maternity and neonatal services in Scotland. It puts the family at the centre of decisions so that all women, babies and their families get the highest quality of care according to their needs.

The future vision for maternity and neonatal services across Scotland is that:

- **All mothers and babies** are offered a truly family-centred, safe and compassionate approach to their care
- **Fathers, partners and other family members** are actively encouraged and supported to become an integral part of all aspects of 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.

The key recommendations were:

- **Continuity of Carer:** all women will have continuity of carer from a primary midwife, and midwives and obstetric teams will be aligned with a caseload of women and colocated for the provision of community and hospital-based services
- **Person centred care:** Maternity and neonatal care should be co-designed with women and families from the outset, and put mother and baby together at the centre of service planning and delivery as one entity
- **Multi-professional working:** Improved and seamless multi-professional working
- **Safe, high quality, accessible care**, including local delivery of services, availability of choice, high quality postnatal care, colocation of specialist maternity and neonatal care, services for vulnerable women and perinatal mental health services
- **Neonatal Services:** A reconfiguration to a whole new model of neonatal care ranging from intensive care to community-based services
- **To develop National Frameworks for Practice for Scotland**, which are evidence based and describe minimum acceptable standards for newborn care

- **Workforce planning**, role development and high quality education and training for all neonatal staff
- **Integrated team care for women, babies and families** will, over time, take place in local community 'hubs'
- **Supporting the service changes**: recommendations about transport services, remote and rural care, telehealth and telemedicine, workforce, education and training, quality improvement and data and IT.

The priority throughout the national strategy is putting the mother and child, and family, at the centre of care. In the redesigned continuity of care model, all women will have continuity of midwifery carer from a primary midwife.

The primary midwife will have a buddy midwife who can support him/her and provide cover for annual, and other, leave and by a small group of local community midwives who will support labour and birth, unless elective operative delivery is required. Women will be supported in her decision-making as her pregnancy progresses, her shared care plan recording these decisions.

The approach will remain flexible to address changing needs and expectations at every stage. The planning will include consideration of expectations of post birth care, with the final decision on place of birth based on the situation at the start of labour.

Seamless Person Centred Care

This person centred approach to care will continue through the intra partum and post-natal period for women and babies. Our services must regard mother and baby as one entity and truly put the mother, baby and family at the centre of service planning and delivery at every stage of the postnatal journey. No matter how complex the care, the mother and baby should stay together and barriers to this occurring should be removed.

Transitional Care

Whilst many women and babies are able to leave hospital very shortly after birth, there are those who require further support. Keeping mothers and babies together must be a cornerstone of our approach to new born care. National Transitional Care supports the mother as the primary care provider for a baby with care requirements in excess of normal new born care but short of the neonatal intensive care.

Specialist Care

For conditions which require very specialist treatment such as neurological conditions or complex cancers there should be a balance between local treatment and the requirement to be seen quickly by a dedicated team of specially trained staff who have access to specialist equipment and facilities.

Cancer Services

Greater Glasgow and Clyde cancer services are part of the West of Scotland regional delivery network and as such cannot be seen in isolation.

The West of Scotland Cancer Strategy has a clear direction of travel with respect to the main areas of cancer care which aligns to both the wider Moving Forward Together principles and those established in the Moving Forward Together cancer tumour groups.

There is a requirement to ensure that cancer management is delivered to the highest standards and is safe, sustainable and accessible. Services need to be optimised for the change in demographics, epidemiology and demand, take full advantage of the new and emerging treatments and new technology and find innovative solutions to the predicted workforce challenges.

The priorities for cancer care align to the National Cancer Strategy Beating Cancer: Ambition and Action:

- Prevention
- Improving survival
- Early detection and diagnosis
- Improving treatment
- Workforce
- Living with and beyond cancer
- Quality improvement.

Detect Cancer Early (DCE) and Cancer Screening

In the West of Scotland during the first five years of the DCE programme there has been a 9.5% increase in the proportion of patients diagnosed with stage 1 lung, breast and colorectal cancers. The introduction in 2017 of faecal immunochemical testing (FIT) is expected to increase uptake and early diagnosis of colorectal cancer.

The screening and early detection agenda is being taken forward through plans to address variation in screening uptake, supporting national campaigns and developing future work to target uptake at both population and community levels.

Diagnostic Access

Regional solutions to the known areas of workforce challenges such as breast radiology and interventional radiology will be pursued to develop solutions which ensure optimal service provision and sustainability. These challenges are not limited to the delivery of cancer services.

Integrated diagnostic reporting solutions will be examined particularly in relation to the reporting of haematological malignancies in conjunction with laboratory colleagues and potential advances through new technology will be examined such as the advances possible through the use of molecular diagnostics.

Tiered Network of Service Delivery

Throughout Moving Forward Together there has been reference to the evidence base published in the National Clinical Strategy demonstrating improved clinical outcomes in high volume units and this is also a central aspect of the West of Scotland cancer strategy which drives a consideration based on making optimal use of workforce, equipment and financial resources, to reducing the number of facilities offering inpatient cancer management, especially for highly specialised and complex care.

Similarly to non cancer care, the focus of Moving Forward Together and the West of Scotland work is that cancer care will be delivered as locally as possible. Models of central assessment and local delivery and the establishment of non medical prescribing and local follow up enable the future prospect of cancer care being increasingly delivered in the community and self directed care becoming a realistic option for increasing numbers of patients. This requires changes to be made to improve local access to appropriate diagnostic, outpatient, and day case treatments.

The recent **West of Scotland Systematic Anti Cancer Therapy (SACT) Review** which examined the future of chemotherapy and biological therapy describes a model of centralised assessment but local delivery of ongoing treatment where possible. This model would see complex cancer treatment and initial assessment and treatment planning delivered from a highly specialist cancer centre but ongoing treatment delivered through a series of more local cancer units and outreach centres.

This model once it is fully implemented would see a large proportion of the SACT treatment currently delivered in the Beatson West of Scotland Cancer Centre made available more locally through cancer units and outreach facilities including community pharmacies for certain low risk oral cancer treatments.

Cancer Surgery

Cancer surgery services in GGC are also delivered as part of the regional network. There are changing demands on surgical cancer services in the West of Scotland over the next decade arising from the projected changes to the population demographics, rising incidence of cancer and increased complexity of care.

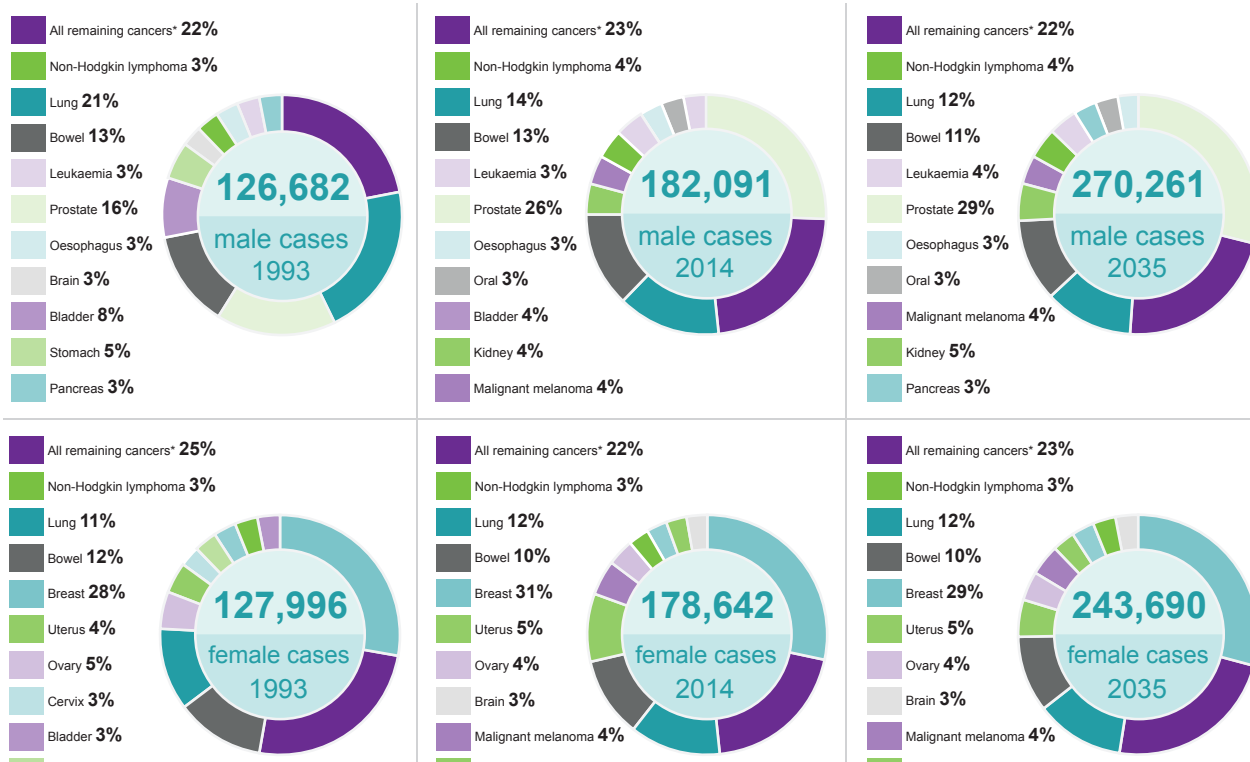
Current provision of care involves a complex network of local, health board wide and regional services.

There are several key drivers which drive change in the way these surgical cancer services are delivered in the West of Scotland.

- **As the population ages, so cancer incidence will increase.** This will place a greater burden on diagnostic services, surgical services and community services for all aspects of care
- **There is a need to maintain diagnostic and palliative treatment** as close to our people as possible, necessitating maintenance of local hospital and community services
- **There is now overwhelming evidence that the best outcomes for patients with many cancers are achieved by delivery of care in specialist, high volume centres.** This and the likely increased complexity of care, with the increased use of multi-modality therapy, robotics and precision medicine, will necessitate the centralisation of much complex cancer care into fewer sites within the West of Scotland
- **The future of local surgical services is best sustained by embedding local hospital teams** within wider networks of clinicians providing the full spectrum of care for local patients.

The incidence of cancer has increased by 12% since the 1990s and is projected to increase by a further 2% by 2035. Not all cancers will increase in incidence and some cancers will increase in incidence more than others. For example, it is projected that the incidence of pancreatic and liver cancer will continue to grow and that the incidence of gastric cancer will continue to decrease.

Proportion of cancer deaths by cancer tumour group; projections to 2035



In the mid 1990s there was a change in the delivery of cancer care in the UK, such that cancer surgery was delivered by surgeons with a sub specialty interest. This has changed the way in which surgery is trained and delivered and has been associated with steadily improving cancer outcomes.

Managed clinical networks were introduced in Scotland in 1998 as a means of linking services and clinicians across hospital sites and health boards to ensure access to the full range of services for complex cancer care. These have driven improvements in quality of service provision through provision of guidelines, audit and setting of standards.

There is now overwhelming evidence argued in the National Clinical Strategy that certain cancers are best managed in high volume specialist centres, particularly where care is complex and the surgery is associated with high morbidity and mortality. Examples include, but are not restricted to, pancreatic cancer, oesophageal cancer, ovarian cancer and sarcoma. There are also emerging endoscopic treatments that also require specialist skills and are best delivered in fewer higher volume centres. Surgery for these complex tumours involves close cooperation of a multi-disciplinary team and several essential colocations including 24/7 access to interventional radiology and critical care.

The majority of cancer care however is best delivered as close to people as is possible and this is one of the key aims of the Scottish Government Cancer Strategy. This follows our principle that specialist care is only delivered when that care cannot be delivered in a community setting or on an ambulatory basis from a local facility.

There are opportunities for early identification of patients who are unlikely to benefit from surgery but who may benefit from local delivery of high quality palliative care or chemotherapy within the overall supervision of the network.

For some cancer types, most care can be delivered in each of the three GGC sectors, North Glasgow, South Glasgow and Clyde. Examples include breast cancer and most colonic cancer. Local management of other cancers will necessitate diagnostic evaluation, palliative interventions and early referral for specialist care for pancreatic and oesophageal cancer.

As with non cancer procedures, there will be cases where a person's health or the complexity of care will necessitate treatment in a highly specialist unit.

Diagnostic services are under pressure throughout the West of Scotland and these pressures will continue. Further investment in local diagnostic hubs and in training of advanced nurse practitioners is seen as key to supporting these services over the next decade.

Emerging technologies will also impact on the delivery of cancer surgery in the West of Scotland. Already, robotic surgery is offered on a regional basis for prostate and some kidney surgery. In many parts of the world, robotic surgery is being increasingly used for pelvic surgery, upper gastrointestinal and hepato pancreato biliary cancer and evidence is growing that this innovation improves outcomes for patients and may reduce hospital stay.

In the future ovarian cancer, including maximal cytoreductive surgery, will require complex multi-disciplinary surgery and oncological approaches not yet readily available in the West of Scotland.

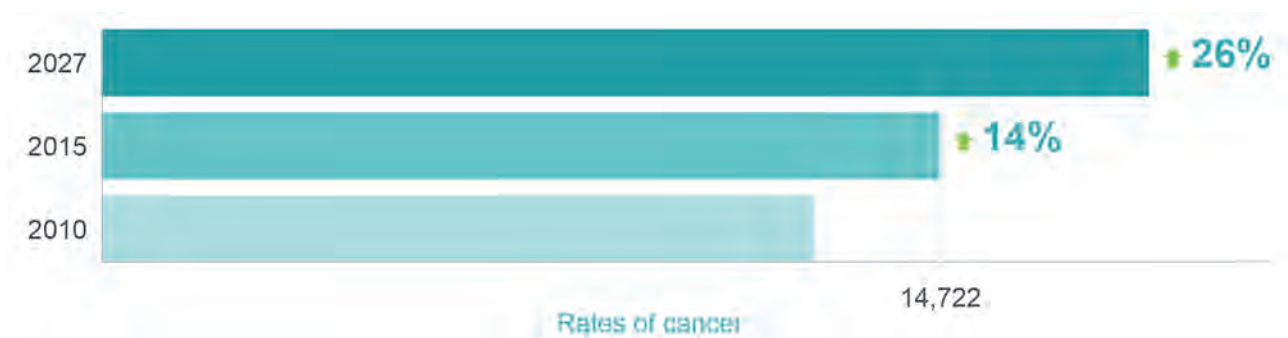
Lastly, there should be no barrier to people receiving local treatment having access to clinical trials and expansion of the clinical trials infrastructure to local hospitals would facilitate this.

Systematic Anti Cancer Therapies (SACT)

The National Cancer Strategy sets out the aims of improving prevention, detection, diagnosis, treatment and after care for people affected by cancer. The Cancer Strategy highlights the challenging background against which these aims need to be delivered with two out of five people developing cancer at some point in their lives. At the same time, with improved screening, earlier detection, better diagnosis and continuing advances in treatment, more people than ever are surviving cancer.

The National Clinical Strategy describes the aim that, where clinically appropriate, services should be planned and delivered at a local level. Where there is evidence that better outcomes could only be reliably and sustainably produced by planning services on a regional or national level, we must look to the future and plan our services on a population basis regardless of geographical boundary. The Chief Medical Officer's report Realistic Medicine also sets the challenge for services to consider how we can further reduce the burden and harm that patients experience from over treatment and reduce unwarranted variation in clinical practice.

The Modern Outpatient Programme details an ambition to deliver care closer to people's homes, providing more person centred care, utilising new and emerging technologies, whilst optimising the use of resource across primary, community and hospital-based services.



The number of people diagnosed with cancer is increasing; in 2015 14,722 people were diagnosed with cancer in the West of Scotland which is an increase of around 14% over the last ten years. By 2027 cancer incidence is projected to have increased by over 26% due to the combination of an ageing population and increasing survival rates from other diseases.

Through effective population based screening programmes, earlier detection, better diagnostic methods and advances in treatments, more people are surviving cancer than ever before. This has an effect on the future demand from an increased prevalent population.

There have been significant changes in the last decade in service requirements and delivery coupled with the introduction of novel diagnostic and treatment technologies.

There has been a year on year increase in demand for SACT due to increasing cancer incidence and the introduction of new, effective anti cancer medicines. Activity data shows a 31% increase in total episodes of SACT delivered in the West of Scotland between 2013 and 2016.

The mode of treatment delivery is also evolving with many new treatments given orally or subcutaneously as part of treatment rather than exclusively via intravenous treatment. This has enabled an 80% increase across the West of Scotland in the number of SACT episodes given as an oral outpatient treatment between 2013 and 2016. However the overall rising demand has meant that there was a decrease in day case activity. Day case activity has risen by 22% over the same timeframe.

Increase in demand for SACT is also impacted by increasing treatment duration. An increasing number of treatments are given until progression of disease or death, as opposed to the traditional set number of cycles of treatment. The impact of this is an emerging pattern of treatment over years rather than months of treatment.

This strategic context led the West of Scotland to review the future delivery of SACT services. A Review was commissioned with the aim of developing a strategy to:

- Improve patient experience and outcomes
- Deliver treatment in the most clinically appropriate place
- Ensure consistency of pathways and processes
- Provide equitable access to treatment, including access to clinical trials
- Optimise resource use.

The principles underpinning the development of the strategy were to:

- Ensure the appropriate level of specialist care should be available to people as close to home as possible
- Redesign how services are delivered to generate the capacity to meet future demands
- Emphasise competency based roles and enhancing the role of the wider multi-disciplinary team
- Optimise the use of existing infrastructure
- Minimise over-treatment
- Provide high quality, safe SACT services across the region, ensuring required standards are met
- Provide value for money and propose future investment targeted at clearly identified need.

The emerging new model of care is based on high quality evidence which supports the implementation of a model which builds capacity across the network of primary, community and hospital-based care to ensure appropriate level of specialist care available to people as close to home as possible. The tiered approach adopted to SACT service delivery proposes a hub and spoke model which expands the delivery of SACT out with the specialist cancer centre firstly to local hospitals and then to community-based outreach facilities as clinically appropriate.

	What	Services offered
<p>1</p> <p>Cancer Centre</p>	<ul style="list-style-type: none"> Specialised centre providing tertiary/ complex services at a regional level Assesses and initiates inpatient, outpatient and day case treatment for patients with cancer Onsite specialist oncology medical team (24/7) Delivering approx. 20% total SACT activity Serving a population of ~2.5 million (1 for West of Scotland) 	<ul style="list-style-type: none"> Treatment for rare cancers Complex treatments Chemoradiotherapy Phase One and Phase Two clinical trials National services for some very rare cancer types All services delivered at tiers below
<p>2</p> <p>Cancer Unit</p>	<ul style="list-style-type: none"> Large unit which assesses and initiates outpatient and day case treatment for a defined cohort of patients Delivers day case treatment locally for patients centrally assessed, as appropriate Provides inpatient haemato-oncology facility Onsite specialist oncology medical team (Mon-Fri, 9am-5pm) Delivering approx. 30% total SACT activity Serving a population of ~300,000-600,000 (4/5 for West of Scotland) 	<ul style="list-style-type: none"> Treatment for main tumour types and some less common cancers Phase Three clinical trials Long infusions Consultant and NMP led prescribing All services delivered at tiers below
<p>3</p> <p>Outreach Service</p>	<ul style="list-style-type: none"> Small to medium sized facility delivering day case treatment to patients assessed and prescribed in cancer unit/centre Delivering approx. 50% total SACT activity Serving a population of ~150,000-300,000 (10-15 for West of Scotland) 	<ul style="list-style-type: none"> Simple short infusions Subcutaneous treatments Supportive medicines (e.g. bisphosphonates) Chemotherapy Specialist Nurse-led delivery
<p>4</p> <p>Community</p>	<ul style="list-style-type: none"> Primary/ community care facilities providing care to cancer patients locally 	<ul style="list-style-type: none"> Dispensing of selected oral SACT Primary care shared care Delivery of SC/supportive medicines Community staff delivery

Figure 9: Emerging Model of Care

This direction of travel is entirely in keeping with the tiered approach adopted elsewhere in Moving Forward Together. This is in keeping with a stratified care model which sees treatment moving from being focussed in the hospital to increasing provision in the community recognising the changes expected in systemic anti cancer therapy in coming years.

The Beatson West of Scotland Cancer Centre

As part of the wider review of cancer services the Moving Forward Together Cancer Tumour working groups have been examining options for the colocation of services. These initial options have included a preferred interim model and three other longer term solutions:

- **Develop a Cancer Centre on the Gartnavel site with enhanced high acuity facilities** and transfer arrangements to support maximisation of cancer treatment taking into account lower acuity after move of Bone Marrow Transplant
- **Develop a Cancer Centre on the Gartnavel site and colocate complex surgical services** at Gartnavel which generates the requirement for an onsite critical care facility, emergency theatre and Out of Hours medical cover
- **Develop a Cancer Centre on an acute site** other than Queen Elizabeth University Hospital and colocate complex surgical services on that site
- **Develop a Cancer Centre on the Major Trauma Centre** site and colocate complex surgical services at Queen Elizabeth University Hospital.

These options will continue to be examined in preparation for being considered as part of a wider West of Scotland Cancer Strategy.

Palliative and End of Life Care

The principles established throughout this chapter of providing care as close to home as possible whilst balancing the need for specialist input to provide high quality person centred care is equally important as people reach the end of their lives.

Our system must support people in being able to continue to make choices at the end of their life as we have done during the course of their life.

In our experience, before they are in that period of their life, people generally have a wish to die at home or in a homely setting. However as people enter that phase their priorities at that time may be different. The need for pain relief and the impact on carers and families may lead to a different preference. Our system needs to be adaptable to those changing circumstances and personal preferences in order to give a range of options and to ensure that people are supported in making the best decision for them and their carers and family at that time.

Palliative care is an approach that improves the quality of life of patients and their families as they approach the end of life through illness. This approach uses tools to support clinical judgement by multi-disciplinary teams when identifying patients at risk of deteriorating and dying. Early identification of the need for palliative care by generalists in primary and secondary care enables engagement with patients, their family and carers about their options.

As with anticipatory care throughout life, early identification is vital with early planning, input from specialist teams and appropriate intervention the key to better outcomes in terms of quality for people, their carers and their family. In assessing the need for palliative care there are four dimensions which should be considered;

- Physical
- Psychological
- Social
- Spiritual.

The majority of people who need palliative and end of life care are identified by the non palliative specialist care teams in primary care, the community and hospitals. Palliative care planning will be initiated and then enhanced by early intervention by the specialist palliative care teams. These teams provide specialist advice on care plan and treatment options to optimise care and support people to make choices. Interventions will be designed to ensure the maximum quality of life for people including active disease management and pain control.

For people in a hospital setting the role of the specialist palliative care team is to manage the care of people with more complex needs. The specialist team provides advice, support and education to hospital staff and can also provide direct specialist intervention for people being cared for by other specialties. With a rise in incidence of frailty and multimorbidity there is likely to be an increasing need for specialist input to people with a range of palliative and end of life care needs.

Community-based care and specialist advice and support is available from the community palliative care teams and local hospices.

Specialist palliative care services are provided in six adult hospices across GGC. These hospices provide an option for care in a more homely setting where hospital care is not required but home is not the best place.

In order to support more people to be able to choose to be cared for at home at the end of life, whether this be their own home or a care home, we will enhance the joint working between the specialist palliative care teams, GPs and other members of the community network to assess people's needs and work with them and their carers and families to develop care plans. This care will still be a focus of the wider health and social care teams and the full range of care providers will be critical to the successful delivery of these plans, with appropriate access to specialist advice at crisis points to enable timely changes in care levels and medication.

We are developing a care model which enables the specialist teams to reach a wider group of people, offering a wider choice of care model.

Central to the delivery of high quality palliative and end of life care is integrated team working, access to an integrated care record and care planning and using these tools to support person centred decision making which takes account of the person's needs and preferences through offering a range of care options.

Planned Care: Tiers

In line with the precepts of the National Clinical Strategy, the Moving Forward Together Programme has adopted population-based planning through the service model working groups and the subsequent development of this strategic vision.

Primary Care

- Each local community population will have access to GP services
- The GP practice will be part of a cluster
- The GP practice will be part of an enhanced team.

Community Network

Each community will have access to an integrated community network or service delivery teams as detailed in the whole system chapter. These community services will be arranged as a hub and spoke or core and cluster approach.

In some areas the hub will be a physical location such as a health and care centre whilst in other areas this may be a virtual hub with teams being connected via technology rather than colocated in a building.

Intermediate Care

In each area there will be access to intermediate care services which provide care for people who do not need to be cared for in a hospital setting whether this is to avoid admission to hospital or to enable discharge from hospital after treatment.

In some areas this may be a provision based around beds in community commissioned facilities and in some areas this same care may be delivered in people's homes by teams within the community network.

Specialist Community Care

For highly specialist care some services will be delivered from a few or perhaps only one team or facility across GGC.

Each local community will still have access to those services but that provision will not necessarily be within their local community.

Hospital-based Planned Care

Each local community will have access to a wide range of outpatient services within their local geographical sector.

There will be access to a wide range of day case and short stay treatments available within their local geographical sector.

Each geographical sector will have a hospital that offers access to routine inpatient surgery and other treatments of medium complexity which do not require highly specialist teams or equipment. That facility will have onsite critical care facilities and the necessary diagnostic support.

For highly specialist planned care such as complex cancer treatment or highly complex surgery these services will only be delivered from selected sites across GGC which have the necessary highly trained staff and specialist equipment to be considered as centres of excellence.

These centres are designated to deliver services for the whole of GGC or in some cases the West of Scotland or even the whole of Scotland.

This model means that not every community will be able to access these services in their community but each community will have access within GGC and the outcomes from these centres of excellence are proven to be better for the few members of our population who need access to these services.

Chapter 9: Unscheduled Care

Key Issues

Our approach to unscheduled care echoes that for planned care. Our system wide approach should ensure people are admitted to hospital only when it is not possible or appropriate to treat them in the community. Admissions should be reduced whenever alternatives could provide better outcomes and experiences.

- Care is better coordinated between the hospital and community services at crisis/transition points
- Services should be tiered to provide an appropriate level of care
- Some specialist services should be provided on fewer sites in order to achieve a higher volume of cases and better outcomes.

Key Considerations

We should develop our system wide approach to unscheduled care in which:

- People have access to a range of alternatives to attendance at their GP surgery or local hospital emergency department
- Care is better coordinated between community and hospital services at crisis/transition points
- Services are tiered to provide an appropriate level of care
- Some specialist services are provided on fewer sites in order to achieve a higher volume of cases and better outcomes
- Local access to emergency care is at a level that is clinically safe and sustainable
- The enhancement of community-based services provide a more appropriate alternative to hospital care
- IT systems enable the rapid exchange of up-to-date information between services and support integrated working
- Ambulatory care services reach out into the community-based networks with jointly designed and delivered pathways across the whole system with specialist support and diagnostic services provided when required
- There is better connectivity with community services and participation in agreed ambulatory care pathways across the whole system, involving also NHS 24, GP out of hours services and the Scottish Ambulance Service, to ensure the most appropriate care for individuals by the most appropriate person or service at the right time and in the right place.

Strategic Context

The founding principles for planning unscheduled care as established in the National Clinical Strategy, the Health and Social Care Delivery Plan and the NHS GGC Clinical Services Strategy published in 2015 have a number of common themes.

We need to make sure people are admitted to hospital only when it is not possible or appropriate to treat them in the community. Admissions should be reduced whenever alternatives could provide better outcomes and experiences.

Care should be better coordinated between the community and acute services at crisis/transition points. To support this there should be:

- **Access to specialist advice by phone or electronically**, in community settings or through rapid access to outpatients
- **Jointly agreed care plans** with input from the person, their carers, GPs, community teams, specialist nurses and consultants, with shared responsibility for implementation
- **Rapid escalation of support** on a 24/7 basis.

Services should be tiered to provide an appropriate level of care.

- **Some specialist services should be provided on fewer sites** in order to achieve a higher volume of cases and better outcomes
- **Local access to emergency hospital care** should be provided where this is clinically safe and sustainable
- **There should be an enhancement of community-based services** as a more appropriate alternative to hospital care.

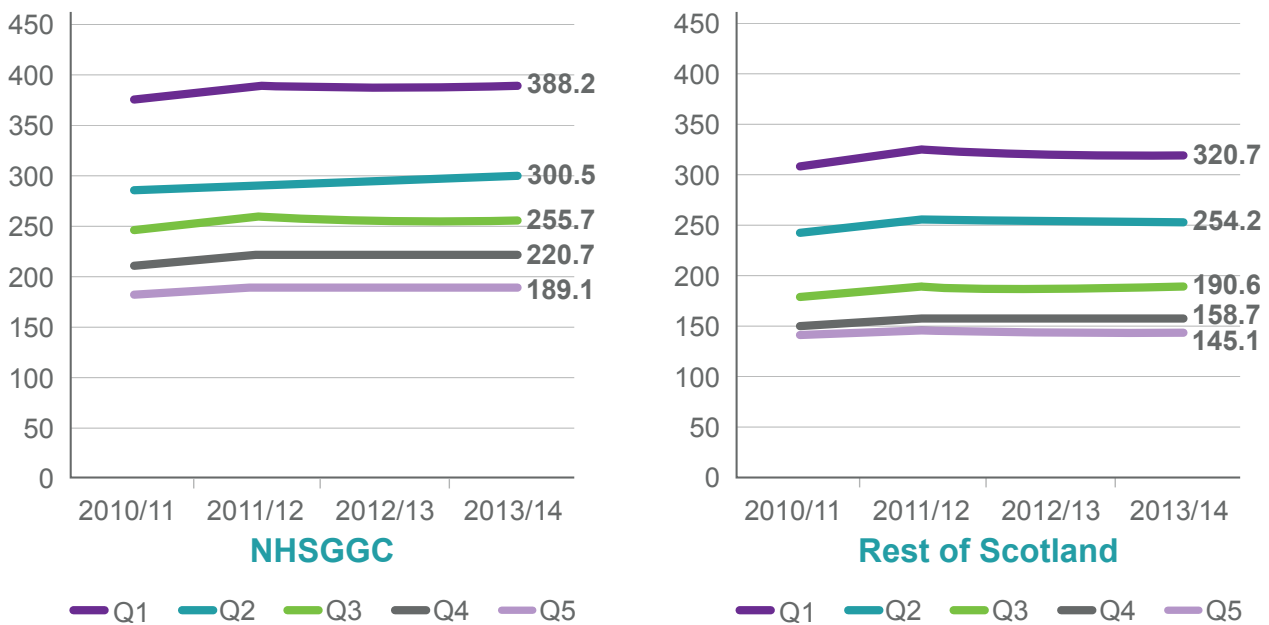
IT systems should provide rapid exchange of up-to-date information between services and mobile access to information to support community working.

Our Specific Case for Change

It is recognised that in GGC we have high rates of hospital care and are currently continuing to see an increase in emergency attendances and admissions.

The chart below shows GGC to be experiencing higher emergency attendances than the rest of Scotland in each of the five deprivation categories.

European age standardised attendance rate (per 1,000) to ED in a patients health board of residence by SIMD and health board of treatment (financial years 2010/11 to 2013/14)



At the same time there has also been an increase in demand for urgent access to GP appointments and community services both in and out of hours. This shows most impact in the most deprived populations who have the highest rates of emergency care utilisation. GGC has a higher admission rate than other Scottish health boards even when adjusted for age, sex and deprivation. Some people stay in hospital longer than is clinically necessary and alternatives to hospital care are not always as available or as easy to access as hospital care.

There is also evidence that there is a culture that leads to attendance at hospital where there may have been an appropriate alternative. This culture will continue to drive demand unless we work with our population to provide and encourage the use of alternative services that are trusted and equally accessible. If we are to continue to provide high quality, efficient and effective person centred care we must provide our population with the knowledge and confidence that enables them to access these appropriate services rather than default to a GP surgery or a hospital. Alternatives need to provide the same or a better level of responsive care that is targeted to, and appropriate, for the people's needs in a more appropriate setting and reduces the reliance on existing traditional and more expensive methods of care.

System-wide Support for Alternatives to Admission

Unscheduled care starts in the community and there should be options that prevent unnecessary escalation to hospital. The first contact may include GP surgeries, community pharmacies, NHS 24 and other community-based services. A range of options should be available including information and advice at an early stage to allow effective self care or direction to the appropriate community-based service where necessary.

Community-based Network

A community-based network of health and social care provides services within or as near as possible to peoples' homes. This network incorporates a wide range of service providers including, where appropriate, acute specialist teams jointly managing people with long term conditions. We will seek to enhance this network and enable these teams to work more effectively together.

The GP has a central role both to provide general medical expertise and overall clinical leadership. The new GP contract will enable GPs to exercise their skills as expert medical generalists to support this model. The role of GPs in managing patients with complex needs will be essential to providing the right level of care within the community and critical to the escalation process when further input is required.

The GP and the extended primary care team will have the leading role in the assessment of undifferentiated acute illness. We will seek to enhance the options available to them. These will include:

- Definitive treatment/reassurance
- Direction to other community resources
- Consult with acute specialist colleagues to agree a management plan
- Referral to an intermediate care service
- Hospital admission.

Early identification of higher risk individuals will be key to allowing early intervention by the community-based network to support care out of hospital. Any member of the enhanced team should have the ability to signal concerns that a person may be at risk of deteriorating and communicate this concern to relevant colleagues to enable early intervention and support.

Where a person has complex needs, their care should be coordinated by a named practitioner who will be responsible for the care planning and will ensure that there is appropriate multi-disciplinary involvement. Such people should be managed through a register of people at high risk of hospitalisation or deterioration. This will involve regular multi-disciplinary review and monitoring of their health needs and early intervention in the event of deterioration.

Hospital-based specialists should be part of the extended team and should contribute to care planning. There should be a clearly understood mechanism whereby specialist input is readily available to support management when a person's condition is causing concern. The ability to provide timeous assessment and to access diagnostic support is critical. This can be provided by a variety of mechanisms including rapid access to clinical advice, direct access to diagnostic tests and rapid access to 'hot' clinics or Day Hospital. Specialist nurses will also be important contributors to the sharing of expertise and bridging between the hospital sector and the community network.

Geriatric Medicine, in particular, should have an enhanced community role. The focus of specialist geriatric teams should be to work closely with colleagues in primary and community care to maintain elderly and older people in their own homes if possible and to support alternatives to hospital care via access to intermediate care services.

Intermediate Care

We should look to develop a range of services which offer an alternative to hospital treatment for those who cannot be cared for at home but do not require the full range of facilities and care available in hospital.

Developing such services will minimise the number of people who remain in hospital care once they are ready for discharge but not yet fully ready to self care/manage at home. For a number of reasons hospitals are not always the most appropriate environment for frail elderly people who can rapidly lose muscle strength with prolonged bed rest. In addition, busy hospital wards can be disorientating and can contribute to delirium and there is a small but increased risk of healthcare acquired infection. A service focussed on rehabilitation and re-ablement more appropriately aligned to people's needs in their own community will provide better care and outcomes and a better use of resources.

Intermediate care services should be further developed to provide alternative options to inpatient care, both as 'step up' for people needing care at a level below that of an acute hospital admission, and 'step down' to enable those to move on from acute beds to a more appropriate level of care. These services could be provided either as a physical care facility, as a network of community support or a mixture of these options. These services should be provided collaboratively by the extended community network teams with specialist input including Geriatric Medicine.

Alternatives to Admission Through Condition Specific Pathways

The Unscheduled Care Report presented to the NHSGGC Board in May 2017 contained the recommendation to develop ambulatory care clinical pathways to provide consistent care and alternatives to admission for both GP and self referred patients.

There are number of opportunities currently being developed on condition specific clinical pathways to reduce the number of avoidable admissions. These include Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Acute Abdominal Pain, Chest Pain, Cellulitis, Self Harm, Falls and Seizure.

Ambulatory care pathways have already been put in place for a number of conditions.

Soft Tissue Infection Affecting Upper or Lower Limb or Face

Previous Care Model

Soft tissue infection of the upper or lower limb or face is a common condition that is managed in the community for the majority of patients. However those patients assessed by their GP as having a more significant infection, or an infection that has visibly worsened despite oral antibiotics, were often admitted to hospital for intravenous antibiotic therapy and many of these patients remained in hospital for up to seven days.

New Care Model

Self-caring ambulant patients with a significant infection or worsening infection despite oral antibiotics and are self caring are now (in certain situations) able to be managed on an outpatient basis via the Outpatient Parental Antibiotic Therapy (OPAT) Service.

For those patients with a low NEWS (0-1) score a referral is made to the OPAT team from the Assessment Unit. They have a same day review by the service, are commenced on intravenous antibiotics and discharged home the same day. There is then ongoing daily review by the OPAT team and intravenous antibiotic administration. This service is also available to those patients with a co-existent condition such as peripheral vascular disease or morbid obesity which may complicate or delay resolution of their infection.

The complete pathway for the management of patients with soft-tissue infection affecting upper or lower limb or face is available on clinical knowledge publisher which can be accessed by any healthcare provider. This allows the patient's GP to give an indication to the likely management plan ahead of referral to the hospital.



There is an opportunity to extend and expand the scope of pathways for ambulatory care conditions to connect better with the community-based network. Improved access to urgent diagnostics from the community would support this process.

Work is already underway to deliver these pathways and this should continue. Examples of progress to date include:

- **COPD:** Much has been achieved to provide a comprehensive service for people with advanced COPD. A number of services already existed in the hospital sector and the community but these were not always well connected and did not function as a single system of care. An eHealth initiative has allowed better information sharing and has provided a 'dashboard' whereby the status of individuals with COPD is visible across the whole system of care and a common record is maintained. This allows for improved teamwork with earlier recognition and escalation of people whose clinical condition is causing concern. It is also possible for community-based teams to see when anyone on their system has had a hospital contact whether through Emergency Department attendance or admission. This allows them to proactively contribute to ongoing management. A care pathway has been developed and each individual's care plans can be accessed by the members of the team. Access is provided to senior clinical advice and people causing concern are referred to and discussed at a multi-disciplinary team meeting supported by an acute respiratory consultant.
- **Frailty:** A common Frailty Screening Tool developed with Health Care Improvement Scotland is in use across all acute receiving sites in GGC. Appropriate patients can then be managed by a dedicated frailty team with Comprehensive Geriatric Assessment undertaken and supported discharge back to the community. Use of the same or a similar tool by community-based services could aid in the early identification of people who would benefit from an alternative to mainstream hospital admission. Further work to improve interface working with community-based teams is ongoing to further improve this service.

Out of Hours Services

A network of services exists to provide unscheduled care out of hours. These include NHS 24, the GP Out of Hours Service and the Scottish Ambulance Service. There is an opportunity to establish better connections between acute and community-based services and participation in agreed ambulatory care pathways as part of a whole system.

Role of the Scottish Ambulance Service

Over recent years the Scottish Ambulance Service (SAS) have developed a number of pilot projects to support the provision of urgent care and avoid unnecessary hospital admissions. The service has been exploring areas where paramedics can provide care that is currently only available in hospital but could appropriately be provided elsewhere. This includes the introduction of paramedic prescribing and a focus on high volume pathways such as falls, COPD and mental health. Pathways that optimise the skills of the ambulance service ensure that the person accesses care at the most local appropriate level and avoids unnecessary hospital presentations.

Minor Injury Units

Minor Injury Units (MIUs) are part of the extended network to provide a service for patients with less serious injuries through the provision of a nurse-led service designed to deliver timely and appropriate high quality care. The attendance profile at MIUs peaks during core daytime hours and avoids this demand presenting to hospital thereby improving flow and emergency waiting times.

At present these units are specifically targeted at minor injuries rather than illness but there is potential for that scope to be extended.

Ambulatory Emergency Care (AEC)

An important component of the new model of care will be the provision of alternatives to admission for people who require a more urgent response but are not acutely unwell and therefore do not need to utilise the services provided from a hospital emergency department.

Hospital Assessment Units provide direct access for GPs to refer patients who require further assessment or admission. The development of the Acute Assessment Units to provide direct access for GPs to refer patients has seen a highest level of growth in activity over the last few years and by April 2018 these are directly managing and discharging 48% of referrals without the need for hospital admission.

Our data shows there are significant numbers of people who have hospital stays of a single day or less who are being managed as inpatients on our hospital sites. A planned reduction of these short stays through service change that provides alternatives to hospital attendance for GP referrals would reduce congestion and bottlenecks during core operational hours and provide a better experience for service users.

There is an opportunity to extend the use of ambulatory care services to reach out into the community-based networks with escalation to hospital care only where this is clinically appropriate. The pathways should be jointly designed and delivered across the whole system with specialist support and diagnostic services provided when required.

The pathways should incorporate elements such as 'hot clinics', direct access for GPs to specialist clinics, rapid access to diagnostic investigations, professional to professional advice, provision of frailty clinics and access to Day Hospital appointments, in addition to ambulatory care management within a hospital setting.

New Cholecystitis Pathway

Cholecystitis is common clinical presentation where definitive management is by laparoscopic cholecystectomy. This is a minimally invasive and commonly performed procedure with a time window for successful non invasive treatment.

Current Care

A person presents to their GP with acute upper quadrant abdominal pain. The GP refers the person to the local hospital. They are admitted for a number of days during which investigations confirm the diagnosis of cholecystitis. With conservative management the pain settles and the person is discharged home with the intention of bringing them back at a later stage for a planned operation to remove their gall bladder. Some weeks later, however, the person's symptoms recur resulting in a further hospital admission. Again, the symptoms settle with conservative management and the patient is discharged to wait for the planned surgery. The person is eventually admitted for the planned procedure. By this time the chronic inflammation of the gall bladder means that a laparoscopic operation is no longer suitable. The patient undergoes an open cholecystectomy and as a result has a longer hospital stay to recover.

Future Care

A person presents to their GP with acute upper quadrant abdominal pain. The GP invokes the relevant clinical pathway and seeks specialist advice. The GP and specialist agree the person is most appropriately managed according to the agreed ambulatory care pathway. The person attends hospital for a pre-booked emergency appointment. They receive pain relief and undergo diagnostic tests including ultrasound that day. Following confirmation of the diagnosis the person is reviewed by the specialist team and found to be suitable for laparoscopic cholecystectomy. They are assessed by the anaesthetic team and they agree that day case management at the Ambulatory Care Hospital is appropriate. The person is fast-tracked through to a dedicated theatre slot and undergoes definitive surgery within days.



Opportunities of the Enhanced Community Network

During our Moving Forward Together service modelling sessions a number of examples were provided by the clinical teams of care management and services that could be provided more appropriately in a community setting. These include:

Cardiology

- Loop recorders, transthoracic echo and exercise testing
- Home/community ECG and BP monitoring.

Ear, Nose and Throat

- Otitis externa
- Dizziness
- Sore throats
- Vestibular rehabilitation
- Chronic sinusitis.

Older People's Care

- Increase community-based geriatricians attached to clusters facilitating clinical dialogue
- Care home liaison service
- Single point of access to community services
- Improve links to palliative care and hospice teams
- Hospital/hospice at home.

New Model of Tiered Care

Hospital-based unscheduled care should be an extension of a range of responses available based on providing the most appropriate care as close to a person's home as possible. This will require a whole system approach with collaboration between hospital and specialist care, primary care and community services in partnership with our population.

Our model should provide a seamless service which can respond flexibly to put a person's needs first and to minimise unplanned and unnecessary handovers between services. Hospital inpatient care should only be provided for those individuals who, by reason of clinical acuity, require that level of care. Out of hospital services should be developed jointly across the system and organisational barriers removed or minimised. Better sharing of knowledge and actively managed care for higher risk individuals will allow more informed, risk assessed decision making and allow for a more appropriate response to changing health needs.

There are some services where, by nature of the complexity or low volumes of cases, better outcomes can be achieved by providing the service on fewer or a single site. However, the principle underlying this approach is that care and services should be provided as locally as possible to bring services closer to people and communities whenever clinically appropriate.

Community-based Care Networks

These services can provide a range of options for unscheduled care in a community-based setting. Some of these services are currently provided in hospitals. A number of the service modelling groups identified elements of their service that may, in the future, be provided in appropriate community settings. This level of service could be provided in a defined physical location or as part of a network of community delivered services. Although the GP would have a central oversight and expert advisory role at this level, much of the care could be provided by advanced nurse practitioners, allied health professionals and pharmacists working as part of a team across hospital, primary and community care interfaces.

Where a person's needs change to a level that exceeds that available in the community there will be clear and robust escalation processes to ensure access to the most appropriate service provider.

Local Hospitals

As defined by the West of Scotland Major Trauma group these hospitals are capable of providing emergency care for a range of lower and medium acuity medical conditions below that which requires a trauma unit. A defined range of higher acuity conditions which require higher complexity of care would bypass these facilities according to agreed protocols to major trauma units or the Trauma Centre.

Trauma Units

These will have the full range of clinical services required to provide emergency care for the majority of high acuity conditions. They will also function as trauma units capable of dealing with all presentations below that of major trauma.

The Major Trauma Centre

This centre provides the specialist colocated services required to support a regional major trauma centre.

Critical Care and Transfer Between Tiers

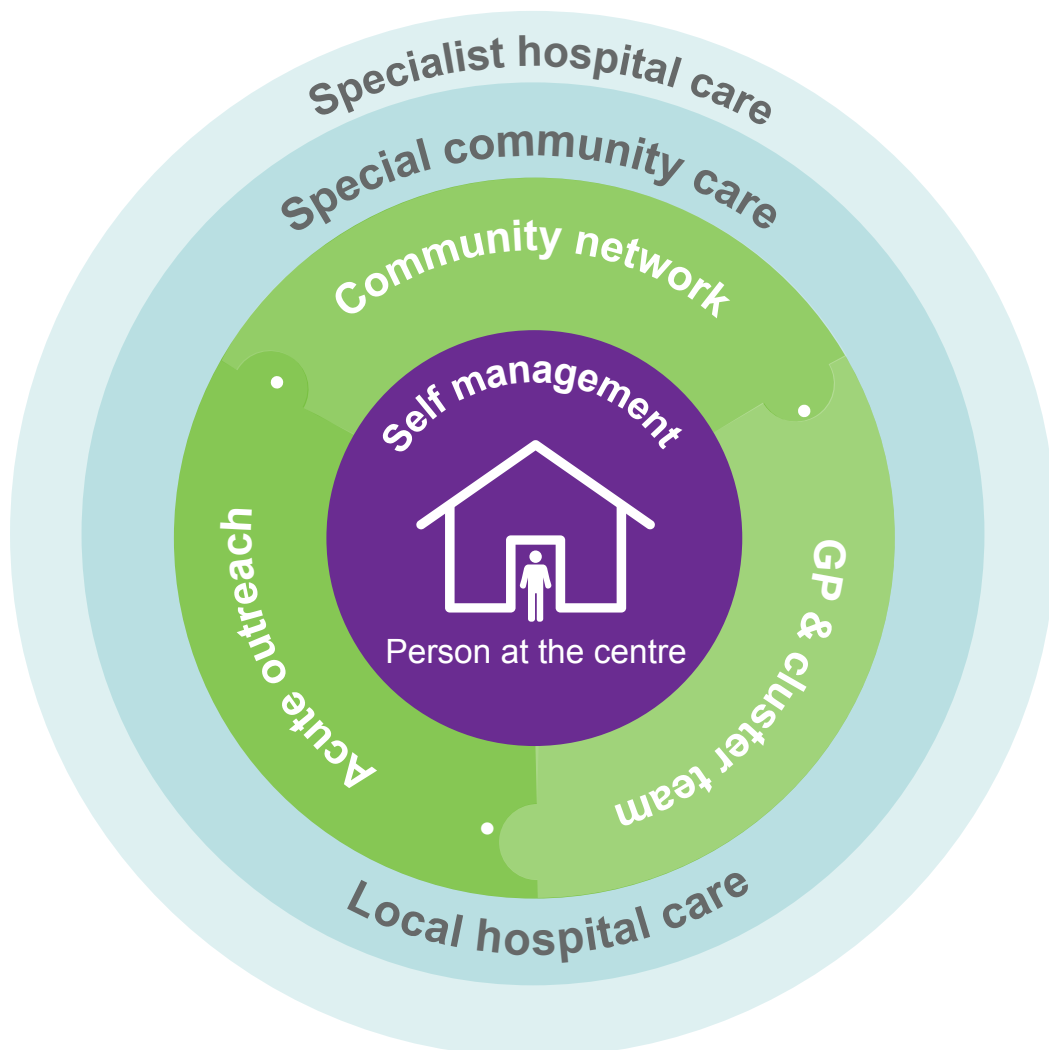
In order for our tiered care provision to function safely and effectively there will need to be systems in place to recognise when a person's clinical condition is deteriorating or their care needs are changing. There then needs to be the ability to safely stabilise and transfer them to another level of care when escalation is required. This may involve transfer to another site. Although bespoke arrangements are in place for the Vale of Leven Hospital and the West of Scotland Cancer Centre, there is no current function to provide such a service across GGC or the West of Scotland.

This will require a model in which people can be assessed and treated by on-site staff with critical care training and advanced skills with remote support from critical care specialists from the trauma units or the major trauma centre.

A transfer service involving suitably trained staff will also be required. It is likely that such a service would have a West of Scotland regional role.

Crucial to the effective delivery of care will be an excellent communications system and the ability to escalate and de-escalate care through the various service levels as is clinically appropriate.

Practitioners at all levels will require rapid access to advice and the ability to share information timeously. A shared, integrated electronic care record and coordinated anticipatory care plans to which all relevant parties can contribute and clearly defined care pathways will be the key enablers.



Unscheduled Care: Implications for Infrastructure

Similarly to the description used in planned care, access to unscheduled care can be described in terms of local, geographical sector and GGC wide provisions.

Local Care

Primary Care

- Each local community population will have access to GP services
- The GP practice will be part of a cluster
- The GP practice will be part of an enhanced team.

Community Network

Each community will have access to an integrated community network constituted as described in the whole system chapter.

In some areas the hub will be a physical location such as a health and care centre whilst in other areas this may be a virtual hub with teams being connected via technology rather than colocated in a building.

Intermediate Care

In each area there will be access to intermediate care services which provide care for people who do not need to be cared for in a hospital setting whether this is to avoid admission to hospital or to enable discharge from hospital after treatment.

In some areas this may be a provision based around beds in community commissioned facilities and in some areas this same care may be delivered in people's homes by teams within the community network.

Specialist Community Care

For highly specialist care some services will be delivered from a few or in some cases only one team or facility across GGC.

Each local community will have access to those services but that provision will not necessarily be within their local community.

Hospital-based Care

Each local community will have access to local emergency care services. These may be provided from the same location as higher complexity emergency services as part of a trauma unit, major trauma centre or may be provided from a more local facility which only offers local services.

The model for the trauma network has been developed to deliver the agreed standards and benefits set out in the National Framework for Trauma. The network will provide all aspects of trauma care, from the point of injury to rehabilitation across the West of Scotland region.

There are three levels of hospitals to support the major trauma network:

- **Major trauma centre** which will provide care for critically and severely injured patients from across the West of Scotland
- **Trauma units** providing most of the care and treatment for those trauma patients who do not require the services of the major trauma centre, but who do require highly skilled specialists offering immediate care and treatment 24 hours a day, seven days a week
- **Local Emergency Hospitals** providing care and treatment for patients with low to moderate trauma.

Major Trauma Centre

A major trauma centre has all the services available to receive and manage seriously injured patients. Major trauma centres provide consultant-level care and access to tertiary and specialist services.

Major trauma centres deploy consultant delivered specialist teams, which have access to appropriate diagnostic and therapeutic facilities 24/7, to provide life saving and life enhancing treatment to the most seriously injured patients.

The Queen Elizabeth University Hospital has been designated as the major trauma centre for the West of Scotland. In terms of GGC the Queen Elizabeth University Hospital will also act as the trauma unit for South Glasgow. The specific requirements of a major trauma centre are:

- A consultant led multi-specialty trauma team 24/7
- Immediate on-site access to the following services:
 - Emergency medicine consultants
 - Anaesthetics/critical care (at senior trainee level)
 - Haemorrhage control surgery (at senior trainee level)
 - General/orthopaedic surgery (at senior trainee level)
 - Imaging services.
- The ability to perform a resuscitative thoracotomy immediately
- A Major Haemorrhage protocol for trauma patients
- Dedicated emergency operating theatre immediately accessible
- Access to the following consultants within 30 minutes:

<ul style="list-style-type: none"> ◦ Cardiothoracic surgery ◦ ENT ◦ General surgery ◦ Intensive care ◦ Interventional radiology ◦ Maxillofacial surgery 	<ul style="list-style-type: none"> ◦ Medicine of elderly ◦ Neonatal medicine ◦ Neurosurgery ◦ Obstetrics ◦ Ophthalmology ◦ Orthopaedic surgery 	<ul style="list-style-type: none"> ◦ Paediatric medicine ◦ Paediatric surgery ◦ Plastic surgery ◦ Psychiatry ◦ Spinal surgery ◦ Vascular surgery
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- Immediate access to CT and CT reporting
- Access to MRI
- A Specialist major trauma inpatient service based around a multi-disciplinary team which includes:
 - A major trauma consultant and a major trauma co-ordinator
 - Rehabilitation specialists that are tailored to meet the individual patient's needs
- A major trauma ward
- A defined service for early acute rehabilitation and access to specialist rehabilitation assessment and treatment services seven days a week.

Trauma Units

Each geographical sector will have a hospital that has been designated during the West of Scotland Trauma Network Planning as a trauma unit.

The role of trauma units is to:

- If skills and expertise are present in trauma units, care will be provided with input as required by major trauma centre
- Provide initial care and resuscitation of major trauma patients
- Have a system in place to identify and transfer under-triaged and self-presenting patients to major trauma centre, including availability of clinical escort where required
- Provide acute rehabilitation and has access to specialist rehabilitation as part of a regional approach.

This model means that not every community will be able to access a trauma unit in their community but each community will have access within their geographical sector to a trauma unit and will have access to a major trauma centre within GGC.

What Does this Mean for People?

People will be at the centre of care planning and delivery.

Rather than having to fit in to an often rigid system where care can be fragmented and delivered with little or no consideration of the whole person, there will be a holistic approach.

Improved information and community support will make it easier for people to manage their own conditions and have ready access to appropriate professional support when this is needed. When multi-disciplinary management is required the team will be 'bespoke' and tailored to the person's particular needs and circumstances.

All members of the team will have access to the information they need to avoid duplication and allow a joined up approach to care. When care needs are complex, the person will be guided and supported through the system by a personal care manager. Crucially, the person themselves will be fully involved in any decisions about their care and will be supported to do so.

Anticipatory care plans, to which the person has contributed, as well as better monitoring of those with complex needs will lead to fewer unplanned 'crises' and will help to avoid hospital admission by allowing earlier timely intervention.

The experience of the person should be of seamless care with no unnecessary 'hand offs' from one service to another. Care and services will be delivered as close to their home as possible and, when acute hospital admission has been necessary, they will be supported back into the community at the earliest opportunity.

Chapter 10: Community and Primary Care

Primary and Community Care – Overview

Key Issues

As part of our whole system approach primary and community services areas of focus are:

- Early intervention and a reduction in emergency admissions
- Shifting the balance of care from hospitals and institutions to the community
- Avoiding unnecessary delays in discharge from hospital
- Promoting individual independence and choice
- Supporting unpaid carers
- People have positive experiences of health and social care services, including at the end of life
- Tackling inequality
- Improving life chances for vulnerable children.

Key Considerations

We should develop primary and community services which:

- Have a focus on the GP in their expert medical generalist role and the development of multi-disciplinary teams working together with GP practice populations, building on the list based system of primary care, to ensure that people can access the right professional at the right time and to have more time with that professional when necessary
- Ensure the ability of the integrated community network to take a coordinated approach to supporting people with complex needs, through stronger links with all care groups to support individuals with multiple and enduring complex needs across our services. People with complex needs can have multiple areas of need such as mental health, physical health and disability, learning disability and alcohol and or substance misuse or dependency issues
- Recognise that people with complex needs present with a range of issues and will require varying levels of support. Effective support for people with complex needs should offer trauma informed approaches with emotional support or assistance to access care appointments, care management and referral or signposting to community supports
- In each HSCP and locality bring services together in a virtual network or in some places a single physical hub from which services reach out
- Have a clear strategy for the development of community-based premises and accommodation to ensure that premises are fit-for-purpose and support the new models of working at practice, cluster, health and care centre or community network levels
- Balance local accessibility with colocation to meet need and provide safe and effective delivery of services
- Support people to access additional support if their needs are increasing with timely referral to the appropriate primary or community services, or other appropriate support at point of crisis as well as support to engage with training and employment opportunities when ready.

Introduction

In the Planned and Unscheduled Care Chapters we have described a whole system approach, which is centred on strong primary and community services which are integrated and networked. In this chapter we will describe in more detail the key elements of this network and how integration enables person centred care.

Our primary and community services are focussed on providing and supporting people to access, the right services at the right time and in the right place. There is a drive to promote self management and independence and enable people to live longer, healthier lives in their own homes and communities.

Key to keeping people in their community or in their home is early intervention and having a range of accessible services which provide anticipatory care to prevent escalation to hospital or specialist services if possible.

Strategic Priorities

Under the Public Bodies (Joint Working) (Scotland) Act 2014, Integration Authorities are responsible for the planning, commissioning and delivery of a range of services across the boundaries of primary, community and secondary care. There are six Integration Joint Boards (IJBs) within the NHSGGC Board area and each has in place a Strategic Plan and supporting commissioning intentions. There are a number of common themes within the Strategic Plans of the six IJBs which align to the Moving Forward Together principles.



Specific Case for Change

There are a number of specific drivers for change within primary and community services and a range of challenges which mean that this transformation is necessary.

- **Demand associated with the changing demographic profile**

Age and deprivation are key drivers of demand in primary care and community services. A 2016 King's Fund Report on pressures in general practice described a 15% increase in consultations over a four year period. This rise in demand has been reflected across the full range of community health and social care services. As well as an ageing population there has been an increase in multimorbidity across all age groups and therefore an increase in the complexity of care required, which necessitates different ways of working.

- **Service sustainability**

A number of services have experienced specific issues with recruitment and retention. Within primary care, the new GP contract has in part been driven by a recognition of the pressures on service sustainability in general practice and the need to develop a wider team to deliver services. Across all community services there is a focus on the continuing drive to reduce unnecessary admissions to hospital and maintain people at home or in a homely setting.

- **Financial environment**

Over recent years there has been pressure on the delivery of community-based services and there must be a focus on developing sustainable and efficient service models which are appropriately resourced.

- **Community infrastructure**

There have been several innovative health and social care centre developments in recent years which have created high quality accommodation in communities and enabled colocation and supported joint working. Technology enabled networking of teams provides opportunities for virtual colocation without the need for physical colocation. Across the community there is a need to invest in infrastructure to ensure the capacity for the sustainable high quality community-based care we are seeking to deliver.

Primary and Community Care Through a Tiered Approach

A tiered approach to service delivery has been our methodology throughout Moving Forward Together. Consistent with the whole system approach and planned and unscheduled care, the contribution of primary and community care follows a tiered approach to advice, support and intervention, escalating where necessary into hospital and specialist services.

The diagram below shows the range of service elements across primary and community care which integrate to deliver this tiered approach from services to support self management at home to long term care services delivered in the community.

Support/service category

Self management / independence

e.g. Physical activity/healthy diet and lifestyle; access resources within own community; own needs identified and fulfilled
(eg over-the-counter medication, fitted own handrails, stairlift etc)

Universal / direct access: primary and frontline care and support

e.g GP and practice nurse; community pharmacy (inc. minor ailments service), optometry, dentistry; self referral to physio, podiatry etc; telecare; NHS 24; housing aids and adaptations; carers; minor injuries units.

Referral/criteria based services: community care /support

District nursing; homecare; free personal care; ongoing condition-specific care and treatment; reablement/rehabilitation; supported living; community mental health teams; self directed support; occupational therapy; day care; end of life care (at home)

Short term care / away from home

inpatient (unscheduled, planned, mental health); intermediate care; temporary homeless accommodation; residential rehabilitation; end of life care

Long term care and support away from home

care homes; fostering and adoption; children's residential; secure care

The key focus is on maximising independent living through prevention, self management and provision of the most appropriate interventions or services at the right time.

Where more specialised services or intensive input is required these also should be focussed on enabling people to return to independence and self management wherever and as soon as possible.

Community Networks

Primary and community care services are delivered in localities across the six IJB areas, including within:



A significant volume of contacts take place within primary and community care each year, with the majority of patient contacts and episodes of care taking place entirely within this setting. Estimates suggest up to 90% of healthcare episodes start and finish in primary and community care. This includes:

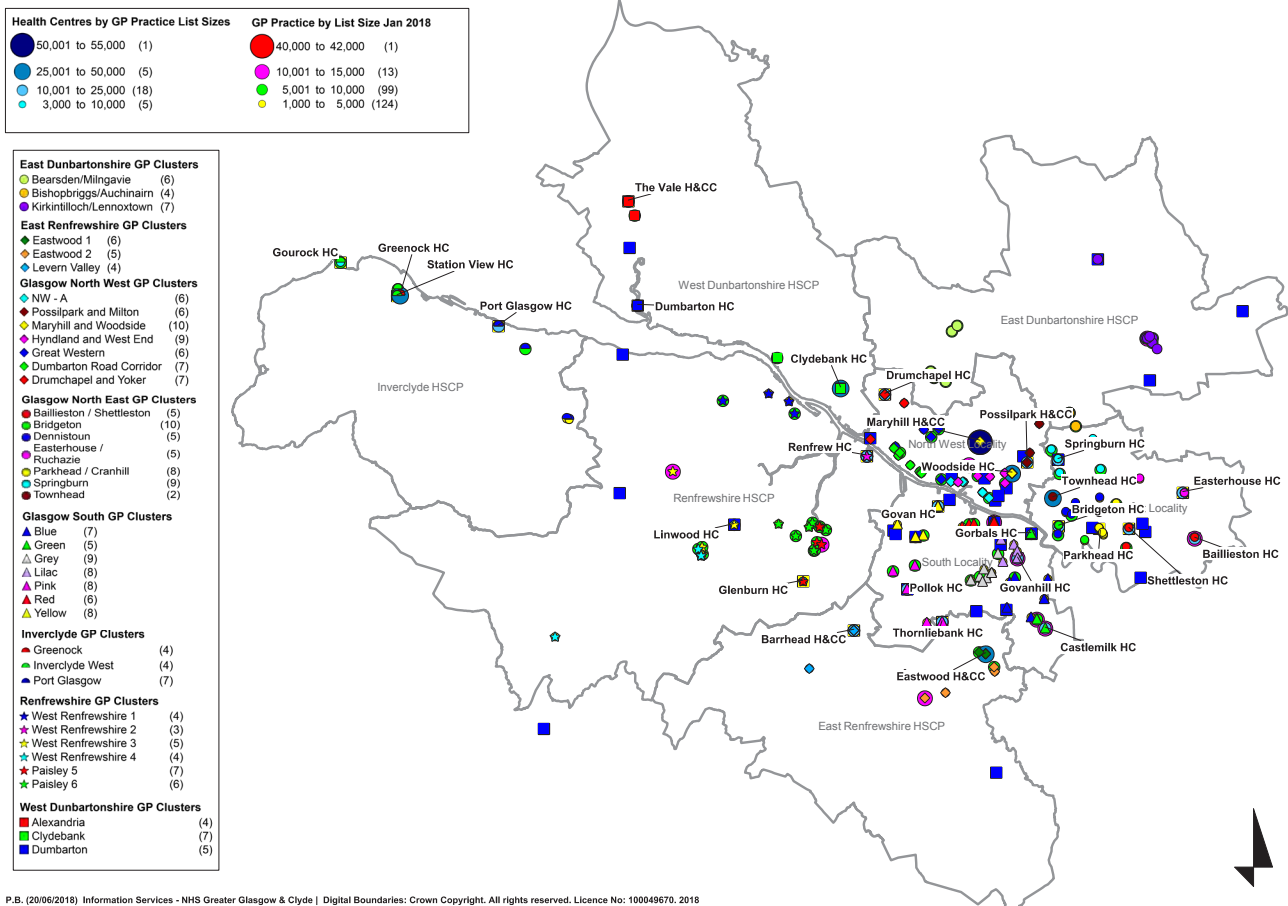
- More than **seven million GP practice consultations** a year across GGC
- More than **half a million eye examinations**
- More than **24 million dispensed prescription** items per year across GGC.

Our tiered approach in the community network sees a single integrated multi service network of teams as detailed in the whole system chapter.

These services are focussed on supporting people to remain independent at home with the most appropriate intervention necessary and enabling people to return to independence following a period of more intensive support and intervention.

Central to this system of care is the list based system of primary care, where people are registered with a GP practice. This provides a foundation for the delivery of a full range of preventative and treatment services, as well as a network of locations for the delivery of care

This also provides an opportunity for coordinated care within a defined geographical area, with a wide network of services. The graphic on page 142 shows the location of GP practices and health centres across GGC.



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On average 90% of people contact their GP practice over the course of a year.

Dentists, optometrists, community pharmacists and, increasingly, other members of the wider multi-disciplinary team offer direct access for a range of conditions and for supported self care.

The 'Four Cs' Framework

This network provides an opportunity to support population health including the challenge of multimorbidity using 'Four Cs' framework:

- **Contact** – accessible care for individuals and communities
- **Comprehensiveness** – holistic care of people – physical and mental health
- **Continuity** – long term continuity of care enabling an effective therapeutic relationship
- **Coordination** – overseeing care from a range of service providers.

Enhancing the Community Network

Our vision is for an enhanced community network of services, which promotes joint working across all of the parts of our health and social care system. Together with a range of partners and the person at the centre this will allow us to respond effectively to the demographic challenges we are facing and provide the most effective and appropriate services.

This network may be based around a physical hub in some areas and in others may be delivered via a virtual network of linked teams.

This network includes services provided at home, in primary care, in the wider community and where necessary in or by specialist or hospital teams and facilities. It also includes a range of partners in the third and voluntary sector.

There will be a clear route in and out of services for people when they need support and interventions, escalating and de-escalating support as required to maximise independence.

Within this community network we would ensure that individuals and communities have access to a wide range of services.

An example of this model is the work on developing a model for the future North East Health and Social Care Hub in Glasgow, where it is intended that a wide range of services will be delivered including:

- Health centre services (such as GP, pharmacy, dental, MSK physio, podiatry, speech and language therapy)
- Specialist children's services
- Rehabilitation and enablement services
- District nursing
- Health visiting and school nursing
- Social work children and family teams
- Older people's mental health services
- Learning disability services
- Sexual health services
- Primary care mental health services and psychotherapy services
- Health and social work addiction services
- Criminal justice social work services
- Acute hospital services, such as chronic pain clinics, older people services, speech and language therapy, physiotherapy, anti-coagulant services and possibly low toxicity oral cancer therapy.

The North East Hub will also be the main city wide facility for staff training and development within Glasgow City, and there will also be scope for community use of meeting rooms, such as recovery cafés.

This example illustrates how in the future a wide range of health and social care services could work together to provide holistic, person centred care.

Services will be able to work together in a flexible way depending on the level of support required:

- **Signposting and enabling direct access** to the most appropriate service
- **Triage and referral** to the appropriate service in a timely manner
- **Access to a range of support services** to enable care across a range of settings, for example community-based phlebotomy and treatment services

- **Referral between services**, enabled by better understanding of different roles and the range of available services
- **Ability to share relevant information**, seek advice and discuss individual cases across the network
- **Coordinated care** with input from multiple teams where required for particularly complex cases
- **Specific intensive interventions** when required.

Social Work Services

Across our communities Social Work Services provide a range of services which contribute to our aim of enabling people to live independently in their own homes or as near to their home as practicable for as long as possible.

These services form part of our integrated community network of health and social care.

Some of these services are provided in the community and some are provided in people's homes.

Support in the Home

Reablement

Reablement is a newly developed service that provides tailored support to people in their own home for up to six weeks after discharge from hospital.

Reablement builds confidence by helping people to regain the skills to do things they can and want to do for themselves at home.

Home Care

Home care services' specific aim is to provide support and care to people in their own home in order for them live independently for as long as possible. Support can include help with personal care, such as washing, dressing and going to bed or assistance with practical domestic tasks such as laundry and food preparation. Through access to home care services, people can remain living in their home environment while receiving a package of care which is optimised for their specific needs.

Enhanced home care services provide care for people with more specific needs such as personal care, treatment of specific conditions or specialised feeding.

Meals at Home

Meals at Home services provide regular, pre-prepared healthy meals to people in their own home. These services enable those who do not have the means or ability to prepare their own food at home to stay at home, and maintain independence while having a healthy diet and regular hot meals.

Equipment and Housing Adaptations

There are a number of adaptations that can be made to people's homes or specialist equipment that can be provided which will make everyday tasks easier and therefore enable people to enjoy independent life at home for longer.

Support in the Community

Day Care

Day care services provide services which support people to increase their quality of life while living at home. Day care centres give people the opportunity to socialise with other people in their local community, take part in activities and continue to pursue their hobbies and interests.

Day care centres provide organised activities as well as hot drinks and meals and provide a setting which promotes social activity and entertainment.

There are also specialist day care centres which are designed for people with dementia. These centres provide support in a group setting or on an individual basis.

Supported Living

Supported living includes access to a range of services designed to help citizens retain their independence in their local community.

Previously, housing and support were provided by a charity or local authority however people may now have the opportunity to live in their own home or share with others and have personal support provided by another organisation or by hiring a personal assistant to visit or to live in the home to provide care.

Care Homes

Residential care homes provide 24 hour assistance to people who are no longer able to live independently at home. Care homes cater for people of a variety of ages. The type of facilities and level of care available can differ between care homes depending on the needs of their residents.

Specialist care homes are designed for people who need a specific type of care. They provide care for a variety of people who have very specific needs, such as people with high level dementia and people with alcohol or drug addictions. The different types of specialist care homes include dementia care homes, enhanced residential care homes, nursing care homes and sheltered housing.

Care homes enable people to stay close to their own communities and still be part of that community. Our integrated community network should reach into care homes and ensure that residents have full access to the person centred health and social care enjoyed by people living in their own homes.

Intermediate Care

Intermediate care is a service designed to provide care to people who do not require the level of care provided in a hospital but are not ready to live independently at home. These services provide an appropriate environment where individuals being discharged from hospital with enduring care needs can have these needs catered for. The majority of intermediate care resource is focussed on supporting people to return to their home or community when fit to do so after a hospital stay, with a complementary intermediate care model also supporting prevention of avoidable admissions to hospital.

All HSCPs within Greater Glasgow and Clyde operate intermediate care services.

The precise model used within each HSCP can vary, for example some partnerships deliver intermediate care services in dedicated facilities, while others deliver it within peoples' home, with these variations being based on local needs, opportunities presented by scale, and evidence of what works locally.

Irrespective of the model utilised, all HSCPs have generated a significant evidence base to show that intermediate care meets its two key strategic objectives, both of which relate to shifting the balance of care. These objectives are to reduce the number of older people delayed awaiting discharge from hospital and reducing the number of older people being placed in long term care following a hospital admission.

Intermediate care is regarded as a core element of the older people's health and social care system, which will be further strengthened through ongoing review of service models and professional practice.

For those people who have more complex care needs this will be coordinated across the whole system network including escalation to specialist and hospital-based services when necessary.

This model will be supported by eHealth developments through access to a shared record, integrated care planning and timely sharing of relevant information between care teams.

The ability of professionals to share information, take a coordinated approach to care provision and access shared records can reduce inequality by allowing services to better support individuals who may be less able to navigate the health and social care system on their own.

General Practice

Supporting an Expert Medical Generalist Focus and Developing Multi-disciplinary Teams

The new GP contract represents the start of a significant transformation of general practice, with a refocusing on the expert medical generalist role and the development of multi-disciplinary teams working together with practice populations, building on the list based system of primary care, to ensure that people can access the right professional at the right time and to have more time with that professional when necessary.

This is a key part of the concept of an enhanced community network. The key contribution of GPs in this role will be an opportunity to spend more time on:

- **Undifferentiated presentations**; those people who may require further assessment, investigation, referral or admission
- **Complex care in the community**; those people who may require more GP/multi-disciplinary team time, particularly for anticipatory care planning
- **Whole system quality improvement** and clinical leadership; continuous quality improvement both within and across GP practices in the cluster and the wider health and social care system.

These changes will bring a range of benefits:

- There will be benefits for people through having **improved access and more time with the right professional when they need it**
- GPs and members of the wider team will have an **opportunity to enhance relationships** and deliver more person centred care through shared decision making
- The wider health and social care system will see the benefits expected from **more shared decision making**.

Teams will be developed based in or near to GP practices and working with individual practices or groups of practices. This will support and further develop the key role of primary care in the following areas:

- **Managing episodes of care in a community setting**, providing advice and treatment as necessary, including prescribing and ongoing medication
- **Supporting referral to other services** and having an overview of the whole range of care for a patient
- **Management of chronic disease** and long term physical and mental health conditions including annual comprehensive reviews, support for care planning and empowering people to lead the management of their own condition
- **Effective coordination** and management of multimorbidity care
- **Complex care planning** including anticipatory care planning
- **Preventative health**, including child health surveillance and immunisations, as well as comprehensive vaccination programmes such as flu, to be delivered through the new Vaccination Transformation Programme and screening programmes including cervical screening and brief interventions, such as to target alcohol issues
- **Contraceptive services** and sexual health advice
- **Pharmacotherapy services** to ensure effective prescribing and medicines management, supported by specialist pharmacists working in practices
- **Involvement in complex multi agency case work** including child and adult protection

- **Providing assessment and treatment for patients at home** who cannot visit a local surgery
- **Providing test and investigations** or referring to other services for these
- **A range of treatment services** including ear syringing, suture removal, wound care and minor surgery as part of the extended community network
- **Community phlebotomy service** and development of new services to support monitoring of medication and chronic disease markers
- **Provision of information based on a life time care record:** for travel, schools, benefits, insurance, legal purposes.

As the extended primary care team develops over time, the range of roles and teams carrying out and supporting these functions will increase as part of the enhanced community network.

Providing Care for Older People and People with Frailty

Frailty is a clinically recognised state of increased vulnerability that results from ageing associated with a decline in the body's physical and psychological reserves. Falls are often the first sign of frailty. Recognising frailty at an early stage and offering personalised interventions can support an individual to live well at home. Multi-professional working is key to ensuring that people can access the right services at the right time.

Managing frailty is increasingly an urgent issue for health and social care services. Approximately 10% of people aged over 65, and up to 50% of those aged over 85, are living with frailty. Older people living with frailty are often at risk of adverse outcomes following a relatively minor event and often fail to recover to their previous level of health.

HSCPs are working closely with GPs and hospital clinicians to agree a single approach to screening for, and the management of, frailty in the community where this is appropriate. This approach will involve greater use of anticipatory care planning, closer working between consultant geriatricians, GPs and care homes, falls management and prevention, extending the use of telephone based care and enhancing the input of links workers and community connectors.

The aim of this multi-disciplinary approach is to better manage frailty in the community and support people to continue to live in a community setting, thus preventing avoidable stays in hospital.

Some of the key issues in delivering this agenda are:

- **The need for a consistent approach to frailty across HSCPs** that complements and supports the Healthcare Improvement Scotland screening tool being used by all hospital sites
- **Exploring the potential for the Home is Best (HiB)** team being more closely linked with the hospital discharge hubs; this may involve the HiB team proactively supporting patients out of hospital, as opposed to the current, largely reactive, approach.

There is an opportunity for some consultant geriatricians to spend more of their time in the community supporting GPs and our neighbouring teams, to proactively manage older people's care in community settings, be that in people's own homes, care home or supported accommodation. There are also initiatives to make better use of Day Hospitals to provide an alternative to hospital admission.

We also recognise that there are increasing numbers of older people living with dementia, and our approach to this will require strong links with mental health services across HSCPs, ensuring that all of our approaches to frailty will be designed with the needs of those with dementia in mind. Each HSCP has a Dementia Strategy in place which supports this approach.

People with Multiple or Complex Needs

A key test of the integrated community network will be the ability to take a coordinated approach to supporting people with complex needs, through stronger links with all care groups to support individuals with multiple and enduring complex needs across our services. People with complex needs can have multiple areas of need such as mental health, physical health and disability, learning disability and alcohol and/or substance misuse or dependency issues.

People with complex needs will present with a range of issues and will require varying levels of support. Effective support for people with complex needs should offer:

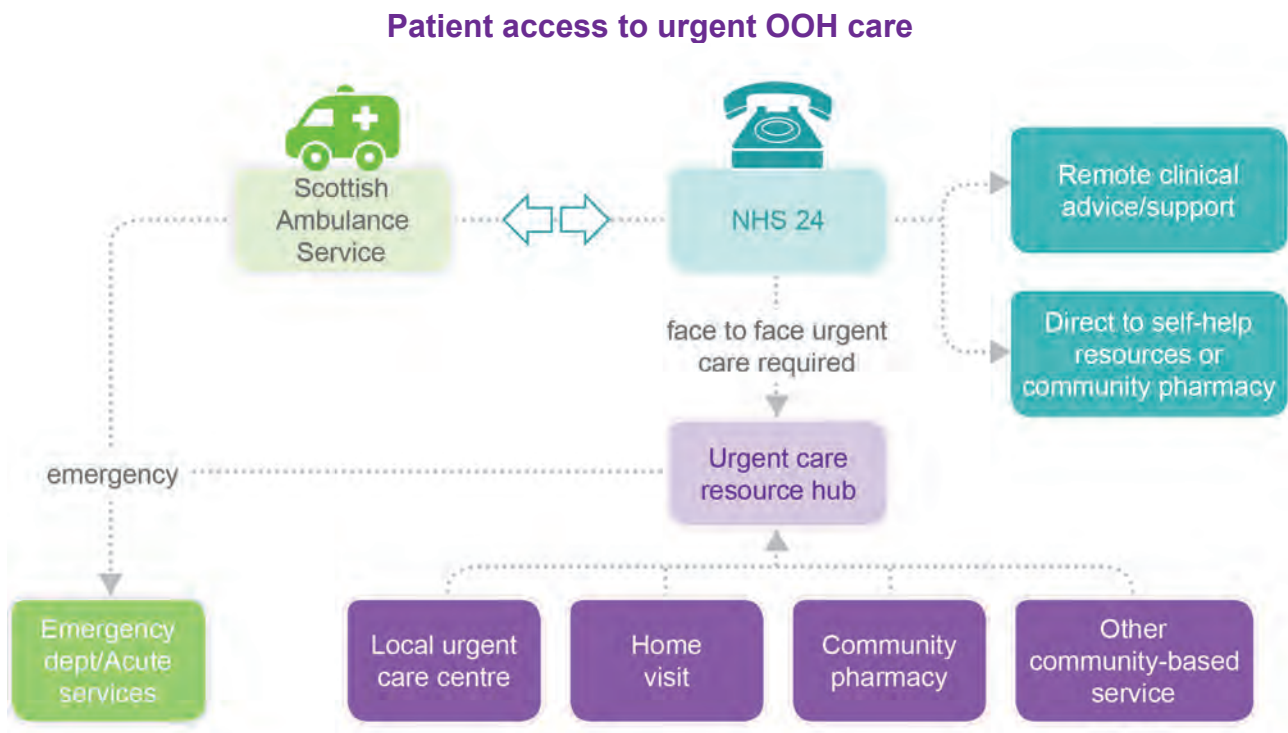
- Trauma informed approaches
- Emotional support or assistance to access care appointments, care management and referral or signposting to community supports
- Support to attend appointments to access support if physical, mental or emotional health is in decline
- Support to access additional support if a person's needs are increasing
- Timely referral to the appropriate primary or community services, or other appropriate support at point of crisis
- Support to engage with training and employment opportunities when ready.

We will continue to review and develop services to ensure that points of access which alleviate barriers for direct access to services are in place and that the complex needs of people who use our services are taken into account.

Out of Hours

The demand for urgent care across the Greater Glasgow and Clyde area continues through the Out of Hours (OOH) period. The enhanced community network has to enable integrated urgent care to be provided over a 24 hour period.

A national review of OOH services described a new model of care where a multi-disciplinary urgent care coordination and communication function would be provided through an urgent care resource hub. This hub, which should be configured for service delivery, workforce support and training opportunities, is outlined in the diagram below:



Many of the approaches and principles incorporated within the review are equally applicable when providing care during daytime hours.

These include the aim of increasing the care provided by well led multi-disciplinary teams in community settings. This aim reflects our approach to creating an integrated network.

Key objectives for services coordinated within an urgent care resource hub would be to provide:

- Single point of access to services from across the system
- Signposting and triage, referrals to a full range of services, based on need
- Provision of a focus on continuity of care and coordination of individuals with multiple conditions
- Coordinated care at crisis or transition points and for those most at risk
- Access to specialist advice
- Rapid escalation of support or clinical care.

Community Pharmacy

Aligned to the 'Four Cs' framework element of contact, described earlier in this chapter, community pharmacists provide the initial contact for many people to receive definitive care and/or be directed to other parts of the network. This treatment and triage facility is a way of signposting people to other professionals after the pharmacist has assessed the person's needs and established if a further specific treatment is required. Further development of the community pharmacy role will be a way of easing the pressure on other services, by optimising contractual arrangements to allow the maximisation of the clinical skills that pharmacists have.

We will encourage the proactive involvement of community pharmacists and their staff in supporting people to self care. This can be done by offering suitable advice and interventions to promote healthy lifestyles. This will include accessible programmes such as nicotine replacement therapy, emergency hormonal contraception, free condoms, healthy start vitamins and flu treatments. This could be further developed to include Travel Vaccinations and advice, blood pressure monitoring and blood and cholesterol testing amongst other services.

Acute Medication Services

The national acute medication service uses the electronic transfer of prescription details for the supply of medication to the person. This allows community pharmacists to engage with other healthcare professionals to help to maximise patient concordance with their medications to ensure that medication is given every opportunity to have a safe and effective outcome for each patient. Advice and counselling on the person's medication is delivered by the pharmacist at the point of supply. With the potential accessibility to the relevant information from the person's care records, the pharmacist will be better placed to manage and care for the person in the community.

Minor Ailment Service

This service allows eligible individuals to register with, and use a, community pharmacy as the first port of call for the treatment of common illnesses. The pharmacist advises, treats and/or refers the person according to their needs. In 2017, pharmacies within GGC prescribed 576,866 medication items to people accessing this service. A pilot within Inverclyde investigated extending this service to every person as well as allowing pharmacists to prescribe prescription only drugs for certain conditions such as urinary tract infections. The prescribing of prescription only drugs has now been rolled out across all pharmacies into a national service and has been shown to take pressure off GP practice and OOH services with over 3500 interventions at a community pharmacy level in GGC within a three month period. Further conditions where pharmacists can play a major role in the care of people are being considered to extend this service provision.

Chronic Medication Service

This allows people with long term conditions to register with a community pharmacy of their choice for the provision of pharmaceutical care as part of a shared agreement between the person, community pharmacist and GP. It includes the supply of a prescription which can last up to a year and supports the person and the pharmacist to manage their condition with a supply of drugs for an agreed care plan without the need for a GP practice to be directly involved during that time period. Enhanced work on IT platforms will allow this service to enhance the care given to a person without the need to attend the GP practice. The collaboration of prescribing support pharmacists working within GP practices and the community pharmacist to identify people who would benefit from this service has the potential to take a significant amount of work out of the GP practice.

Enhanced Services

Further advanced services are being developed within the community pharmacy network where the pharmacist shares the pharmaceutical care needs and supplies the medication for those requiring support with conditions like hep C, HIV, oncology, opiate dependency and coeliac disease. This provides clear and easy local access to these important services and ensures that the patient does not require to return time and again to specialist settings to obtain their medication and care. People with a chaotic life or lifestyles such as within the homeless community can be supported either within the community pharmacy or “on the street” by community pharmacy prescribers who are able to bring services to the person rather than the other way around. With the increase in independent prescribing pharmacists within the community network, current clinics being delivered within the community setting including diabetic, respiratory and pain clinics, should be developed to deliver more and cover a larger selection of health board identified key health priorities.

Optometry

There are 178 optometry practices across Greater Glasgow and Clyde, with an established history of working collaboratively within HSCPs and with hospital eye services.

There are a number of opportunities to further develop the integrated person centred eye care service across GGC. The focus of this work is to ensure that people have direct and timely access to the right professional, and to reduce unnecessary referrals between services.

Optometrists are the first port of call for any eye problems and this should be further supported and developed, with appropriate training where required to ensure confidence in dealing with all age groups. Promoting community optometry as the first port of call for eye problems enables people to be seen in a timely way by the professional with the right skills and equipment.

Where further treatment and referral is required, the expansion of direct referral to hospital services and continuing to increase the number of independent prescribers in optometry will ensure that the full episode of care can be managed appropriately.

Optometry provides opportunities for identification, support and signposting to other services. Optometry being part of the wider network of community-based services gives the potential to identify vulnerable frail adults during assessment and link to other appropriate services. Other opportunities come from provision of optometry within care homes and to housebound people in helping to maintain independence.

There are further opportunities to develop community eye care services. Community optometry can play a role in developing patient pathways to create an alternative response to address the increasing pressure within hospital eye services. This development includes post cataract surgery management and stable glaucoma management and examination of other opportunities for community-based follow up and ongoing condition management.

Oral Health

The Oral Health Improvement Plan published in January 2018 sets the direction of travel for oral health services which will be taken forward across Greater Glasgow and Clyde, with Health and Social Care Partnerships working collaboratively with General Dental Practitioners and the hospital and community dental services.

There are over 250 general dental practices across Greater Glasgow and Clyde. As recorded in September 2016, 91% of the Scottish adult population were registered with a dentist and almost three quarters had attended their dentist in the previous two years. As part of the wider community network and tiered approach to care, there are some key priorities for oral health:

Focus on Prevention

Dental disease is almost entirely preventable. In future this will be better reflected within the system of payments and monitoring for practices to ensure there is a strong focus on prevention at all ages. As a key point of contact, dentists may also identify wider health needs. The extended community network model is an opportunity to enhance how GDPs can link to wider services when required.

Reducing Oral Health Inequalities

The oral health of the population has improved dramatically, though there is still significant adverse impact from poor oral health amongst those living in the most disadvantaged communities. This will be addressed through a continuing focus on community level interventions as well as reviewing how funding reflects the needs of patients.

Meeting the Needs of a Population who are Living Longer

The role of GDPs and the PDS in supporting older people will be further developed, in particular to identify challenges in domiciliary care provision, both in care homes and for patients who may be confined to their own homes.

More Services on the High Street

It is necessary to ensure that the balance of care between hospital and GDPs is appropriate; this can be achieved by ensuring that we have a quality clinical information for decision making, clear referral criteria and an appropriate escalation pathway.

Improving Information for Patients

Work is ongoing to develop the standard of NHS oral health information on self care, treatments available, costs and services to be made available to the public by dental practices and dentists.

Sexual Health

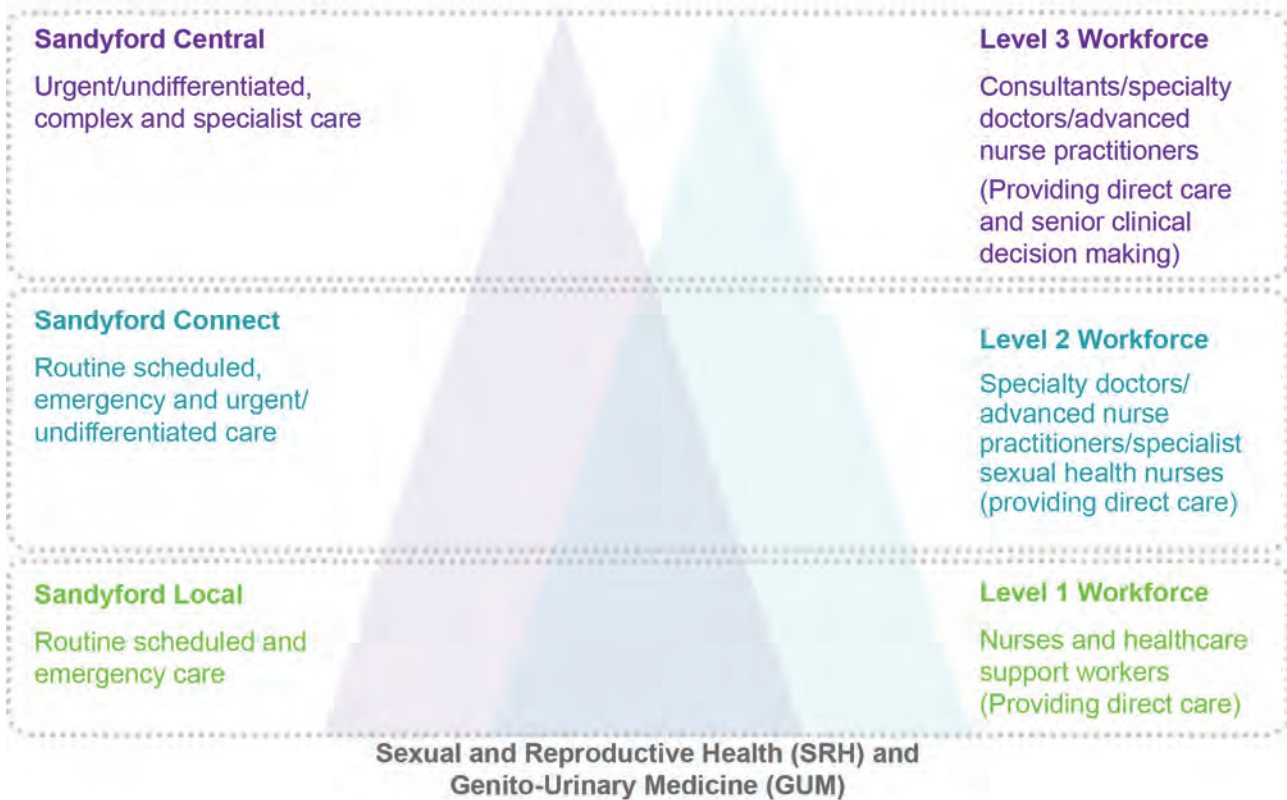
Sexual health services are provided in a range of settings across GGC including pharmacies, GP practices and by accessing Sandyford Sexual Health Services.

Sandyford Services provides universal sexual health services for the GGC population as well as specialist services for complex procedures, presentations and specific population groups.

A tiered service model has been agreed by all IJBs and the Health Board which is in line with the principles of Moving Forward Together. The focus of sexual health services will be on prevention of poor sexual health, early intervention and supported self management. Services will be targeted so that those who can self manage are supported to do so, leaving more time available for those with vulnerabilities or more complex or specialised needs.

Outreach and out of hours services will be provided for specific priority groups. Three tiers are proposed as shown below:

Proposed service model – Tiers of service provision



Sandyford Services have already adopted many Moving Forward Together themes.

The service provides a GGC service for key conditions such as gonorrhoea, syphilis and HIV where technology enables self collection of results which avoids unnecessary follow up visits. A single record system is shared across all locations, allowing safe oversight while care is physically provided more locally.

Implications for Infrastructure

The enhanced community network will have to function at a number of levels and locations.

Population sizes/locations



In each HSCP and locality therein, services will come together in a virtual network or in some places there will be a single physical hub from which services reach out.

This will require a clear strategy for the development of community-based premises and accommodation to ensure that premises are fit-for-purpose and support the new models of working at practice, cluster, health and care centre or community network levels.

Each HSCP will need to balance local accessibility with colocation to meet need and provide safe and effective delivery of services.

Chapter 11: Mental Health

Key Issues

There are three main themes to our approach to mental health services within our system:

- **Prevention** – acting to reduce demand through prevention and early intervention, particularly in collaboration with public health, health improvement, primary and community care, and multi-partner approaches to reduce health inequalities
- **Productivity** – improving service productivity and efficiency, as well as adopting the stepped care model to ensure services are targeted appropriately and people receive “all the care you need, but no more”
- **Recovery** – further shifting the balance of care to support people to live as independently as possible, including greater access to recovery orientated care and in line with assessed need and the stepped model of care, greater consideration of non statutory care and support options. These will be developed with the full involvement of service users and carers.

Key Considerations

We should develop services which are focussed on:

- Reconfiguring inpatient beds and lengths of stay, with accompanying investment in alternative forms of health and social care, including Board wide availability of home treatment
- Enhancing capacity in community mental health teams, primary care community mental health teams
- Extending the role of specialist teams
- Mental health as part of a single GGC wide system to provide unscheduled care
- A recovery oriented model of care
- Implementation of new models of care for people with borderline PD and bipolar disorder
- Trauma sensitive care
- Investment in early years, childhood behavioural problems and Adverse Childhood Experience reduction.

A draft five Year Strategy for Adult Mental Health Services in Greater Glasgow and Clyde 2018-23 has been developed in parallel to Moving Forward Together which is aligned to the Scottish Government’s Mental Health Strategy 2017-27 and the NHSGGC ‘Healthy Minds’ 2017 report. The strategy is consistent with the guiding principles of the Moving Forward Together Programme.

The mental health ‘family’ of services includes mental health social care, older people’s mental health (OPMH), child and adolescent mental health (CAMHS), alcohol and drugs, learning disability and forensic mental health services.

The importance of continued collaboration and coproduction with provider organisations, the independent sector, service users and carers is recognised throughout this document.

A History of Transformation

Over recent decades, service development in mental health services in Scotland has been characterised by improved community services to enable a reduction in hospital beds. NHS GGC led much of the UK in a large scale psychiatric hospital reconfiguration programme which started in the 1980s. The reconfiguration programme accelerated in the 1990s and has continued. The number of beds required in Glasgow City has reduced from 4,370 in 1978 to 783 in 2017.

“Modernising Mental Health” Strategies (2001 for Greater Glasgow and 2006 for Clyde) set out frameworks for the development of comprehensive community services to support the continued reconfiguration of inpatient beds.

The closure of more than 3,500 beds across Greater Glasgow and Clyde during this period has enabled funding for reinvestment in community services and allowed for major improvements in the quality of accommodation in the inpatient estate.

Community service provision was built based around the community mental health teams (CMHT) in adult services, with equivalents in addictions, forensic mental health, child and adolescent mental health (CAMHS) and older people’s mental health (OPMH) services.

In a suite of service developments through the early 2000s, those teams were complemented in GGC by primary care community mental health teams (PCMHTs) delivering “high volume, low intensity” care for common mental health problems and crisis, out of hours and home treatment teams providing emergency and unscheduled care.

A range of specialist teams were developed to meet particular needs, including the adult autism team, the perinatal mental health team, the adult eating disorder team, the trauma and homelessness team and Esteem, which provides early intervention for people with psychosis.

Priorities for our New Care Models

The vision for mental health service developments build on the work of the Clinical Services Strategy published by NHS GGC in 2015. This endorsed the model of “stepped” or “matched” care, in which people would receive “all the care they need, but no more”. Care provision would be based on timely access to the full range of interventions recommended by NICE, SIGN, and other accepted care standards in Scotland, adapted where appropriate through care pathways for delivery in GGC.

Using a “stepped” or “matched” care model, services tailor the intensity of care provided to meet people’s needs, based on routine monitoring of clinical outcomes. Five levels of care were identified as part of the Clinical Services Strategy:

- Public health interventions
- “Open access” services available without referral
- “Brief interventions”
- Longer-term multi-disciplinary care
- Intensive support.

An “unscheduled care” element is also needed to respond to crises and emergency needs, across all conditions and settings. The figure on page 159 represents the levels of care that applies to prevention, treatment and care in mental health services.

Care level	Public	Open access	ERBI: early response brief intervention	Longer-term, multi-disciplinary care	Intensive treatment
Numbers					
Type of interventions	Information, screening, self-help	Education, self-help, peer support, group classes	"Low intensity" work: brief interventions, psychological therapies, guided self-help	Longer-term psychological therapies; community rehabilitation	Risk management, physical health care
Access	Everyone	Open, self referral	Self-referral and GP referral	GP or secondary care referral	GP or secondary care referral

Prevention, Early Intervention and Health Improvement

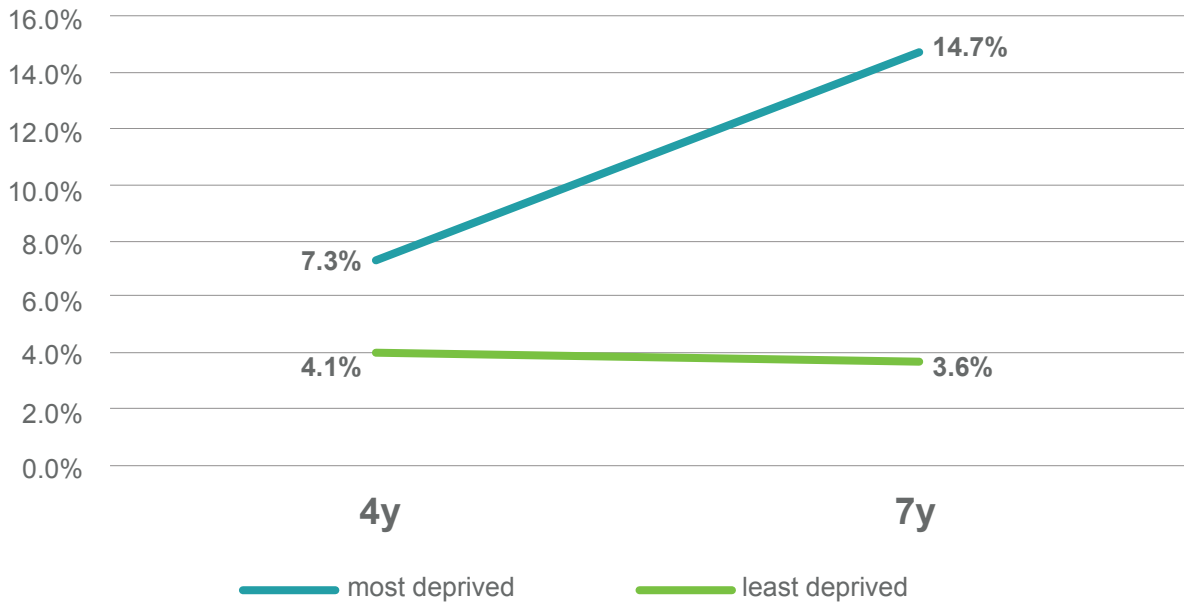
As shown in the Our Population chapter, mental health and substance misuse problems are amongst the leading causes of Years of Life lived with Disability in Scotland.

Suicide is the commonest cause of death in young people aged 20-34 years in the UK.

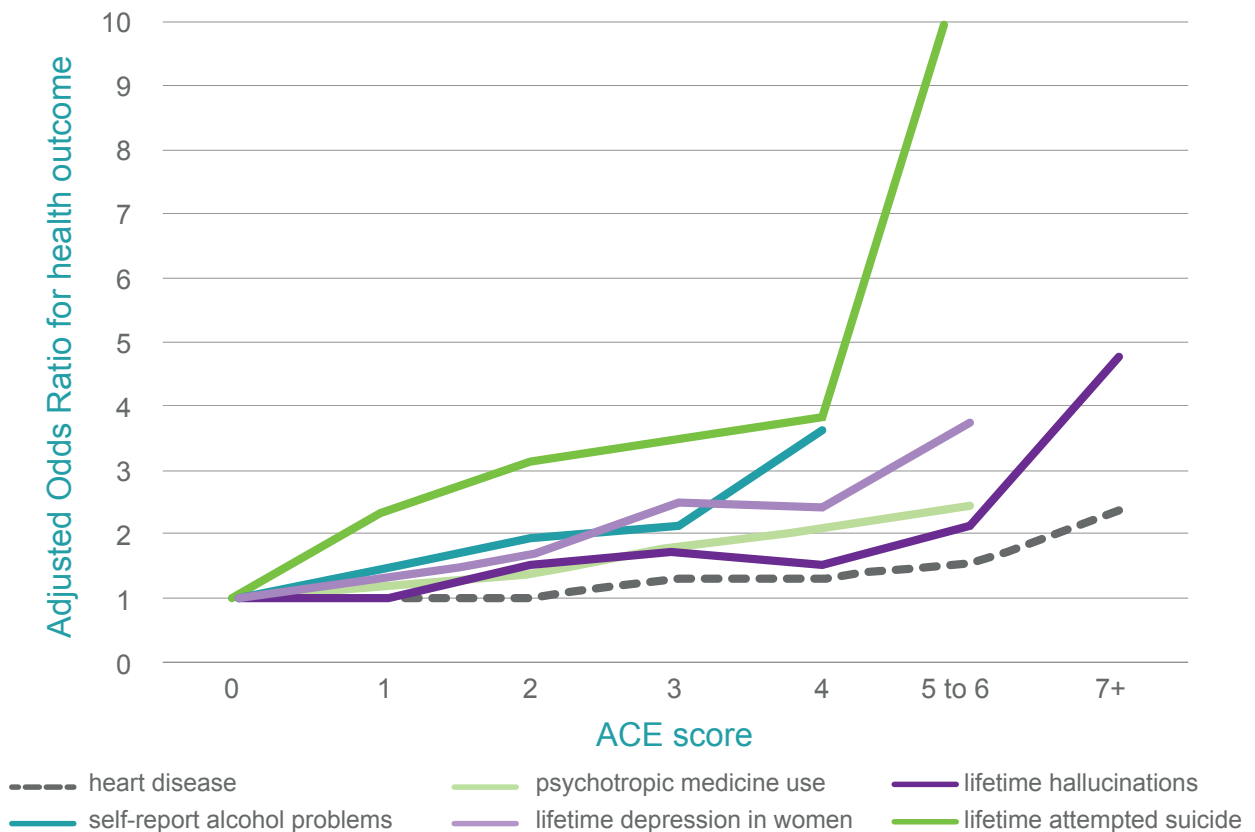
The prevalence of mental health problems is closely linked to poverty, with rates of depression and anxiety in the poorest fifth of the population twice as high as those in the most affluent fifth. Even once deprivation has been taken into account, the West of Scotland has higher mortality than would be expected: two thirds of that "excess" mortality can be attributed to suicide, alcohol and drug misuse and external causes, which includes violence.

Research suggests that half of adult mental health problems have begun by the age of 15, and three quarters by the age of 18. Children living in the poorest fifth of Glasgow households had higher levels of mental health difficulties at age four and this increases over time. By the age of seven, those children had rates of difficulties that were 3.5 times higher than their more affluent peers.

% children in Glasgow with probable psychological problems



Mental illness in children, young people and adults is strongly correlated with exposure to childhood adversity and trauma of various kinds. Adverse Childhood Experiences (ACEs) are an established indicator of exposure to such trauma and an ACEs Hub has been established in NHS Health Scotland to support measures which prevent childhood trauma and adversity, or mitigate its effects.



Early identification and intervention to prevent the effects of long term mental health and other associated illness have system wide benefits in terms of demand reduction for health and social care services.

In order to support prevention and early intervention mental health services should:

- **Work collaboratively** with the ACEs Hub, HSCPs, Education, Criminal Justice, Police, third sector organisations and others to raise awareness of the impact of ACEs and to develop joint approaches to ACE prevention and mitigation
- **Continue to develop and implement suicide prevention initiatives**, including suicide prevention training for all frontline staff
- **Work with Education and other partners** to design and implement responses to conduct and behavioural problems emerging in primary school age children
- **Support community planning partners** to develop and implement strategies to address child poverty within their area
- **Continue to support the MCR Mentoring programme** for care experienced young people
- **Working to support a “trauma-aware” response to service users** with needs and vulnerabilities in relation to homelessness, substance misuse, sexual health and criminal justice
- **Work with multiple partners 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.

Physical Health

The Scottish Government’s Mental Health Strategy 2017-27 confirms that people with mental health problems are more likely to die 15 to 20 years earlier than their peers in the general population from common physical health problems such as diabetes, heart disease and stroke. Addressing this and its causes is multi factorial and will lead to longer and better quality lives for those living with mental illness.

The following developments will seek to address this:

- **Ongoing application of the Physical Healthcare and Mental Health Policy**
- **Improve assessment and referral pathways** to ensure that people with a serious mental illness have their physical health monitored and managed effectively with no barriers to service access
- **Continuing the commitment within mental health services** to a programme of training and development for staff to ensure that the delivery of physical healthcare meets current standards.

Recovery Orientated and Trauma Aware Services

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.

The Scottish Government Mental Health Strategy 2017-2027 promotes peer support as having “added value in Mental Health Treatment Services”. Evidence suggests that mental health can be improved where people have the tools to manage their own health, and are supported to do so.

Our strategy proposes new non clinical approaches to those important goals, building on research and practice from recovery oriented practice around the world. Mental health services will:

- **Collaborate with people with lived experience**, using local mental health networks and Scottish Recovery Network to develop coproduction approaches to promoting recovery
- **Work with partners** to pilot the introduction of Recovery College approach in GGC
- **Develop a model of peer support workers** in community and inpatient settings.

Primary Care

The new GP contract signals significant changes for primary care and it will be important that mental health proposals are aligned to and develop coherently. There are considerable resources available to support mental health in primary care settings, including primary care mental health teams (PCMHTs), computerised CBT, third sector resources and health improvement commissioned resources, such as Lifelink. In particular, there is a need to:

- Work with colleagues in primary care and health improvement to **ensure access to effective resources to support mental health** and wellbeing, including distress
- Ensure **coordination between primary care and mental health services** to support improved physical health for people with long term mental illness.

Community and Specialist Teams

Community mental health teams (CMHTs) have experienced a 3% annual increase in referrals in recent years and will need to ensure they have sufficient capacity to meet population needs as inpatient beds reduce. There is a focus to meet this rise through improvements in productivity in community services without compromising quality of care. This improvement work is examining:

- **Implementation of quality improvement approaches**, working with community teams to manage caseloads and improve productivity
- **The introduction of an evidence based pathway** providing access to programmed care for people with Borderline Personality Disorder
- **Testing and development in a “coproduction” model of a bipolar hub** to improve quality of care for people with bipolar disorder.

Older Adults' Mental Health

The development of services for older people with mental health conditions will take place in the context of wider services for older people. There is scope for a further reconfiguration of the existing inpatient beds, informed by benchmarking against UK comparators, which is being examined through the ongoing mental health planning process. The transition between adult mental health services and those for older people will be managed according to need, services will be designed to provide the optimal provision of care for older people with functional mental illness who are not frail.

Community-based care will be provided as locally as possible, with inpatient care provided from the highest quality facilities. Health and social care services will work in an integrated way to support the shift in the balance of care for Older People's Mental Health.

A stepped care model will ensure that a full range of services are available and services, including supported living and community care, intermediate care, residential care and inpatient clinical care, will be provided flexibly, recognising that care needs change over time.

Pathways for care through a network for people with dementia will be developed to ensure that primary care, mental health, social care and hospital-based and other specialist services can work effectively together.

Substance Misuse Services

Development of a whole system approach to substance misuse services is through local Alcohol and Drugs Partnerships which share a common care governance system and a GGC planning forum. The key areas of focus of this work are:

- **Recovery focussed** specifications across services
- **Implementation of a more recovery orientated system of care** and the development of recovery communities
- **The development of processes and guidance** to support planning and commissioning of evidenced-based prevention programmes
- **Reviewing inpatient bed configuration**
- **Reviewing day hospital services** and improving community interfaces
- **Developing principles in relation to delivery of opiate replacement therapies**, alcohol care pathways, psychiatric co-morbidity and child protection
- **Providing an opportunity for system wide coordination** such as developing approaches to new psychoactive substances
- Supporting measures to **achieve improvements in psychological therapy waiting times**
- **Reviewing alcohol related brain damage services**
- **Refreshing care pathways and actions** to improve interfaces with acute liaison hospital services.

Other areas of development are improvements in the interface between acute, mental health and alcohol and drug services.

Social Care

Commissioned social care services will support the wider system to ensure that people do not stay in hospital for any longer than they need to and that community-based support encourages autonomy, recovery and quality of life for service users. This will require coordinated service models which can:

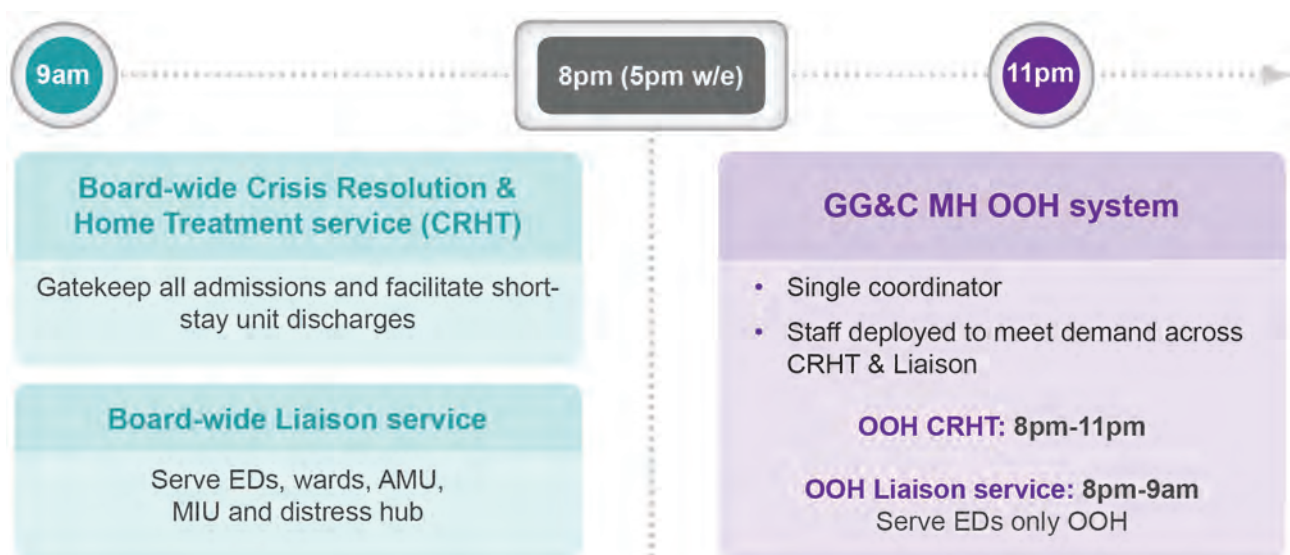
- **Ensure effective interfaces** between inpatient care, care home placements and supported living arrangements in the community to improve patient flow, avoid delayed discharges and deliver appropriate support
- Where appropriate, **access 'step-down' intermediate care services**
- **Review mainstream and specialist care home needs for older adults** currently receiving inpatient care, enabling discharge where appropriate.

Unscheduled Care

Our unscheduled care delivery is based on a prompt and appropriate response to people's unexpected needs. While recognising that some flexibility is required to meet local needs, we need to develop a more standardised approach to maximise efficiency and effectiveness. Our approach includes actions to address this, including:

- **Psychiatry liaison services to acute hospitals**
Provide a single adult mental health liaison service across Greater Glasgow and Clyde, with designated teams working into each acute hospital during working hours, and a coordinated out of hours response via a single point of access to emergency departments 24/7. Services will operate to defined response and accessibility criteria
- **Crisis resolution and home treatment**
Implement Board-wide access to crisis resolution and home treatment teams as an alternative to hospital admission. Teams will operate from 8am to 11pm, 7 days a week, and will offer home-based care visits up to three times daily
- **Out of hours**
A single point of access will coordinate care across all unscheduled activity arising outside normal working hours. A senior clinician will be available to offer telephone advice to referrers, and to coordinate responses from community mental health teams and crisis resolution & home treatment teams (CRHTs) as needed.

Unscheduled care for mental health in GGC



Assessing our Capacity Needs

In developing our long term strategy we continue to examine the balance of care between the community and inpatient provision. For adult mental health short stay beds, this includes attaining optimal activity levels benchmarked against the current exemplar hospital site within Greater Glasgow and Clyde; improving discharge planning and patient flow; and proposed service enhancements that are predicted to reduce demand for inpatient provision. For adult mental health rehabilitation and hospital-based complex care beds (HBCC), account has been taken of Royal College of Psychiatry benchmarks as well as national guidance. The proposals seek to deliver:

- **A reconfiguration of the adult mental health inpatient bed capacity** to enable proposed reinvestment in enhanced community services
- **Development and implementation of an adult acute care pathway** across all adult acute inpatient sites; the application of more clearly defined standards and consistent practice within intensive and high dependency rehabilitation wards; and an aim to move away from hospital-based wards for people requiring long term, 24/7 care
- **A greater focus on addressing delays in discharge** and ensuring a proactive approach to discharge planning. This will include closer integration with community and social care services to ensure joint prioritisation of resources and a smoother patient flow across inpatient and community settings.

Summary

The proposals in the developing vision for mental health services build on the Clinical Services Strategy with the move to a stepped or matched model of care. In summary, there are three themes to the work set out above:

- **Prevention**

Acting to reduce demand through prevention and early intervention, particularly in collaboration with public health, health improvement, primary and community care, and multi-partner approaches to reduce health inequalities.

- **Productivity**

Improving service productivity and efficiency, as well as adopting the stepped care model to ensure services are targeted appropriately and people receive “all the care you need, but no more”.

- **Recovery**

Further shifting the balance of care to support people to live as independently as possible, including greater access to recovery orientated care and in line with assessed need and the stepped model of care, greater consideration of non statutory care and support options. These will be developed with the full involvement of service users and carers.



Balance of care

- **Reduce inpatient beds & lengths of stay**, and invest in alternative forms of health and social care, including Board-wide availability of home treatment



Productivity: specialisation & matched care

- **Enhance capacity** in CMHTs, PCMHTs
- **Extend role** of specialist teams
- **A single Board-wide system** to provide unscheduled care



Transformational

- **Task & Resource Shifting:** recovery-oriented models of care
- **Quality Improvement:** implementation of new models of care for people with Borderline PD & bipolar disorder
- **Culture:** trauma-sensitive care



Prevention

- **ACE reduction**

Chapter 12: Our Workforce

Introduction

NHS Greater Glasgow and Clyde employs over 38,000 staff across a range of occupations and professional groups who are all bound by a core set of values focussed on improving the health and wellbeing of our population. Our staff are key stakeholders in the development and delivery of future healthcare models for our current and future generations.

Moving Forward Together provides the opportunity for us to review our future workforce requirements in order to plan sustainable services which meet the changing needs of our population. The national context and focus on integration creates an opportunity to assess and grow capacity and capability which will allow us to maximise the impact of our skilled and motivated health and social care workforce. In this chapter we will examine our current workforce and our challenges and look beyond these challenges to find solutions, recognising that education, training and workforce changes take time to develop and that early planning is essential.

Background

The Health and Social Care Delivery Plan (HSCDP) published in 2016 marks the beginning of a process to develop that national view of integration. The HSCDP challenges Boards and IJBs to put individuals and families at the centre of planning for services. This will mean a different focus to workforce planning to ensure we deploy our workforce where they need to be, delivering the right treatments and care in the right place and in the right way.

Similar to the projected changes to our population, our workforce demographics have changed, with more staff working longer and there are specific challenges in recruiting and retaining staff across a spectrum of roles and professions. Traditionally, workforce planning has not been managed across the system. Moving Forward Together will mean that we change our workforce paradigm to putting the patient at the centre and planning services in an integrated way to ensure that we strive towards the Scottish Government 2020 Vision where everyone is able to live longer healthier lives at home, or in a homely setting and that we have a care system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self management
- When hospital treatment is required and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Our Current Workforce

The future of health and social care in Scotland sees a move from hospital and residential care toward community-based services. These services are supporting people to, wherever possible, live well and die well, independently in their own homes or in their own communities and on their own terms. One of the major factors contributing to our ability to deliver the 2020 Vision is our workforce who are at the forefront of our services.

Since the NHS was created, the demand for services has changed and health and social care services are providing care for an increasing number of older people.

Our services must keep pace with changing demand and the changing demand profile.

This requires changes to the constitution of our health and care workforce. It requires staff to develop new skills and for them to work together in different ways. For medical and nursing staff, it may mean providing more flexible and complex care outside hospital settings. For GPs, that may mean a more focussed role in caring for people with undifferentiated or complex conditions, with enhanced support from multi-disciplinary teams.

In moving from distinct hospital and community services to a new integrated and networked whole system, our services and workforce will need to work differently at the interface of hospital and community-based care, removing previous boundaries. The step change to achieve the Moving Forward Together vision is based on enhanced comprehensive community services, hospital services focussed on assessment and management of acute episodes and those services being integrated together into a single system.

Working differently in a single system may involve new services, extending existing services, creating new ways of working through inreach, outreach and shared care as well as changes to the way we communicate and share information digitally across the system.

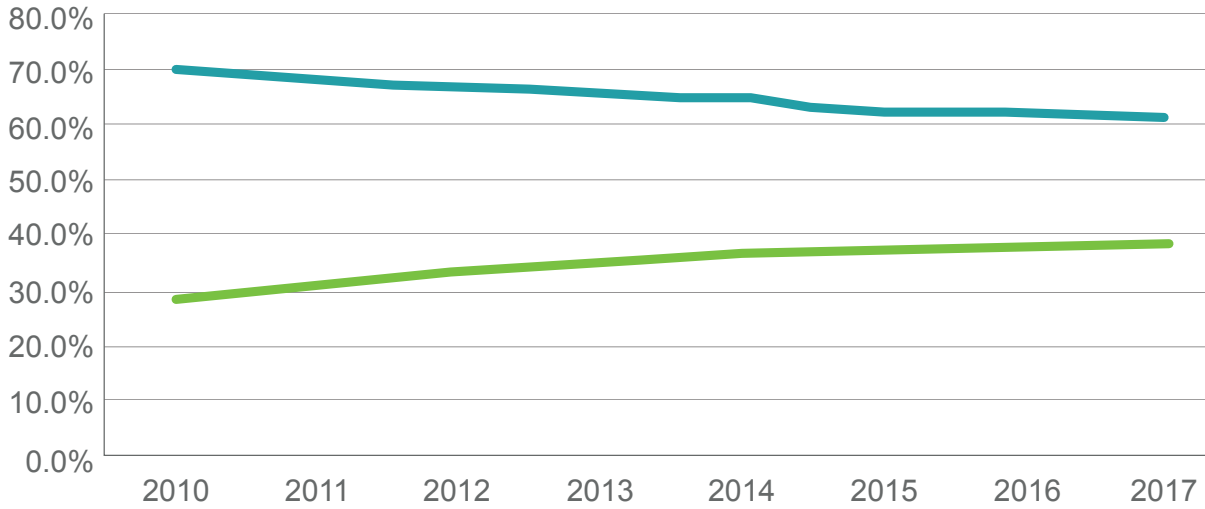
GGC has started to develop integrated services across hospital, community and primary care which include:

- A range of services in care homes, delivered with the support of consultant medical staff, enabling early discharge from hospital
- Development of community rehabilitation teams which enable early discharge from hospital
- Single point of access to HSCP services enabling GPs to avoid referrals to hospital.

Our Ageing Workforce and Changes to Retirement Age

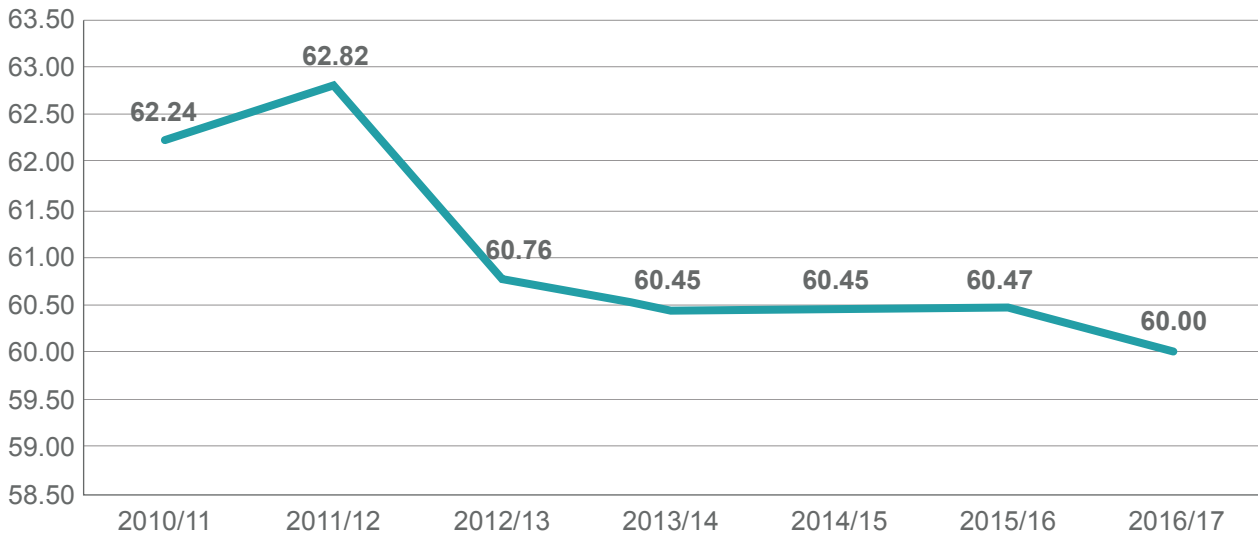
Since 2010 the proportion of our staff over 50 years of age has increased from 29.8% to 38%

NHSGGC % of headcount workforce under and over 50 years old, 2010-2017



During this period the average retirement age has decreased from 62.2 years of age to 60.0.

NHSGGC average age of retiral, 2010-2017



Highly Specialist Retention and Recruitment Issues

In common with a number of health and social care organisations across the UK, GGC is experiencing difficulties in recruiting to and retaining a number of specialist posts. As GGC delivers a number of highly specialist services both for GGC and the West of Scotland this can lead to challenges in meeting the demand for these services.

These challenges go beyond finance as often there is a national or even international shortage of the particular skill set that is required to deliver these services. Often a specialist service will have been built around a small number of highly skilled individuals with the requisite skill set and there is a difficulty in succession planning due to the rarity of this skill set.

Our smaller neighbouring health boards also suffer from this effect and they increasingly run the risk of not being able to deliver services due to staffing shortages. In these circumstances GGC is often asked to deliver the service on behalf of the other health board until it can recruit. In specialist services which rely upon a few key individuals there is a disproportionate impact of a single period of absence. With increasing specialisation and complexity of some procedures this is a growing issue.

Working with the West of Scotland a solution to these challenges may be to recruit to the region and develop a clinical network which works across the health boards within the area.

Junior Doctor Staffing

Recruiting and retaining junior medical staff is an area of great importance. We are continuing to develop solutions to minimise the risk associated with the number of trainee doctors coming into the service.

Seven Day Services

Both Scottish and UK Governments are committed to working with NHS Boards to ensure patients access consistent high quality and safe care during evenings and weekends. As well as more consistent clinical outcomes seven day working makes the most of our infrastructure and is shown to lead to maximum efficiency due to a reduction in variation.

Society as a whole has adopted seven day working as the norm and our services should adapt to turn this challenge into an opportunity for improvement.

Staff Expectations

Many of our current staff have different expectations of working life and there is an increasing demand for flexibility and non linear careers. Many staff require flexibility in working hours beyond the traditional 12 hours shifts to accommodate their domestic responsibilities as a parent, carer or family member.

Training Requirements

When considering the changing expectations of our workforce we also need to take cognisance of the changing expectations of our population.

If we are committed to delivering services which focus on prevention and self care we need to look at how we train and develop our current and future health and social care workforce to support the aspirations of Moving Forward Together. The creation of a new health and social care economy delivered in the community, with inreach to and outreach from hospital may require a different skill set and we need to look at how we train staff and our models of training delivery.

Technology

Embracing the opportunities presented by modern technology changes the relationship between care delivery and location and means more services can be delivered at home or in community settings. This will mean that we need to prepare the workforce in GGC to work in new ways.

Integration of Health and Social Care Staff

The integration of health and social care provides the opportunity to redesign how services are delivered which requires strategies for all areas of our workforce to be aligned.

Integration Joint Boards have responsibility for planning and commissioning services covering adult social care, adult primary healthcare and unscheduled adult hospital care, children's care and criminal justice social work.

Social workers are a key part of the decision making processes that influence safe, effective and person centred care and have core skills in working with individuals to enable people to live well. In considering new ways of working and service models there is a need to look at all professions who are focussed on enablement and who support self directed care and independence.

Our shared ambition is to develop integrated health and social care services which support people to live as independently as possible. Delivering this vision will require new ways of working, redesign of services, new models of care and innovative and flexible approaches to responding to changing demand.

This has significant implications for the workforce we need now and for the future. There are implications not only for staff numbers, but also for the changing roles, skill sets and career pathways across the health and social care workforce.

Health and social care staff must work together in more consistent and effective ways to develop workforce planning activity across our health and social care sector.

Partnership Across Health and Social Care

We will need to work together across the Health Board and Health and Social Care Partnerships to develop proposals for enhanced career pathways across health and social care, recognising the context of the developing multi-disciplinary, integrated workforce environment. The third and independent sectors, as employers of the great majority of the social care workforce, will be essential partners in this work.

Growing our Future Workforce

We recognise our most valuable resource in both health and social care is our workforce.

The future demands on health and social care require services to support individual, families and carers to understand and manage their health and wellbeing. We will require our staff to have a sharper focus on anticipation, prevention and self management, as well as responding appropriately and in a timely manner to individuals who may require escalated levels of care.

We know from engagement with staff that there are multiple opportunities from integration and advancing professional roles that will enable GGC to consider a different mix of staff, competencies and approaches that can offer an affordable solution, which also improves experiences and outcomes for those using our services, such as:

- **Care coordination roles** to join up care and reduce length of stay in hospitals
- **Extended roles** which widen or specialise the scope of professional practice particularly for registered nurses, registered midwives and allied health professionals.

Engagement and Listening to Develop our Vision

We know that we will require our workforce to be skilled and equipped to work in new ways to deal with the changing needs of the population. From the beginning of the Moving Forward Together Programme, we have had ongoing and meaningful engagement with our staff to understand their experiences and challenges from which we have explored innovative new ways we should and could be delivering services across GGC.

NHS Greater Glasgow and Clyde and our six partner local authorities must continue to be forward thinking organisations that attract, develop and retain a highly skilled workforce, to ensure we achieve “**Better Care, Better Health and Better Value**”.

New Models of Care Requires Transforming Roles

NHS Education for Scotland (NES) is supporting the progression of the Scottish Government’s Chief Nursing Officer Directorate Transforming Roles Programme to ensure the most appropriate skilled and flexible Nursing Midwifery and Allied Health Professional (NMAHP) workforce is adequately prepared and supported to help deliver necessary innovations in care.

We recognise the privileged and trusting relationships NMAHPs have with individuals and communities, we also recognise the significance of this in terms of improving health and reducing inequalities. The public health, diagnostic, anticipatory care and prevention roles of NMAHPs are essential to providing and leading services that support personalised care and improve population health.

Moving Forward Together is seeking to create the conditions across GGC where the workforce will embrace opportunities for development, where career pathways are clear and there is encouragement of ambition in order to maximise the potential of each individual and of the professions they represent.

We acknowledge the scope for transformation in future roles and the need for this to be supported by targeted post registration education and continuous professional development that is embedded across career pathways.

We know that NMAHPs in GGC are already making a significant contribution across primary, community and hospital care settings where they often lead care and always add value. However,

there is recognition that to maximise potential we need to learn from and scale up initiatives where we are seeing tangible benefits for service users.

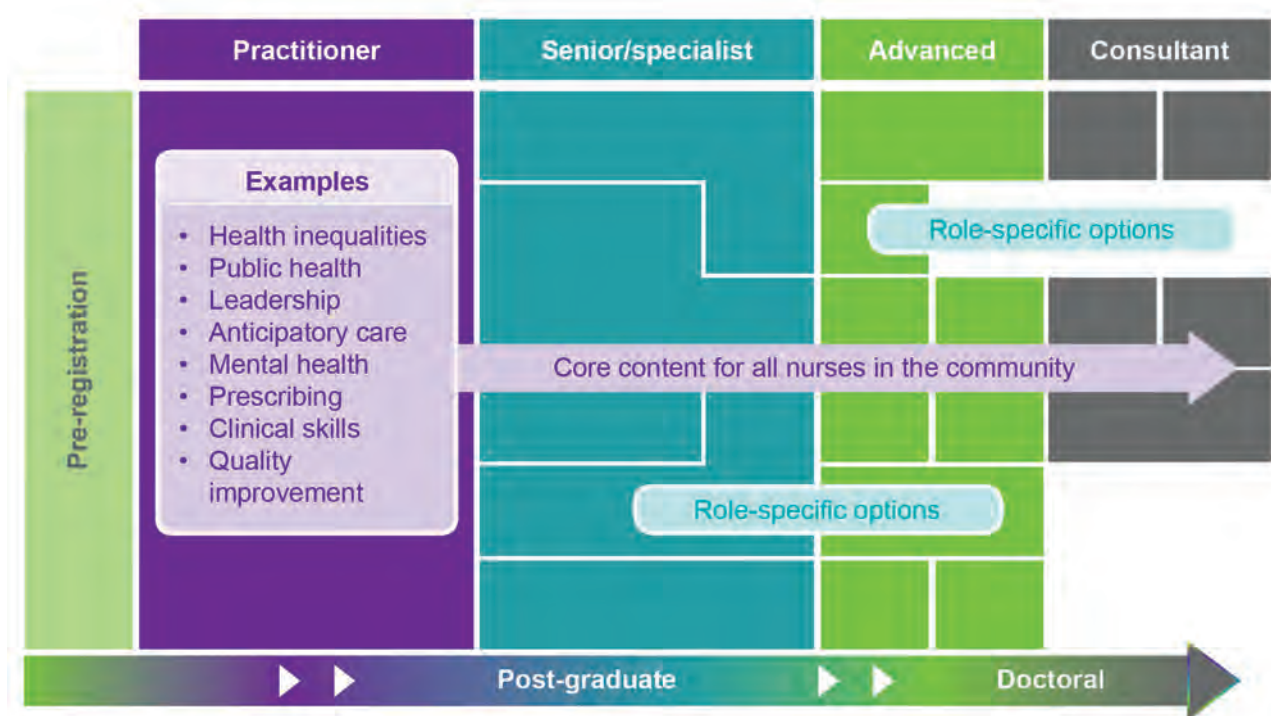
Our staffing must be safe, effective and sustainable in order to provide competent and compassionate care and to ensure consistency all new NMAHP roles must be approved by Chief Nurses or AHP Director prior to ratification by the Board Nurse Director.

The impact and leadership ability of these practitioners is considerable and we recognise their pivotal contribution to managing challenges we face today and also in delivering the future.

NMAHP Roles

There is a broad range of roles, experience and formal qualifications within the NMAHP workforce and the diagram below outlines this from a community perspective. This diagram shows the progressive career from practitioner to consultant by progressive learning from graduate, post graduate on to doctoral level.

Education and career pathway model: Community example



A very prominent theme from most Moving Forward Together service modelling groups was the recognition and potential of NMAHP Advanced Practice roles.

GGC's NMAHP Advanced Practice Strategy provides the route map for the development of advanced practitioner roles. Importantly the strategy ensures robust governance arrangements for consistent application of advanced roles, taking a service needs analysis approach. The strategy also describes the theoretical and practical underpinning of NMAHPs to advance practice, and describes the level of practice.

An advanced practitioner (AP) is an experienced and highly educated registered health professional who manages the complete clinical care for their patient, not solely a specific condition. Advanced practice is a level of practice, rather than a type or specialty of practice. APs are educated at Masters Level (SCQF level 11) in advanced practice and as a clinical leader they have the freedom and authority to act and accept the responsibility and accountability for those actions.

In addition there are nurse practitioners (NP) who have a reduced scope of practice (compared to ANP) and often work in an environment where there is support closer to hand. Educational preparation for this level of practice is usually at honours degree level (SCQF level 10).

GGC also has clinical nurse specialist (CNS) roles. These are registered nurses who have acquired additional knowledge, skills and experience, together with a professionally and/or academically accredited post registration qualification (if available) in a clinical specialty. They practice at an advanced level and may have sole responsibility for care episode or defined client/group. For example, radiology is currently investigating the potential for rapid referral to the falls and frailty service so that interventions can be enacted without the wait for GP radiology reports following an initial short assessment by radiographers who are extending their clinical roles.

Nationally there is recognition that the CNS roles need to be more clearly defined as do the educational requirements and clinical competencies. Work on this will begin through the CNO's Transforming Roles programme later in 2018.

Advanced Nurse Practitioners in GGC

There are currently 130 ANPs working across GGC in areas such as intensive care, primary care, paediatrics and care of the elderly and there are a growing number working in General Practice. At present there are 67 trainee ANPs studying at universities. A similar number are expected to embark on training in 2018/19. The following are examples of advanced nursing practice:

- **There are three nurse-led Minor Injury Units** where ANPs assess, diagnose and manage around 68,000 patients per year. This helps keep the majority of these out of the emergency departments and allows patients to be treated near to home. Virtually all patients are seen, treated and discharged within the Government's target of 4hrs.
- **ANPs also work in the different Assessment Units** including Queen Elizabeth University Hospital's Immediate Assessment Unit, and the Glasgow Royal Infirmary's Acute Assessment Unit managing a range of ambulatory care patients including those with suspected deep venous thrombosis, pulmonary embolism and chest pain. ANPs manage approximately 30% of the medical receiving patients arriving between 8am and 8pm.
- **The Acute Oncology Assessment Unit is also nurse-led** and staffed by ANPs and NPs. Prior to the establishment of the unit, oncology patients who became acutely unwell at home were referred to an emergency department to be seen by the general receiving physicians before being transferred to the Beatson Oncology Centre. Patients are now referred directly ensuring early access to specialist care.

There are ANP roles in some orthopaedic, oncology, cardiology, care of the elderly and addictions wards who work closely alongside medical staff and the nursing teams. ANPs can clerk patients onto the ward, ensure investigations are undertaken and request additional investigations as necessary. ANPs can prescribe for patients and ensure that clinical management plans are implemented, in addition ANPs can act as the first point of contact if a patient becomes more unwell, initiating investigations and treatment as required and escalating care if their initial interventions were unsuccessful.

In both the Royal Alexandra Hospital and Inverclyde Royal Hospital ANPs form the backbone of the Hospital at Night teams. ANPs are called to see patients whose condition has deteriorated or who ward nursing staff are concerned about. Without ANPs on these teams more medical staff would be required to provide the same level of care.



I work as a Hospital at Night (H@N) Advanced Nurse Practitioner within the acute sector of NHS GGC. This role is predominantly a clinical role which involves clinically assessing and managing the care of acutely unwell patients in the out of hours (OOHs) period. This involves initiating and evaluating investigations such as chest X-rays, arterial blood gases, 12-lead ECGs and various blood tests, prescribing medicines including fluids, analgesics, diuretics, antibiotics and referring patients to higher levels of care as required including high dependency and intensive care. The role also involves supporting and educating the ward nursing staff and supporting junior medical staff. ANPs are educated at Masters level in preparation for this type of role”

Advanced Allied Health Practitioners in GGC

Across GGC there are a variety of advanced AHP roles along the continuum of primary through to secondary care. Allied health professions is an umbrella term used to cover a diverse group of autonomous practitioners who work with many other professionals at various points along the care pathway. They include physiotherapy, occupational therapy, radiography diagnostics and therapeutics, orthotics, podiatry, speech and language therapy, dietetics, orthoptists, prosthetists and most recently paramedics. While these are grouped together under the collective ‘AHP’ banner, it is important to note that these are distinct professions with diverse roles each having a unique skill set.

Whilst the national strategic direction for AHP advanced roles mirrors that of nursing, the AHP Advanced Practice (AAP) is a level of scope of practice, underpinned by the following agreed definitions, one for a specialist role and the other for a generalist:

Specialist Advanced AHP practitioner is an experienced and educated registered AAP. They have a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a post registration master’s level education. Advanced practice embodies the ability to manage the complete clinical care in partnership with the patient and their carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance patient experience and improve outcomes i.e. Advanced AHP Paediatric practitioners and AHP reporting radiographers.

Generalist AAP are as above, but manage the complete clinical care of patients, not solely with one condition, as a clinical leader they have freedom to act, and are responsible and accountable for their actions. Their high level of practice is characterised by assessment, diagnosis, treatment, including prescribing, of patients with complex, multi-dimensional problems. High level decision making is evident, with authority to refer, admit and discharge, within appropriate clinical areas’ i.e. Advanced AHP practitioners in older people’s care.

There are many examples of AAP roles within GGC and areas where development of such roles would be of great benefit to service provision. We currently have AAP roles within radiography, podiatry, physiotherapy, and dietetics across primary and secondary care settings. Dieticians are involved in the management and follow up of adults newly diagnosed with coeliac disease without the need medical staff involvement. Speech and language therapists have a lead role in the management of patients following a laryngectomy providing a voice prosthetics service and ongoing review in an Outpatient setting.

Within GGC there are a team of reporting radiographers who provide a musculoskeletal (MSK) plain radiography reporting services across the Health Board. The team was able to report almost 79,000 examinations in 2016-17. Beyond the obvious task of reporting the X-ray, the radiography team alert referrers to unexpected findings on images and direct them where further imaging is required. This work supports radiologists, allowing them to focus on more complex interpretation /examinations, so indirectly aiding the movement of patients through hospitals and helping to ensure patients receive the right treatment either at home or when necessary ensure well-timed interventions are enabled in the hospital environment.

Within orthopaedics across GGC, physiotherapy and podiatry AAPs are specialist clinicians who have undertaken additional training and work in a similar role to the consultants within outpatients. Their role is to assess patients referred for orthopaedic review from GPs, MSK physiotherapy and other specialties e.g. rheumatology. These advanced practitioners will examine and assess patients referred for surgical review. They are able to organise further investigations including X-ray, MRI, nerve conduction tests and discuss the results of these investigations and the treatment options available to the patient.

If further intervention by surgery is indicated, the AAP will discuss this during the clinic appointment and place the patient on the appropriate inpatient waiting list, without the need to discuss the case with a consultant. If other management options are more appropriate, for example, onward referral to other services, this can also be organised directly by the APP. The APP's job plans are such that they all work in two or more joint specific clinics e.g. shoulder, knee, foot and ankle allowing greater flexibility for the management of waiting times. The volume of outpatients managed directly by the podiatry and physiotherapy AAPs in this specialty amounts to over 50% of the outpatient orthopaedic activity in some sectors. This has allowed the medical staff to reduce the number of their outpatient clinics and increase theatre capacity.

Workforce and Integrated Teams

Moving Forward Together recognises the value and necessity for enhanced and expanded multi-disciplinary teams in which the NMAHP contribution will be critical. We should seek to maximise the NMAHP contribution within these teams and enable professional and teams to work differently, across traditional boundaries.

The team will require skills and competencies around mental, physical health and social needs in addition to providing generalist holistic care. This team would provide the first tier of assessment, care planning and treatment as appropriate to an individual's needs. The team would be able to request assistance, having support and access to specialist and /or expert practitioners when required. Where possible, teams would be aligned to GP clusters within localities and have a good understanding of population need and services available within the community.

GGC NMAHP professional leaders are clear that more work is required to explore and agree common core skills, competencies and capabilities locally as such are engaged with colleagues nationally to progress this as part of the CNOD Transforming Roles Programme.

Whilst the new GP contract presents positive and exciting opportunities for change particularly in relation to the role of General Practice Nurses (GPN) further work is required to explore their contribution within an integrated care model.

Whilst GGC welcome the opportunities for change the robust governance in place for NHS staff is not always replicated for GPNs employed by independent contractors. As we move into a more integrated way of working it is clear that a strong learning and development pathway is required for GPNs to provide sturdy benchmarks of education with pathways to career progression.

Integrated health and social care provides opportunities for improved and innovative ways of working by GPN and other health professionals. We must continue to push traditional boundaries and professional roles in order to transform service provision. An excellent example of integrated working is the Inverclyde New Ways test.

The district nursing workforce will be a key part of the team, delivering care which is integrated from the point of view of service users, to ensure high quality person centred care and co-ordination. Their skills and leadership will be essential within the transformation of the multi-disciplinary model for integration care.

The new GP contract will see a significant shift of work from GPs to the wider healthcare team and in order to meet the growing demand it is essential that the NMAHP workforce including physiotherapy, occupational therapy, dietetics and district nursing is adequately resourced to meet the challenge. These resources include not only personnel, but staff with the skills to competently carry out the changing workload.



My day is broken into 15 minute appointments. Patients are 'sign-posted' by reception staff and may include people with acute exacerbations of asthma and COPD, or chest pain as well as many minor ailments. The conditions I see cover from head to toe and include all systems. I'll diagnose a wide range of conditions including diabetes, hypertension, urinary tract infections, respiratory infections and a wide range of common skin conditions. Frequently I'll refer to secondary care either for emergency admission or to clinics such as the rapid access chest pain clinic. Many patients also attend for advice about starting contraception, menopause and pre-pregnancy planning. Part of the day is allocated for checking test results and reviewing treatment plans. This may involve titrating medicines to comply with protocols or referring to specialist nurses such as diabetes, heart failure or respiratory Clinical Nurse Specialists. Auditing aspects of care provided by the practice and clinical supervision of nursing and support staff are also part of my role. ”

General Practice ANP

NMAHPs Contribution to Delivering the Future

This section has provided some examples of how we are advancing professional roles and pushing professional boundaries in GGC, along with tangible examples of how we have improved experiences and outcomes for those using our services. Whilst these developments and future opportunities to transform roles enhance career options is welcome, it is essential that we remain attentive to our existing workforce at every point of service provision and do not inadvertently destabilise this.

Our workforce is our greatest asset to successfully deliver the vision for people in Scotland to live longer, healthier lives at home or in a homely setting. We must ensure we succession plan effectively and promote a career in health and social care as a positive and attractive career option. It is equally importantly that we continue to value, support and care for our existing workforce ensuring they have capacity and capability in order to provide safe, compassionate and effective care.

Consultant Staff

A key focus of Moving Forward Together is enhancing non medical roles for health professional to take on roles traditionally performed by consultant medical staff. The main change for hospital consultants will be the need to engage more with community delivered services and become less hospital focussed. We are also trying to promote the concept of specialists as part of the extended multi-disciplinary team to manage patients as near home as possible.

The use of technology and virtual clinics will create further opportunities for consultant staff to work differently in delivering person centred care using the eHealth infrastructure. In some areas the Moving Forward Together models on tiered care will create opportunities for increasing specialisation for Consultant medical staff within our specialist centres, for example trauma centres. The Programme will create opportunities for NHS Greater Glasgow and Clyde to offer a range of career options for consultant staff and place the Board in a strong position to recruit and attract medical staff for the future.

Diagnostics and Other Staff Groups' Contribution

NHS Greater Glasgow and Clyde has invested in our diagnostic services (including Laboratory Medicine and Diagnostics imaging) to improve patient experience and diagnosis. We have already in place a range of services including extended working for Diagnostic imaging which enables patients to get results quickly and commence treatment. Our Laboratories provide key services including the Microbiology Reference Laboratory for the West of Scotland and genetic testing for Scotland as well as a range of services for the West of Scotland. Moving Forward Together provides an opportunity for us to look at how we utilise our Diagnostic services and consider how we can support community-based teams in accessing diagnostics capability more locally.

General Practice

The new GP contract is supported by a commitment to extending the multi-disciplinary team in support of general practice. This requires the development of additional capacity and new roles, with a focus on the following:

- **Pharmacist and Pharmacy Technicians**
- **Advanced Practice role** including ANPs, Paramedics, and Advanced Practice Physiotherapists
- **Treatment Room Services and Phlebotomy** including Healthcare Support Worker and Nursing roles
- **The Vaccination Transformation Plan**, developing the workforce within HSCPs to carry out immunisations and vaccinations
- **Community Linkworkers**: working with third sector organisations
- **Mental Health Workers**.

These new multi-disciplinary team members will be employed by the Board, and will be aligned to practices or groups/clusters of practices. Existing practice staff will remain employed by GP practices.

This is a major new development which will challenge and transform the roles of staff in practices and across the HSCP, with a need to develop effective team working arrangements and relationships. As part of the development of the framework for the PCIPs, the following principles were agreed:

- **Approaches across GGC should share consistent principles and pathways**, role descriptors and grading, scale (numbers of staff per practice/ patient population)
- **Re-design of existing roles** should be considered alongside new recruitment
- **Recruitment should be co-ordinated across GGC** where appropriate taking account of existing professional lead and hosting arrangements.

Workforce plans will need to be developed in support of the PCIPs which particularly address the following issues:

- **Availability of staff** in the key professional groups
- **Training places** at all levels
- **Access to training**, support and supervision for advanced practice and prescribing
- **Skill mix and balance** of roles within the teams
- **Impact of increase in workforce requirements** for the multi-disciplinary team on other parts of the system, particularly for roles with high demand
- **Team development** to enable new roles to work effectively together.

In addition, the core general practice workforce needs to continue to be supported and recruitment and retention of GPs remains a significant challenge, alongside pressures on the Practice Nursing workforce.

The most recent national primary care workforce survey at the end of 2017 showed a GP vacancy rate of 3.5% in GGC. This compares to 5.6% across Scotland. Practices report recruitment challenges both with salaried and partnership posts, and in particular in recruiting locums for short or long term absence. The profile of the practice nurse workforce shows impending challenges as a significant number approach retirement.

Recruitment to all specialty training programmes is becoming increasingly more difficult but particularly so to GP specialty training programmes. The majority of vacancies are within the four year training programmes in the West of Scotland Region.

In an effort to improve the recruitment of GPs, the Scottish Government introduced two initiatives.

- **In October 2015 the First Minister announced an increase in the number of training places for GPs by 33%** - from 300 to 400, starting February 2017. These new posts would be 3 years in rotation but would continue to offer 18 months in General Practice
- **An enhanced payment of £20,000 for successful applicants** who chose a training programme within one of the hard to fill areas such as posts deemed as remote or rural.

We will therefore continue to work with NHS Education For Scotland and other national bodies on supporting recruitment and development of GPs, practice nurses and the wider practice team, building on local initiatives such as the Pioneer Scheme and working with our training practices.

Other Staff Groups

We recognise the contribution of managers, support staff, porters, and domestics, secretarial staff and all other occupations in helping deliver the Moving Forward Together Programme. We will support our leaders in the skills and capabilities to lead and manage change in their teams and in engaging with the wider workforce to achieve the aims and ambitions of the Moving Forward Together Programme.

Chapter 13: Next Steps

The Moving Forward Programme has allowed us to describe a vision of future health and social care services which we believe will allow us to meet the challenges of our changing population needs and ensure we are working together to put our people at the centre of their care.

Transformation and Transition

We recognise our vision will not be delivered overnight, however Moving Forward Together gives a clear direction and strategic framework within which we can make decisions and changes which will in time deliver that vision. It allows us to develop options for the use of our resources against agreed strategic priorities which will help us move toward our vision.

While delivering change is more challenging in the face of current and future resource pressures, we cannot stand still as we cannot continue to do things in the same old way(s) if we are to continue to improve and evolve our services to meet the increasing demands placed upon them. We must continue to change how services are organised and delivered and we must do so if we are to face up to, and meet, the challenges. As we develop options for change these must be deliverable in the short term and transformational in the medium and long term as we move toward the whole system vision.

Moving Forward Together is a strategic blueprint for the future which we believe offers better care for our population. It is a framework within which to make decisions on investment and changes to the allocation of our resources. Having that strategic blueprint provides a common purpose and the assurance that movement in that direction will in time deliver a better care system.

Delivering the Vision

In publishing this vision we are sharing our thinking on what our research has told us and what we have heard from the public, our staff and stakeholders. We have demonstrated the need for change and described our long term vision for an integrated sustainable, safe, high quality and person centred system of health and social care.

Delivery of this vision will require change. Some of this change is already ongoing. Some of this change will be small and can be delivered quickly. However the delivery of our long term vision will require significant and complex change. As we develop these changes we must not only assess their long term impact but also the short term impact on the continued delivery of our services during transition. We cannot stop providing care during these changes nor can we expect large scale investment as an enabler.

Strong and consistent leadership will be crucial. We will require our leaders across the whole system to champion these changes and to manage the balance between driving change whilst maintaining a high quality ongoing level of service.

We will need our staff to work together across the primary, community and hospital-based and specialist care boundaries. We need to make these boundaries porous to our staff and invisible to our population.

As we consider our options for each change we must develop all the detail on deliverability, transitional cost and short and long term impact in order for us to engage with our stakeholders to agree the best implementation choices. We need to do this in partnership to ensure that we consider the impact of changes across all parts of the system, and do not unintentionally shift challenges and pressure from one part of the system to another. That is the benefit of whole system planning. We should no longer see pressures shifted from one part of the system to another. We will need to work in partnership with the Board's advisory structures, staff partnership, our HSCPs and our communities in order to do this.

Each of these decisions must be taken within the context of the whole integrated system and ensure that our change process is synchronised across our network of care. The balance between business as usual and transformational change will be a challenge and we recognise the tension between these elements.

There will be local impact and this must be seen within the context of the whole system and our vision for the whole population.

There is much work to be done before our vision is realised and the publication of this document is a very important first step.

Moving Forward Together is our opportunity to design and deliver a new system of care which will meet the needs of our population in the future and we must rise to the challenges that opportunity brings.

Next Steps

Having developed this vision for health and social care services across GGC, we are now seeking the approval of the NHSGGC Health Board to:

- **Support us in Moving Forward Together to develop**, in partnership with our wide range of stakeholders, a series of fully detailed and costed proposals for consideration which will support progress toward the ultimate realisation of the vision described in this strategy
- **Develop a cross system structure** empowered to generate these proposals through executive, managerial and clinical senior leadership and engagement with our population, our operational staff and advisory structures.

We would seek to continue the inclusive approach to option development we have used in developing our vision and use the relationships we have built during this process.

It is envisaged that the delivery of our vision will take three to five years to implement.

If approved, the proposed first phase of this development process would focus on taking forward the Programme and identifying priorities for the first tranche of proposals in primary, community, hospital and specialist care.

The whole system approach described in the Moving Forward Together vision would be adopted across planned and unscheduled care as well as in working with the West of Scotland Region to develop proposals for specialist services through regional clinical networks.

An early focus would be on determining the maximum potential of our community networks in delivering care to our population in their communities and the impact that will have on the future capacity and services within hospitals and other specialist services.

Phase One: July to October 2018 Setting Priorities and Scoping Change Proposals

- Seek IJB confirmation that this framework aligns with their strategic plans
- Establish priority changes which support delivery of the vision
- Develop and establish a structure based on the priorities and commission work streams and short life working groups.

Phase Two: November to December 2018 Develop Option Appraisal and Recommendations for Prioritised Areas

- Develop prioritised options for the delivery of changes with stakeholders
- Complete option appraisals on proposed changes
- Develop business cases for preferred changes
- Assess whole system impact and coherence
- Seek NHSGGC Board and IJB approval, as appropriate, for first tranche of proposed changes.

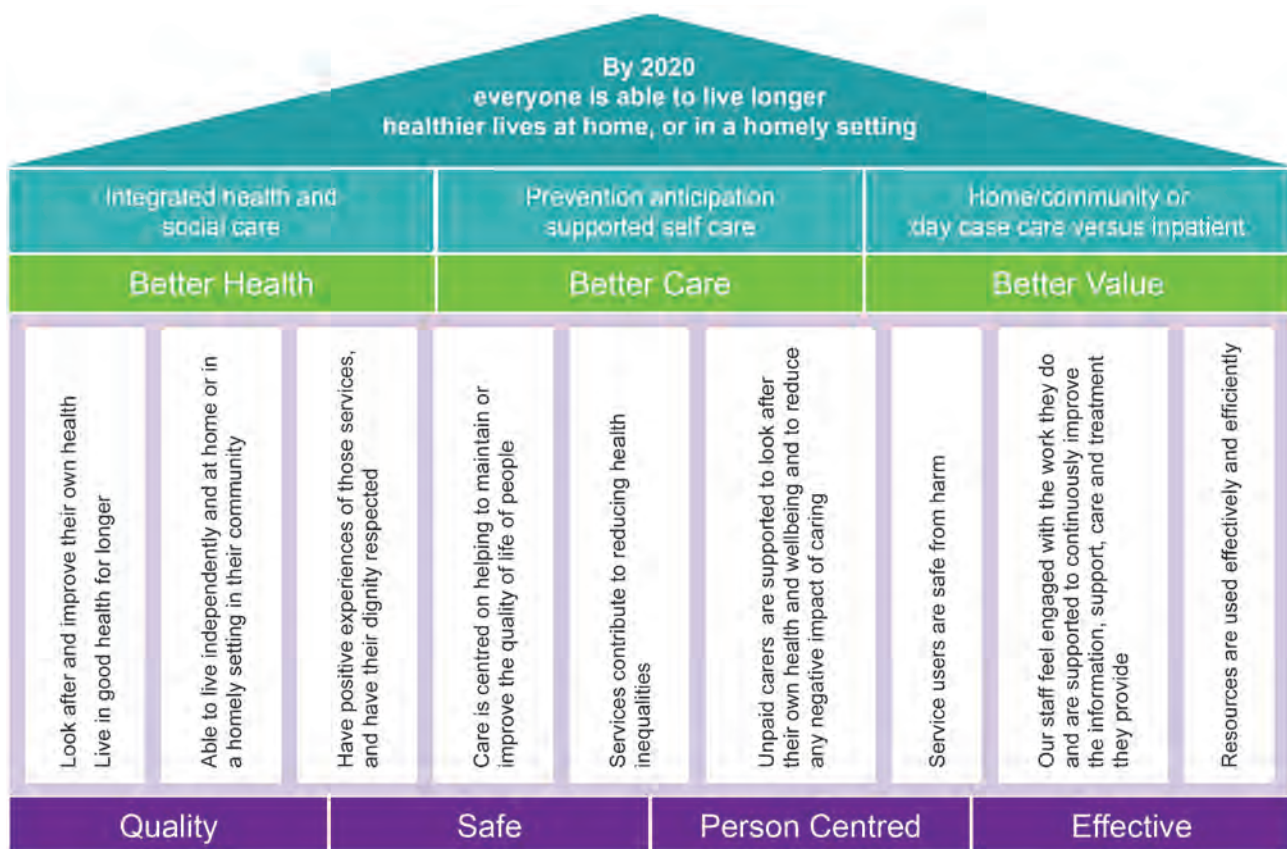
Phase Three: January 2019 onwards

- Continue to develop implementation plans for approved priority changes
- Continue to assess impact and benefit realisation
- Extend scope to next priority areas.

Each of these proposals will be aligned to our Moving Forward Together principles and will be tested for strategic alignment with our Cathedral of Care.

Our Principles

- Aligned to national strategic direction
- Consistent with West of Scotland Programme
- A whole system programme across health and social care
- Using the knowledge and experience of our wide network of expert service delivery and management teams
- Involving our services users, patients and carers from the outset
- Engaging with, and listening to, our staff and working in partnership
- Embracing technology and the opportunities of eHealth
- Affordable and sustainable.



Annex A: Tiered Approach to Hospital-based Services

A Population-based Approach to Planning Hospital-based Services

In *Moving Forward Together* we have adopted a methodology which builds a tiered network approach across health and social care spanning a local and community-based element which can then escalate care as required into specialist or hospital-based care. The ethos across this network being focussed on delivery of anticipatory care and early intervention to enable care is delivered as locally and as early as possible.

In the hospital-based element of this care network we have described a series of tiers of care. We have worked with our service modelling groups to develop and refine these tiers of care.

Through this process we have developed and agreed a tiered level of service delivery and supporting infrastructure which is characterised by:

- **In the local tiers**, the need for low complexity and lower acuity services to be provided at home or as close to home as possible
- **In the increasingly complex tiers**, the need for complexity and higher acuity services with relatively low incidence to be provided for a population at the minimum number of locations commensurate with the size of population served.

This framework of tiers of care has served as the mechanism through which we have described the differing specialty service delivery requirements in terms of colocation and interdependency.

This mechanism can be considered in three steps which were followed to develop and agree a tiered level of service delivery and supporting infrastructure

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

The hospital sector was described in tiers for each of the following care groupings, unscheduled care, planned care, rehabilitation/older people's services and cancer services.

Annex B: Moving Forward Together Top 100 Transformational Articles

During Phase One of the Moving Forward Together process the GGC library network were tasked with collating examples of transformational change in health and social care from around the world that could support the discussion on developing our GGC Vision.

The list below provides links to the 100 most influential or helpful articles from that search. All of the articles are available at www.movingforwardtogetherggc.org

- The GP Contract for Scotland
- NHS England » System change (STPs and ICSSs)
- NHS England » General Practice Forward View
- Hospital-integrated general practice to reduce inappropriate ED use in Switzerland
- After hours primary care in the Netherlands
- Community services transforming care in England
- Transformation of care and support in England
- Transforming social care through information and technology in England
- Integrated care and support in England
- Reimagining community services in the UK
- Social care reform in England
- Changing models of health and social care in Scotland
- Staff at the heart of new care models in the UK
- Delivering sustainability and transformation plans in England
- Realistic medicine in Scotland
- Choosing Wisely UK
- Interprofessional model of self management support in complex long term conditions in England
- Intentional whole system redesign in Alaska – Nuka system
- Learning from Canterbury New Zealand integrated model of care
- Some assembly required – implementing new models of care
- Will moving care out of hospitals save money in the UK?
- House of Care – a framework for long term conditions in the UK
- GP one cluster networks in Wales use anticipatory care
- Population approach to integrated care in Valencia, Spain
- The Modern Outpatient in Scotland
- The Modality Partnership in Sandwell and West Birmingham
- Technologies that will change health and care
- Red to Green Days at Ipswich Hospital
- Heart failure integrated care in the UK

- ‘Virtual consultants’ to reduce outpatient appointments in Cheshire
- Right critical care at the right time in Wales
- Teledermatology in practice world wide – a review
- Integrated dermatology service in Huddersfield
- The future of diabetes Diabetes UK
- GP Federation model for diabetes from North East Essex Diabetes Service (NEEDS)
- Super-six-diabetes-model in Portsmouth
- Query Cancer patient self referral scheme in South Manchester
- Multidisciplinary Diagnostic Centres for earlier cancer diagnosis in London
- Achieving world class cancer outcomes – taking charge in Greater Manchester
- Using technology to improve cancer care in the USA
- New care models (vanguards) for health and care in England
- Integrating cancer care across the patient pathway in Canada
- Telemedicine to support outpatient palliative care in advanced cancer in Brazil
- Multidisciplinary fast track oncology clinic for gastrointestinal symptoms in the Netherlands
- Nurse led telephone supportive care following oesophageal cancer surgery in Sweden
- Nurse led telephone follow up for prostate cancer in England
- ENT preop assessment combined with listing clinic in Sheffield
- ENT national implementation plan from Wales
- ENT hub and spoke model in Mid & South Essex
- Self management in inflammatory bowel disease in Clyde
- Nurse led fast track service for bowel disorders in London and South East
- Getting it right first time for general surgery in the UK
- Tiered hospital structure for upper gastrointestinal surgery in the UK
- New hospital structure including elective centres in Dorset
- 6 Essential Actions to Improve Unscheduled Care in Scotland
- Integrated care for older people with frailty in the UK
- Fit for frailty UK
- Making our health and care systems fit for an ageing population in the UK
- Integrated care pathway for frailty in NHS England
- Living Well in Communities
- Collaborative care models for patients with severe mental health problems in Australasia
- MSK & orthopaedics quality drive in Scotland
- Patient initiated follow up in Morecambe Bay
- Separating elective and emergency orthopaedics in South West London
- Physiotherapy roles in musculoskeletal disorders: a review from Australia
- Orthopaedic Surgery - Getting It Right First Time - GIRFT
- Digital self management interventions for asthma – a review
- Telerehabilitation for cardiopulmonary disease – a review

- Best practice for COPD in Scotland
- A single respiratory service in Manchester
- Health and social care delivery plan Scotland
- Rheumatology case studies of good practice in the UK
- One stop integrated rheumatology service in Finland
- Remote home management for chronic kidney disease – a review
- One stop clinic for urology in Luton
- Advancing technologies for kidney disease in the USA
- Regional model for vascular care in New Zealand
- Models of care for people with multiple conditions in the USA
- Many diseases, one model of care in Europe
- A model of care for people with both diabetes and chronic kidney disease in Australia
- Multimorbidity – What do we know? What should we do?
- Multimorbidity care model from Europe
- Addressing complex needs through primary care social work – a review
- Improving the appropriateness of prescribing in older patients – a review
- Expanding pharmacy roles in general practice in England
- Community pharmacy extended role with heart failure patients in Greater Glasgow and Clyde
- Pharmacist roles in the management of diabetes – a review
- Telephone pharmacy to improve medicine adherence in the UK
- Early physical therapy for back pain in the USA
- Dietetic therapy in primary care – a review
- Occupational therapy led self management support for people with multimorbidity in Ireland
- Patient direct access to physiotherapy for musculoskeletal pain in the UK
- Telephone physiotherapy advice in Bristol
- Physiotherapy by Skype in Australia
- Nurse led programme to preserve function of older people in the community in the Netherlands
- Interventions as alternatives to the emergency department for older people – a review
- District nurse role in advance care planning in the UK
- Most Canadians die in hospital yet many desire to die at home
- Nurse case management for older people with myocardial infarction in Germany
- The future of community nursing – hospital in the home in London

Annex C: Moving Forward Together Engagement Summary

In Moving Forward Together we engaged with people, our staff and other key stakeholders to coproduce, develop and refine our shared vision for an integrated health and social care system. We have worked to inform and engage with; our people to hear and understand their needs and our staff to access their knowledge, expertise and ideas to shape how we might develop new models of care.

What We Heard

We used a variety of methods and materials, detailed later, to inform and engage with people and staff about the Programme to enable us to hear their feedback

Feedback From People

A set of questions, developed and tested with a Stakeholder Reference Group, were used to provoke thought and frame engagement with people about the Programme asking if they understood the rationale for change, agreed with the proposed direction of travel, for their views on increasing use of technology; and if they had any other thoughts or comments.

A log of engagement was developed to capture and record all comments that people provided about the Programme. We received over 450 comments about the Programme.

In summary what we heard was that the vast majority of people were aware of the changing demographics, subsequent rising demand and that this was putting substantial pressure on health and social care services. People welcomed the opportunity to start having open dialogue about the affordability, feasibility and sustainability of future health and social care services and expressed a need to be fully involved in the process of determining what these might look like.

“What I’ve heard across all the meetings has provided hope for the future and I’m glad to see and be part of all the work done in the background to ensure high quality services.”

“It’s about ensuring that we have an opportunity to influence things”

Beyond the ageing population, people also recognised that there was a culture about how people use and access services and an expectation to be seen by a limited number of professional groups as ‘the experts’ rather than appreciate the range of skilled practitioners available.

“Long held perception that hospitals are the best place to be as that’s where the specialists are will need to be challenged along with the belief that you need to see a doctor for expert advice.”

“There are difficulties accessing other services, but people know they will be seen at A&E by a professional.”

“Culture change is a great idea but very difficult to effect, great to hear the speaker explaining about NHS history to illustrate why we need change and what hospital culture is, didn’t realise this before.”

People expressed a genuine understanding that resources are limited and that doing ‘more of the same’ was not a realistic option. However, some did question the availability of local services and access to more centralised services if having to travel from out with Glasgow; others expressed initial views that transformation is another way to save money; and some said that other community planning partners such as housing need to be more involved.

“Use measurements i.e. the cost of prescription paracetamol equal to nursing hours. Make it meaningful. Services are stretched.”

“Centralisation in Glasgow and the cost of this, what about the cost of travel for people from elsewhere”

“[Programme] Cannot be seen as being about cutting services but about improving services”

The early concepts and examples for new ways of working and the use of technology were well received, however efforts would need to be made to support people to understand any new pathways; and that technology should not ‘leave behind’ or become a barrier to those not able to use it.

“Having more services closer to home that promote independence is positive, but in complex cases people either need to be empowered to coordinate their own care or someone should be assigned to do this.”

“If people are better informed then they will be empowered to manage their own health better.”

“Not only fixing the immediate problem, but helping people improve their health is a very positive approach.”

“There is potential joining with Health and Social Care integration and opportunities to make things more joined-up and much better for those using a whole range of services.”

“If the public were made more aware of the much better outcomes, then the majority of people would be okay with having to travel to a specialist centre.”

“One day we’ll have all the details about our health on our phones and we’ll be more in control of it. I personally can’t wait.”

Feedback From Staff

A set of questions, developed via a Workforce Reference Group, were used to shape and encourage discussion on and seek views from staff about the following:

- What do you see and do we have the right answers?
 - Do you recognise the challenges?
 - Discuss how we are planning to meet the challenges
 - Do these feel like the right things to be doing?
 - What might these changes mean for you or your service?
 - How can you help to make the changes successful?
- How can technology enable change?
 - What opportunities do technology and innovation create to organise your service differently?
- General questions, comments and feedback.

In summary what we heard was that the majority of our staff recognise the rising demand and the subsequent pressures that this places on how they are able to provide treatment and care. They absolutely understood the need to look at how we might work differently through better integration and by shifting the balance of care, but that we also need to support the public in understanding the changes required.

“The ‘vision’ needs to match the decisions being made - investment in community resources, plus the voluntary and third sector agencies.”

“Things have to change, but we need to better manage public expectation.”

All acknowledged the need for better integration and closer working across specialties, services and settings to enable the system to be more seamless to people. In some areas they had already begun to work differently by moving services out of hospitals into communities and people’s homes. Others reported better team working and improved effectiveness by sharing resources, but primarily efficiency was realised through sharing information or investing in technology. Where this has worked we were told we need to share practice more widely or enable others to easily adopt good practice.

“Engage with staff. Need stories of success to get people on board by providing real examples of what is working well.”

Staff also recognised that they themselves are a resource, especially when it comes to effecting change in those who are using services through engaging with people to educate and support them to use them differently, or by encouraging prevention and self management. To enable this staff will have to feel involved in how services are transformed and they need to feel that we are not asking them to do more with less.

“We [staff] need to change the public perception of healthcare and where it is provided. We are the ones who see patients.”

Technology was widely recognised as a critical enabler to how we will transform services and develop new ways of working. Many staff expressed frustration at the lack of access to other systems and the delays and duplication that this can cause. The ability to see information and communicate with each other across the system in near real time was the single biggest aspiration.

Not only this, but for people who had the ability, technology had huge potential to improve how they interact and support services users, patients and carer.

“Technology enables change but systems need to talk to each other.”

“The current systems are too closed. They need to talk to each other.”

“Technology could do so much... provide specialist advice from dedicated supports to enable more complex work by other staff in routine settings.”

“We could Skype or Facetime people to provide people with advice or to prevent them having to travel for ongoing review when there is no change to their condition.”

How we Informed and Engaged

Planned Engagement

From the outset of the Programme we developed an Engagement and Communications plan to engage with people and staff about how we will develop our new system of care. We began by undertaking a stakeholder analysis of all those involved or affected by the programme and a process for communicating with and involving them.

Level of influence and engagement	
Engage and consult regularly	Involve in governance and decision making of whole programme
Engage and consult on specialty interest	Involve in decision making for specialty area
Keep informed and discuss area of interest	Engage with through involvement at area of interest level
Keep informed via regular communication	Engage with broadly and hear feedback

Stakeholders	Methods of engagement	Channels of communications
Programme Board	Briefings & Papers, presentations	Regular Meeting Structure
NHSGGC Board	Briefings & Papers, presentations	Regular Meeting and Seminar Structure
Integration Joint Boards	Briefings, papers, presentations	Regular Meeting Structure
Local Councils	Briefings, share papers, presentations, individual discussions	Regular Meeting Structure

Other WoS Regional Boards	Briefings, papers, presentations, individual discussions re specific aspects/services/cross board interests	Through inputs to WoS Regional Planning Process and specific focussed meetings
WoS Regional Planning	Cross membership of core team(s), briefings, papers, presentations shared and discussed as required- links with Other WoS Boards as above	Regular Meeting Structure
Stakeholder Reference Group	Meetings	Cycle of meetings described in the summary plan
Wider public	HSCP Locality Meetings	Promoted via NHSGGC and HSCP channels
	Information Materials	<ul style="list-style-type: none"> • Web portal on NHSGGC and HSCP websites • HealthNews • IPN news bulletins • NHSGGC Facebook and twitter accounts • Press releases • Media
Scottish Government Health Directorates	Briefings – via Chief Executive/Medical Director and specific discussions with policy team(s)	Dedicated Meetings and Briefings
MSPs	Information Materials & Briefings as required	IPN news bulletins and dedicated meetings and briefings
Local politicians	Information Materials & Briefings as required	IPN news bulletins and dedicated meetings and briefings
Local groups & organisations	Information Materials & Briefings as required	IPN news bulletins and dedicated meetings and briefings
Clinical Senate	Routine slot on meetings agendas to update	Regular Meeting Structure
Area Clinical Forum	Routine Agenda item plus information materials and briefings as required	Regular Meeting Structure

Acute Operational Directors	Routine Agenda item plus information materials and briefings as required	Regular Meeting Structure
Acute Directorate Senior Teams	Routine Agenda item plus information materials and briefings as required	Regular Meeting Structure
HSCP Chief Officers	Routine Agenda item plus information materials and briefings as required	Regular Meeting Structure
HSCP Senior Teams	Routine Agenda item plus information materials and briefings as required	Regular Meeting Structure
Consultant Body Board Committees Sectors Speciality Groups Divisions	Specialty Level Modelling and Routine Agenda item plus information materials and briefings as required	Dedicated meeting structure and regular meeting
Specialty Clinical Groups GGC WoS GJNH	Specialty Level Modelling	Dedicated meeting structure and regular meetings
Workforce Reference Group	Information materials and briefings as required	Meetings
NHSGGC Staff Area Partnership Forum Acute Partnership Forum Trade Union Full Time Officers Chief Nurses Network Chief AHP Network Senior Charge Nurse Network	Routine Agenda item plus information materials and briefings as required	<ul style="list-style-type: none"> • Regular Meeting Structure • Team Brief (monthly) and monthly cascade • Core Brief (real time) • Staff Newsletter (monthly) print and digital • Staff Comms portal • Meetings • Email

HSCP staff	Routine Agenda item plus information materials and briefings as required	<ul style="list-style-type: none"> • IJB meetings (and IJB Committees where these are in place) • IJB development sessions/ one-off briefings • Papers/updates to Council committees and elected members • Senior Management Teams and other management forums • Internal newsletters and core briefs • Intranet/public-facing websites and social media
GPs LMC Local Bodies	Specialty Level Modelling and Routine Agenda item plus information materials and briefings as required	<ul style="list-style-type: none"> • Clinical modelling groups • nGMS Steering Group • HSCP primary care strategy groups
Independent Contractors Pharmacy Opticians Dentists	Specialty Level Modelling and Routine Agenda item plus information materials and briefings as required	<ul style="list-style-type: none"> • Advisory committee regular meetings: AOC, APC, ADC • Lead optometrists group • HSCP primary care strategy groups
Scottish Ambulance Service	Programme Board Representatives As above, within local, regional, national context discussions/planning	
NHS 24	As above re local, regional, national context	
Golden Jubilee National Hospital	Information Materials & Briefings as required	
Local Authority Staff COSLA	Information, updates, briefings as required	
Further and Higher Education	Information Materials & Briefings as required	
	Information, updates, briefings as required	

Housing Police Fire Services		
Third Sector	Information Materials & Briefings as required	
Private Sector	Information Materials & Briefings as required	

The Plan was intended to be flexible so that we could work with people, staff, our stakeholders and partners to refine our approach and materials using their feedback to maximise reach and the potential for us to widely inform and engage about the Programme.

Engaging with People

Stakeholder Reference Group

Engagement with people was informed by establishing a discreet Stakeholder Reference Group that contributed to the co-production of content and materials. Invites for representatives to participate were sent to Integration Joint Boards, charities that support patients, service users' and carers that use health and social care services and Public Partners who work with us on the Patient and Carer Experience agenda.

Twenty-one people agreed to work with us regularly receiving correspondence and providing feedback and 130 attendances over 9 meetings. Participant feedback was positive and people welcomed early involvement and widely accepted the rationale for the Programme. They also provide valuable insights for the content of key messages and helped shape the type of information materials developed and the approach used for wider public engagement. The themes that emerged from the Group strongly aligned with that of the Programme:

- The need for a greater focus on prevention, self management and empowerment to allow people to be more in control of and manage their own health better to live independently at home longer
- Education is key to improving people's understanding of when and how they access and use healthcare and is essential to support and change culture, attitudes and expectations of what will be provided, where and by who
- Use appropriate media to clearly demonstrate and describe the service user and provider perspective illustrating that:
 - When people need care this should be delivered wherever possible in the community via integrated and seamless health and social care services
 - As treatment or care becomes more complicated with acuity or complexity that this needs to be provided by specialist teams working together in fewer locations
 - Advancements in treatment and care, innovation, technology and workforce have and will continue to drive change and will help realise new ways of working to deliver Programme aims
- The need to have open conversations about resources and clearly illustrate how increasing demand cannot be met in terms of affordability, feasibility or sustainability.

The details of the Group including their terms of reference, membership, the content of each presentation and an agreed commentary of each meeting were made available online on the Moving Forward Together website. The Group also played an integral role in wider communication about their purpose, how they were involved and their thoughts and comments about the programme by working with us to create videos that they shared with their peers and networks.

For example the Glasgow Mental Health Network agreed to share information with 750 people and organisations on their mailing list and on their Facebook page with over 500 followers. George, their service user representative also had this to say about his involvement:

“I became involved in the Moving Forward Together Stakeholder Reference Group after the Programme made a request for someone to be representative of the Glasgow Mental Health Network. I have been involved in the Group since the on set and have I offered my views on how services can be improved and how people can be helped to understand the changes as well as making the most of them. I have a particular interest in Mental Health and also use my GPs a lot so I was keen to understand how changes would affect services that I use. I have already seen a number of changes at my GPs and being a member of the Reference Group helps me understand these changes a lot better and why they are happening.”

Wider Public Engagement

Feedback from HSCP officers and the Stakeholder Reference Group was that traditional methods of engagement that relied on printed materials and a single meeting or event often failed to extensively reach into and engage with communities and the general population. Their advice led to the development of a range of primarily digital materials and alternative methods to raise awareness of the Programme and inform people about where and how to access further information and provide feedback.

However, with their established networks we also worked with each Health and Social Care Partnership who hosted a meeting about the Programme with their respective locality/advisory groups. Several of these meetings also extended invitation to the wider public and over 10 meetings 228 people attended. In addition we also spent a morning or afternoon at each of the 8 main acute hospital sites to distribute over 2,500 leaflets and directly engage with people using services to raise awareness.

How we Engaged with Staff

Engagement with staff was informed by establishing a Workforce Reference Group comprised of trade union and human resources, workforce planning and organisational development from across the whole system. The Workforce Group worked jointly to provide consistent advice and develop a core script and materials to raise awareness and inform staff about the Programme. To hear feedback a series of staff engagement events were scheduled and took place across Greater Glasgow and Clyde for health and social care staff.

Venue	No of sessions	Staff Registered
Victoria ACH	2	22
QEUH	1	44
GRI	1	35
Stobhill ACH	1	31
Dental Hospital	1	31
Commonwealth House	2	17
GGH	1	40
Kirkintilloch Health Centre	1	12
RAH	1	49
IRH	1	37
VOL	2	24
GRH	2	29
Hartfield Clinic, Dumbarton	2	11
Renfrew	2	36

Across the 20 sessions 418 staff registered to take part. They heard a presentation that described the rationale for change; provided examples of how we might work differently to meet predicted demand and were then encouraged feedback through facilitated group discussion.

In addition, throughout the Programme, we worked to create wider awareness across all our staff and advise them of progress through a series of communication briefs using the established communication channels within the Board and the Health and Social Care Partnerships.

Materials and Methods for Raising Awareness

Following the advice of our Stakeholders we aimed to develop a range of resources and products that would raise awareness and extend our reach across people and staff. These would be focussed on digital media that could be shared electronically via established and trusted mailing lists or using social media platforms.

Core Narrative

As an early priority, we agreed a core narrative for the programme which would be based as the basis for all communications and engagements materials to ensure consistency and clarity of message.

Website

A standalone Moving Forward Together branded website with a unique URL www.movingforwardtogetherggc.org was developed to show that the Programme was being delivered jointly. Links to this website were created on all partners' main websites. This was used as the main repository and conduit for people and staff to easily access information about the Programme including documents, presentations, newsletters, meeting details and videos. It also provided a means of getting in touch to find out more or provide feedback either via a dedicated email feedback@movingforwardtogetherggc.org and a freephone telephone number.

Animation and Videos

Again listening to the advice of our stakeholders we took the decision to invest in novel approaches to how we could inform people about the Programme and encourage engagement. One of the main resources was the commissioning of a short animation video that provided a core narrative and overview about the rationale for change, what this might look like and how to find out more information. The intention was to capture people's attention by being played on screens in waiting areas and provide something more immediately 'shareable' on social media.



We also developed a range of ‘talking head’ videos that could be used individually or as part of presentations to deliver key messages. We believe that information conveyed by those involved or affected is far more accessible and credible than other delivery methods.

These included five members of the Stakeholder Reference Group working with us to describe their involvement, what they thought about the Programme and their key messages. Twelve staff videos were produced that provided an overview of the programme and illustrated how services had and will continue to transform covering aspects of:

- Acute Medicine
- Breast Surgery
- Cancer
- Community Respiratory Care
- eHealth
- Mental Health
- Older People
- Primary Care

In addition three short videos each with three staff members stating that ‘we are Moving Forward Together by...’ were produced to be played on social media.

Leaflet

In addition to our novel approaches using digital media we recognised that this might not reach everyone and especially those not connected to the internet. We therefore developed a full colour printed leaflet with basic information about the programme and detailed other ways to find or more and how to provide feedback. These have primarily been distributed in person in our acute hospital sites and have been offered to HSCP locality officers for any engagement they might undertake.

Presentations

Standard presentations were created for use with all target audiences, including public and staff, consistent with the core narrative. These were pre-tested with the stakeholder reference group and the workforce reference group.

Communication Channels

The six Health and Social Care Partnerships and NHSGGC’s Equality and Human Rights Team worked alongside us to utilise their existing networks and extend our reach into localities and communities. The shared materials and information directly to 376 health, service user and community groups. Additionally, where available these were shared with local Community Volunteers Centres for them to forward via their extensive mailing lists.

In addition to this, NHSGGC used all its main communications channels to communicate with the public and staff, including:

- **Health News digital magazine** issued in April 2018 which was sent to 20,000 people on the NHSGGC Involving people network (our online network of individuals, community representatives and elected representatives who have subscribed for regular news update) and then shared widely on social media with a further reach of 40,000.
- **Video clips** played regularly to drive people to the movingforwardtogetherggc.org website. Within one week they had more than 36,000 views.
- **Core Brief, Team Brief and Staff Newsletter** used to inform staff of progress with the Programme throughout the year. Core Brief and Team Brief are issued electronically to all staff. Staff Newsletter is published online (averaging 33,000 page views per month) and in print (16,000 copies per month).

References

Chapter 5

Carlisle R, Avery AJ, Marsh (2002). Primary care teams work harder in deprived areas. *J Public Health Med* 2002, 24(1):43–48.

O'Cathain A, Knowles E, Maheswaran R, et al. (2014) A system-wide approach to explaining variation in potentially avoidable emergency admissions: national ecological study. *BMJ Qual Saf.* Jan; 23(1):47-55.

