

**NHS BOARD MEETING**

**Dr Jennifer L. Armstrong,  
Medical Director**

**17 April 2018**

**Paper No: 18/14**

**MOVING FORWARD TOGETHER: PROGRAMME UPDATE**

**Recommendation:-**

The Board is asked to note progress on the approved work to develop a Transformational Strategic Programme for GGC Health and Social Care Services; Moving Forward Together, in line with Scottish Government national and regional strategies and requirements and the projected needs of the GGC population.

**Purpose of Paper:-**

To update the Board on the development of a Transformational Strategic Programme for GGC Health and Social Care Services: Moving Forward Together.

**Key Issues to be considered:-**

The requirement for GGC to develop an implementation plan, for the National Clinical Strategy and the National Health and Social Care Delivery Plan.

**Any Patient Safety /Patient Experience Issues:-**

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 Care.

**Any Financial Implications from this Paper:-**

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.

**Any Staffing Implications from this Paper:-**

No issues in the immediate term, however the outcome of the completed Programme could recommend changes to our workforce.

**Any Equality Implications from this Paper:-**

No issues.

**Any Health Inequalities Implications from this Paper:-**

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

**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-**

No.

**Highlight the Corporate Plan priorities to which your paper relates:-**

Develop a new five year Transformational Plan for the NHS Board working in partnership with other key stakeholders and taking cognisance of the key local and national strategies, including the Health and Social Care Delivery Plan

**Author – Barry Sillers**

**Tel No – 07534919383**

**Date – 3 April 2018**

## **MOVING FORWARD TOGETHER: PROGRESS UPDATE**

### **EXECUTIVE SUMMARY**

Phase 1 of the Moving Forward Together Programme was completed between October and November 2017. The programme has achieved all the Phase 1 deliverables set out.

Phase 2 of the Moving Forward Together Programme was completed between December 2017 and February 2018. The programme has achieved all the Phase 2 deliverables set out.

A key milestone in Phase 2 was the first whole system event which took place on 30 January 2018 in the City Chambers.

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

The event was attended by over 270 participants from across GGC health and social care and also enjoyed representation from the WOS Programme.

Phase 3 of the Programme is on schedule to complete at the end of April 2018.

### **BACKGROUND**

As described in the October 2017 NHSGGC Board Paper and subsequent Health and Social Care Partnership IJB Papers the Moving Forward Together Programme has the following aim and objectives.

The aim of this transformational strategic programme is:

- to develop and deliver 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 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
- to review the NCS and CSS cases for change in light of these and produce an updated 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.

## **OUR APPROACH**

The key principles on which our approach is based are summarised below:

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

## **PROGRAMME TIMELINE**

Phase 1 of the programme was completed between October and November 2017.

Phase 2 of the programme was completed between December 2017 and February 2018.

Phase 3 is currently ongoing and is due to complete at the end of April 2018.

## **PHASE ONE DELIVERABLES**

Phase One had a series of key deliverables which were described in the October Board Paper.

PHASE ONE – October to November 2017

- Review the current range of relevant National and Regional Strategic Documents;
  - eg National Clinical Strategy , Health and Social Care Delivery Plan (2016) Cancer and Mental Health Strategies
- Review the outputs of the GGC Clinical Services Strategy for comparison with National and Regional Guidance to create and amalgamated set of principles on which Transformation Strategy will be based
- Update the predictions on population changes to develop a demand picture up to 2025
  - Using the same methodology as WOS 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 IJB strategic plans and commissioning intentions
- Carry out a stakeholder analysis and develop engagement plan
- Highlight the gaps where further work should be commissioned.

## **END OF PHASE ONE UPDATE AND DELIVERY STATUS**

The MFT Core Team acts as the central group through which the work of the Programme is driven. The team was established on 7 September 2017 with representation covering the following areas:

- Policy
- Public Health
- Health Economist
- Business Intelligence and Data Analysis
- General Practice
- Primary Care Management
- HSCP Planning
- Social Work
- Mental Health
- Nursing and AHPs
- Acute Consultant Body
- E-Health Consultant
- E-Health 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 Board Medical Director as Programme Executive at the end of each week.

### **Review of National Strategies**

**Status: A comprehensive review of the extant National and Regional Strategic landscape was conducted in the early weeks of the Programme.**

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

**Status: Public health and business intelligence have 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.**

Public health and business intelligence have been working 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 has 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 have been grouped against conditions or specialty pathways ready to support the service modelling sessions.

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

There has also been an underpinning examination of primary and community care which is relevant to all conditions and specialties.

### Stock take of progress against Clinical Services Strategy

**Status: Completed, with ongoing assessments and further work expected to continue as required as MFT progresses.**

A full review was conducted by the Core Team and outreach teams of the progress made against the Board's extant Clinical Services Strategy (CSS), published in January 2015. This process examined areas where the CSS recommendations had been fully or partially implemented but also areas where it was considered that the CSS recommendation no longer fully represented what was thought to be the optimal service model. The most significant example of this is in the work of the project for Improving Rehabilitation Services for Elderly People in North East Glasgow which proposed a major shift to intermediate care in the community rather than care in an acute setting when no longer clinically necessary. The examples of successful implementation already in place were used to illustrate transformational change in the Annex to the October Board Paper.

### IJB review of Strategic Plans

**Status: Completed and incorporated into programme work going forward.**

A review of the current Strategic and Commissioning Plans published by the 6 Integrated 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

**Status: We have developed this planning approach for application across health and social care.**

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. A considerable amount of work has been 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 covering planned and unscheduled care, cancer care, mental health, older peoples care and primary and community care.

We have discussed this approach with the Clinical Leads in the West of Scotland Programme and we are using this approach as the basis for discussing future service models with our teams.

## Stakeholder Engagement

**Status: Stakeholder engagement plan in place.**

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

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

A comprehensive stakeholder engagement plan is in place which not only identifies the range of our stakeholders but also describes the specific mechanisms and channels through which we will ensure each stakeholder group is appropriately informed and engaged.

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

Representation has been invited from the widest possible range of patient and carer representatives, interested groups and third sector organisations from across the 6 HSCP areas. Not all invited groups can attend all the meetings but the agreed membership of the group successfully has representatives from all the intended stakeholder sectors and has members from across all HSCP areas.

Mr Ian Ritchie has been invited to and has agreed to act as the SRG chair.

The SRG will meet 9 times as part of the process with each meeting focussing on a specific element of care delivery.

## The Programme Board

**Status: The MFT Programme Board has been established.**

A Programme Board has been established with Jane Grant as Chair and met for the first time on 1 December 2017. The Board has since met on 23 January and 23 March 2018.

The Board has senior representatives from across health and social care delivery as well as employee partnership and clinical representatives. It also has external members from the Scottish Ambulance Service and West of Scotland Planning.

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 HSCP IJBs

Discussing and resolving any conflicts escalated by the Programme Executive

#### Service Engagement and Modelling Process

**Status: There has been a preparatory project for each of the 31 specialty or condition based groups that meet in Phase Two.**

These projects have developed and shared with our teams a series of documents which include:

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



## **END OF PHASE TWO UPDATE AND DELIVERY STATUS**

From the initial October 2017 description of the sequential phases of the MFT Programme, Phase 1 focused on the following outcomes;

- Take forward the Phase 1 principles framework, case for change, **care stratification model and evidence base** to enable a **structured discussion** with small clinical groups from and then across primary community secondary and tertiary care
- Commission **specialty groups** to review Phase 1 predicted service demand and produce **proposals for future service requirements**, the impact of which can be modelled.
- With clinical groups produce a **matrix of stratified clinical interdependencies** for each service which will inform **options development** and a plan for enabling changes and/or supporting services which are required to sustain the **new service models**

The delivery of Phase 2 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 have been 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 AHPs
- GPs
- Community nurses and AHPs
- HSCP Heads of Service
- Acute and HSCP Planning
- Public Health
- E-health

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 order to prepare the group for the physical meeting an extensive reading pack was provided based on the Phase 1 work. This included:

- Results of the global literature search on new or alternative models
- Activity projection using synthetic estimates based on demographic change
- Briefing on the tiered approach to service planning
- Survey issued to all group members based on preparation material

In addition to the specialty and condition based groups each of the 6 HSCPs has established locality groups to discuss primary, community and cross cutting issues.

The diagram below shows the groups which have been established as Part of Phase 2.

## Phase Two Service Modelling Groups

- Cardiology
- Endocrine/Diabetes
- ENT
- Gastroenterology
- General Surgery
- Geriatrics
- Respiratory
- Rheumatology
- Orthopaedics
- Urology
- Haemato-oncology
- Breast Cancer
- Dermatology
- Glasgow HSCP
- Vascular
- Diagnostics
- Urological Cancer
- Gynaecological Cancer
- Upper GI Cancer
- West Dun HSCP
- Renfrewshire HSCP
- East Dun HSCP
- East Renfrewshire HSCP
- Inverclyde HSCP
- Colorectal Cancer
- Lung Cancer
- Head and Neck Cancer
- Critical Care
- ACH OOH Model Group
- Palliative Care
- Tier 3/4 Unscheduled Care

### **END OF PHASE TWO UPDATE AND DELIVERY STATUS**

#### **Development of a Tiered Approach across Acute Primary and Community, Health and Social Care**

**Status: The description of tiers of care in the delivery of unscheduled care, planned care, rehabilitation and older people's care, cancer care, primary care and community services has been central to the structured discussions in Phase 2 and has provided a very robust framework in which to discuss current and future service models.**

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 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 collocations and interdependencies

**Status: The description of tiers of care allowed a common framework for the 31 service modelling groups and has allowed a comprehensive set of clinical and operational dependencies to be developed which will be used as part of the strategy development process in Phase 3.**

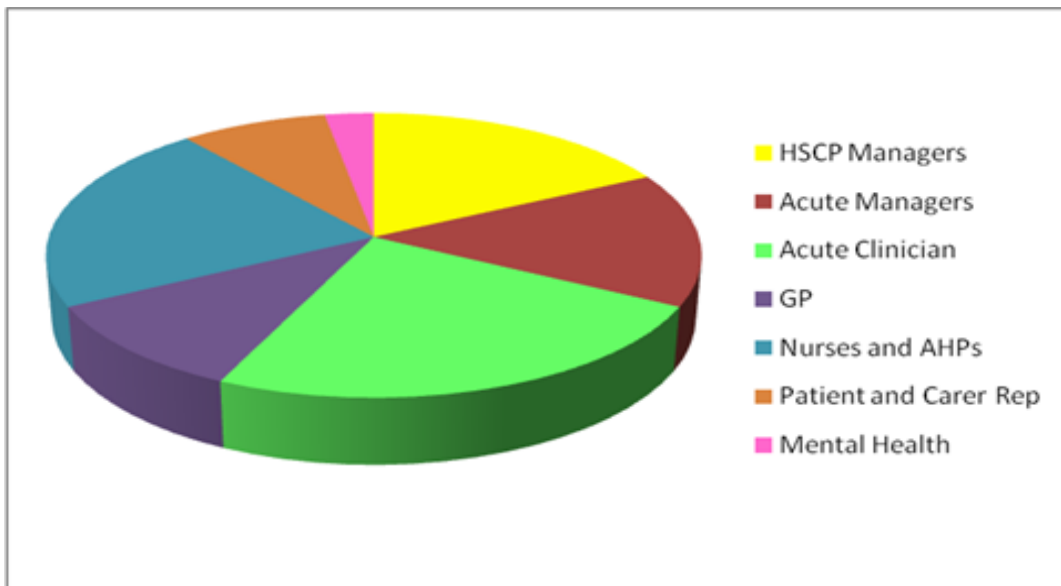
**WHOLE SYSTEM EVENT - 30<sup>TH</sup> JANUARY**

On 30<sup>th</sup> January the Core Team hosted the first whole system MFT event which took place in the City Chambers in George Square.

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

The event was attended by over 270 participants from across GGC health and social care and also enjoyed representation from the WOS Programme.

The diagram below 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 based discussions of the themes presented.

Presentations and table based 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
- E-health 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.

On 23 March 2018 the event was reviewed at the Programme Board and the write up from the table discussions agreed as a valuable contribution to the overall programme in terms of system wide views.

## **PHASE TWO THEMES**

From the 31 groups that have been established and the discussion on the 30<sup>th</sup> January at the whole system event there are a number of consistent emergent themes.

### **Local Hospital and Community Based Services**

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

### **Access to Comprehensive Records and Improved Cross Sector Communication**

- This has long been a desire but now there are e-health solutions that can make this a reality
- A shared cross system record and a shared cross system care plan with better communications across the network of teams is seen as vital to delivering transformational change

### **Working to the top of a licence**

- All specialty groups have identified service provision that could be done by more appropriately qualified staff which would allow each practitioner to spend more time doing only the work that they can do

### **Cross System Team Working**

- Many of the specialty groups have already shown areas of good cross system working but there is a real enthusiasm that this could be expanded and rolled out to be universal practice

### **The opportunities of integration**

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

### **Developing 'generalism'**

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

## **PHASE TWO: ONGOING STAKEHOLDER ENGAGEMENT**

**Status: Stakeholder engagement plan being delivered according to plan.**

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

A comprehensive stakeholder engagement plan is being delivered which not only identifies the range of our stakeholders but also describes the specific mechanisms and channels through which we will ensure each stakeholder group is appropriately informed and engaged.

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

Representation from the widest possible range of patient and carer representatives, interested groups and third sector organisations from across the 6 HSCP areas is in place.

The Stakeholder Reference Group (SRG) was established to primarily; act as a sounding board for concepts; and advise on the development of information materials for wider public use. It was highlighted that for successful engagement the content must be fit for purpose, describing key concepts and communicated in a way that people can understand i.e. they could reasonably be expected to explain and share key concepts with peers.

A collaborative approach with NHSGGC and HSCPs was suggested to maximise reach and engage effectively. A programme of communications was jointly delivered via a coordinated approach using established and trusted communications channels. This included a nominated IJB lead to be fully briefed on MFT to have ownership of engagement with their local communities and respond to local requests for information, presentations or talks to community groups.

From a wide ranging list of invitees twenty one patient, carer and service user representatives from across Greater Glasgow and Clyde agreed to participate on the SRG. The group has met 7 times and heard presentations and provided feedback on a range of topics related to the Programme:

1. MFT Background and Context
2. Role of eHealth in Transformation
3. Current and Future Primary Care Services
4. Mental Health
5. Tiered Models of Care
6. Transformation in Acute Care:
  - I. Surgical Services
  - II. Cross-system Approach to Respiratory Disease
7. Integration Joint Boards and Primary and Community Care Direction of travel

Some Group members also attended the Whole System Event held on 30 January and including this, in total there have been 118 attendances from across the membership. A Group approved summary and full commentary of each meeting with links to the presentations has been made available on the [MFT website](#) to provide a descriptive account of their engagement.

SRG feedback has been largely positive, participants have welcomed being involved early in the process and the rationale and aims of the Programme have been widely understood and accepted. In addition to explaining the underlying principles and the Programme's approach the themes emerging from SRG feedback to shape engagement with the wider public are:

- There should be a 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
- Clearly demonstrate and describe using appropriate media such as videos to illustrate the service user and provider perspective or via easy to understand infographics;
  - That when people need care this should be delivered wherever possible in the community via integrated and seamless health and social care services
  - That 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
  - How 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
- Education is key to improving the public's understanding of when and how they access and use healthcare and to change culture, attitudes and expectations of what will be provided and by whom
- The need to have open conversations about and clearly illustrate how increasing demand cannot be met within existing resource and that often this is not just in terms of affordability but feasibility

A Group approved summary and full commentary of each meeting with links to the presentations has been made available on the [MFT website](#) to provide a descriptive account of the SRG engagement.

It is important to note that the value of this work and the insights of the group are realised and used to frame the engagement and opportunities to have meaningful conversations with the wider public. In recognition of this the SRG feedback is now being considered by the Core Team and Communications to develop products and materials with which to engage with the wider public.

The Workforce Reference Group, including Trade Unions and Human Resources staff was established in Phase 2 and meets regularly with a programme of meeting dates set for throughout 2018.

The group have planned staff engagement events across all Acute and Health and Social Care partnerships through Phase 3 to provide the opportunity for health and social care staff to learn more about the programme and feedback their thoughts and views". These events have been communicated widely and all staff have been encouraged to attend.

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

These include a core script which sets out the background and drivers for change and a dedicated website [www.movingforwardtogtherggc.org](http://www.movingforwardtogtherggc.org)

The website will host 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 is being taken to ensure that key messages for staff and the public are consistent and, to this end, the Communications Team continue to work closely with colleagues delivering public and staff engagement

### **PHASE THREE EMERGING THEMES**

The agreed outcomes for Phase 3 are:

- Review current WOS planning and other Health Board strategic intentions and assess the impact on GGC options
- Review all the work of Phase 1 and 2 and adjacent relevant 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 is progressing 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 are also taking 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<sup>th</sup> January at the whole system event and the ongoing Stakeholder engagement work stream, the Programme has collected a vast data base of opinion, ideas and innovations that could support transformation. This has been gathered from the full range of staff stakeholders across health and social care and has also involved patients and carer representatives.

The central task of Phase 3 is 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 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.

The approach to Phase 3 which is currently underway is based around a series of intensive workshops, internally known as the "Think Tanks".

There is a programme of these workshops throughout Phase 3. These workshops are delivered by the Programme Core Team along with different groups of key stakeholders who bring expertise and opinion to allow the forming of an emergent vision for the various aspects of health and social care.

At this point Phase 3 is very much a work in progress however some of the early emergent themes which are being developed in the think tanks are described below.

### **Empowering the population**

The benefits of healthy lifestyle choices in preventing ill health are well known, with poor lifestyle choices such as smoking, drinking excessive alcohol, eating a poor diet and lack of exercise being major contributors to a demand for healthcare.

- Education in healthy lifestyle choices.
  - The population need to be supported in making healthy lifestyle choices and this should be a societal priority.
  - Schooling is key; young children are not only our future adults but can have a major influence on the opinions and lifestyle choices of parents, grandparents and other family members
  - Easy access to information on healthy cooking and eating
- The Opportunity to make healthy choices. The importance of access to facilities which make taking exercise an easy choice, whether this is as an individual or as part of a social group.
  - Leisure centres
  - Walking and running clubs
- The power of Community Empowerment
  - Tackling social exclusion and the other determinants of poor mental and physical health
  - Peer support to make healthy choices
- Early intervention and support
  - Having a system that enables people to return to independent healthy living without escalating up through the tiers
- 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 well being as well as providing care
- Use of the third sector and other partners
  - Recognising the wider system impact on health and well being



- Being able to develop influence on housing and other community planning programmes to join up communities
- Contributing to the reduction in health inequality
  - Seeking to bring about system wide change which contributes to the reduction in health inequality
  - Reviewing proposed service model changes against EQIA criteria
  - Working with HSCP local teams to consider the differing socioeconomic environments across GGC when designing services

### **The mechanics of integration**

There has been a focus on developing a vision of how a new system would come together to deliver better health and social care

- An absolute requirement for an integrated system with the patient at the centre
- Making boundaries porous across Primary Community and Acute Care
- Joining up the GP practice enhanced 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
- Acute care being an extension of that community network to make a single system
- The care of multi morbidity high risk patients coordinated across the network
- A system wide focus on prevention and early intervention to prevent avoidable escalation
- A system where people have a range of accessible options which are suitable for and adapted to their needs as they change
- A system where moving down the tiers back to healthy independent living is the focus and is facilitated

### **Opportunities of the new GP contract**

GP colleagues on the Core Team have lead early cross system discussion on the transformational opportunities which may arise from changes to the GP contract.

- Expert generalist role
- Cluster working for networking and quality
- Operating at the top of the licence
- Thinking time for complex patients
- Treatment and care services as part of the community network
  - Opportunity to enhance further community hub services
- To be at the centre of the community network
- Pharmacy role improving safety and cost management
- Urgent care home visiting; supporting care in community setting

### **Tiered Care in the community network**

The tiered approach to service delivery has continued to be a central concept of Moving Forward Together and in Phase 3 more work has been done in carrying this approach seamlessly across primary community and acute, health and social care .

### **Single integrated multi service network of teams**

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:

- GP Practice
- Extended practice based MDT
  - Practice and cluster based
- Wider community network
  - District Nurses
  - Health Visitors
  - Pharmacists
  - Optoms
  - Advanced Practice nurses
  - Physio
  - OT
  - SLTs
  - Podiatry
  - Specialist nurses
  - Acute Outreach
  - Palliative Care Team
  - Dentistry
  - Specialist nurses
  - Addictions team
  - Community Mental Health Teams
  - Aids and adaption
  - Learning Difficulties
  - Home Care
  - Weight Management
  - Financial Inclusion
  - Respite Care
  - Carer Support
  - Community Groups

## **Community Hubs**

The concept of a community hub as part of the network is being developed. In some localities this may be based around a health centre and in other localities this may be a virtual hub based around integrated teams rather than a fixed location.

- Core and cluster
  - Local options for delivery but comprehensive and equitable access to service outcome

## **E-health – the key enabler**

The importance of new technology and the use of information and communication systems has been seen as a key enabler to the delivery of person centred care throughout the Programme and a great deal of emphasis has been placed on this vital work.

There are three elements to our E-health emerging strategy which support the rest of the networked and tiered model.

- Integrated patient record across all services
  - Visible to all the teams involved in service delivery and also to the person at the centre
- Integrated patient care plan shared and controlled across all services;
  - Owned by the person and accessible by all the teams across the network
- Networked team communications to support better person centred decision making
  - Connecting the GP, the practice team, the community network and acute specialist services to make holistic person centred decisions having reviewed all options

## **System Wide Unscheduled Care**

The delivery of unscheduled care is not the sole responsibility of the hospital emergency department. The population need to understand, have access to and have trust in alternatives to hospital attendance for conditions that can be safely dealt with out of an acute hospital. The establishment of a community based network of services that give our population access to services that promote self care and provide early community based interventions which are easily accessible is a key theme.

- Options across the system to support alternatives to hospital based care
- Early identification
- Early intervention
- Community network supporting care out of hospital
- Connected team and efficient communications to enable risk assessed decision making
- Coordinated care of high risk patients - complex care planning and monitoring in a community “virtual ward “
- Team access to specialist opinion and diagnostic support to avoid acute hospital care
- Access to high quality acute care when necessary
- Intermediate care services
  - A network of options out of hospital
  - Anticipatory and pro active in nature

- Acute outreach to community
  - Education and support
  - Decision making advice
  - Specialist nursing staff
  - Hot clinics and alternatives to admission
  - Input to intermediate care and the community network

### **Planned Care**

Planned care 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 is potential to take this further by delivering planned care services out with the hospital setting as part of the community based network.

Through our service engagement process each of our 31 groups have identified elements of care that can be delivered in more local tiers.

- 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.

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 and is being used increasingly.

The ability of a non collocated team of clinicians to review a patient as a multidisciplinary 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.

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.

### **NEXT STEPS**

Phase 3 will continue to develop these emerging themes by the continuation of widespread engagement and discussion to refine and further develop these concepts to deliver the intended outcomes of Phase 3.

### **SUMMARY**

Phase 1 of the Moving Forward Together Programme was completed between October and November 2017. The programme has achieved all the Phase 1 deliverables set out.

Phase 2 of the Moving Forward Together Programme was completed between December 2017 and February 2018. The programme has achieved all the Phase 2 deliverables set out.

Phase 3 of the Programme is on schedule to complete at the end of April 2018.