Moving Forward Together

NHS Greater Glasgow & Clyde

Board Meeting **16th April 2019**

Dr Jennifer L Armstrong, Medical Director

Paper No: 19/15

MOVING FORWARD TOGETHER: IMPLEMENTATION PHASE UPDATE

Recommendation:

The Board is asked to note the attached update on the progress made in the implementation phase of the Moving Forward Together Blueprint for the Future Delivery of Health and Social Care approved by the NHSGGC Board on 26 June 2018.

Purpose of Paper:

To update the Board on the progress made during the implementation phase of the MFT Programme.

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 heath 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

Authors
Rachel Fishlock, Programme Manager, Moving Forward Together
Marjorie Johns, Planning Lead, Moving Forward Together
John Barber, Public Engagement and Patient Involvement Lead, Moving Forward Together

Date
2 April 2019

Moving Forward Together: Implementation Phase
Update at end March 2019

1.0 Progress Summary

Since the last update to the Board in February 2019, the Programme has had a number of areas of focus:

- Ongoing development and delivery of the Public Involvement and Communications Plan
- Development of specific projects by the six workstreams, aligned to the overall priorities which were shared with the Board in February 2019
- Review of the clinical engagement data completed
- Summary of specialty priorities compiled and shared with workstreams
- Engagement with LMC, Clinical Senate, Access Collaborative, Area Clinical Forum, Area Partnership Forum
- Clinical modelling

2.0 Whole System Approach

Ongoing programmes of work will be taken forward on a whole-system basis by the MFT Programme Office to support broader pieces of work which cross multiple workstreams or are in support of the implementation of specific national programmes, such as The Modern Outpatient.

The first grouping of projects to be brought together is focused on new ways of managing and delivering outpatient services, and will encompass:

- Evidence-based Quality Interventions and Procedures [EQuIP]
- Advanced Clinical Referral Triage [ACRT]
- Patient Initiated Follow-up [PIFU]
- Advice-only referrals
- Virtual clinics

3.0 Cases for Change in progress

Two cases for change were presented to and approved by the Executive Group and Programme Board in February/March. These are described in more detail in section 4.

3.1 Systemic Anti-Cancer Therapy [SACT]

This was presented to GGC Board in December 2018, and outlined the approach by which GGC will implement the recommendations of the West of Scotland review. Work is currently underway on modelling scenarios for delivery of SACT across GGC in the future, with a focus on providing more care closer to people's homes rather than in the Beatson West of Scotland Cancer Centre. As previously agreed, this will report back to the Board in June 2019.

3.2 Complex Cancer Surgery

This project is looking at multi-specialty cancer surgery and the potential to develop a single centre of excellence for all pelvic/abdominal cancer surgery. A short-life working group has been formed and is intending to work up a full case for change by Oct/Nov 2019.

3.3 Trauma

3.3.1 West of Scotland Major Trauma Network Model

Major trauma is the leading cause of death in people under the age of 45 and is a significant cause of short and long-term illness or poor health. Evidence from across England and Wales also shows a significant increase in the number of patients aged over 60 who suffer severe injuries as a result of falling from a standing height (Tarn, 2017).

There is a significant amount of evidence to show that patients who suffer a major trauma have a greater chance of survival and recover better if they are treated within a major trauma network.

The North of Scotland officially opened as a major trauma network in October 2018, followed by Tayside in November 2018. Delivery of the South/East and West networks is expected by 2021/22.

The network will provide all aspects of trauma care, from the point of injury to rehabilitation, in the region.

At the heart of the regional network, is the Major Trauma Centre which will be sited at the Queen Elizabeth University Hospital (QEUH) in Glasgow and will provide care for around 450-550 critically and severely injured patients per annum. A further cohort of moderately injured patients estimated at around 450-550 will also be taken to the MTC based on an expected over triage for admission at 100%. This equates to an additional 700 plus patients per annum attending QEUH compared to current levels. Modelling work is underway to review the NHS capacity required to support high quality care for these additional patients.

This is being considered in the broader context of the other service redesign work progressing within the MFT Programme and across the WoS.

The trauma network will also make appropriate links, via the NHS Boards and the MFT Programme Board, to social care and the voluntary sector. There will be a Paediatric Major Trauma Centre which will be located in Royal Hospital for Children (RHC).

The MTC will be supported by Trauma Units and a range of Local Emergency/Remote and Rural Hospitals.

3.3.2 Rehabilitation

Rehabilitation is a key part of the major trauma network and essential to good trauma care and good recovery.

Following major trauma, rehabilitation is essential for patients to address the physical and psychosocial needs that result from their injuries and experiences. Without such input, patients are unlikely to return to their maximum levels of function, which has significant implications for them, their formal and informal carers and society as a whole.

Access to specialist rehabilitation expertise is essential and the timing of delivery is also crucial. The following principles underpin rehabilitation delivered to Major Trauma patients :

- It will be person centred and will support decision making with patients
- Rehabilitation should start *as soon as is appropriate* after admission including in the critical care setting
- Trauma patients will receive rehabilitation at the intensity required, and for as long as is necessary, at all points along their entire rehabilitation care pathway in order to achieve their functional potential
- The rehabilitation and transfer aspects of the patient's pathway should be planned collaboratively across the regional network
- There should be adequately skilled and resourced multi-disciplinary rehabilitation teams in all of a network's services which cover all ages of major trauma patients

West of Scotland rehabilitation model has been based on guidance from British Society of Rehabilitation Medicine (BSRM), learning from NHS England, nationally agreed minimum rehabilitation requirements and models being supported by national group and other networks across Scotland.

The focus of the model is on a hub and spoke provision of specialist rehabilitation ensuring complex rehabilitation needs are met for major trauma patients from Day 1. It concentrates specialist services to improve outcomes for patients and to support patients to move along the rehabilitation pathway seamlessly. Patients' rehabilitation needs will be assessed shortly after they are admitted to the major trauma centre. Their rehabilitation will take place in the major trauma centre and continue in a trauma unit or in the local community.

3.3.3 Benefits of the Major Trauma Network

There are a number of key benefits associated with a major trauma network and these are detailed in the following table:

Benefits of a major trauma network for patients: ➢ More people survive. Evidence shows that if you are severely injured, you are 15% to 20% more likely to survive if you are admitted to a major trauma centre ➢ Patients would receive the best possible care from specialised teams providing emergency access to consultant care 24 hours a day, seven days a week ➢ Patients are less likely to have a long-term disability ➢ Patients will need less long-term NHS care ➢ Patients will be more able to return to work and do other activities ➢ The NHS is able to better plan for and respond to major incidents, improving the care patients would receive ➢ Hospitals specialising in major trauma need to have specialist doctors and clinical support staff available at all times. The major trauma network will help deliver this, making the best use of resources ➢ Local emergency departments are less likely to be disrupted by inappropriate major cases being admitted that can affect the ability of the department to manage its routine work.
Benefits of a major trauma network for organisations who are part of the network: ➢ It provides an opportunity to develop the skills and expertise of existing staff at the trauma units and local hospital sites through closer working with the highly specialist clinicians and other staff at the major trauma centre ➢ A network with a clearly identified major trauma centre and trauma units is likely to have a positive impact on recruitment across the network ➢ A major trauma network is likely to receive support from the Deanery, making it more likely that trainee doctors will be allocated to hospitals across the network to do their training ➢ Services are delivered within a clinical network which allows improvements to be made through an integrated, 'whole system' approach, resulting in standardised services and improved patient outcomes and experience ➢ Clinical services in West of Scotland for major trauma will be in line with the rest of Scotland and UK and will allow the West of Scotland NHS to be more effective as part of the national response to major emergencies.

4.0 Cases for Change to be reviewed in April 2019

Four cases for change have been identified for review at April Programme Board. These are at the initial development stages and following approval by the MFT Programme Board they will be progressed through the MFT Governance Structure and tested with the MFT Stakeholder Reference Group in May 2019. The Board will be updated on the progression of these cases for change as they move through the MFT Governance process, at which point detailed Project Initiation Documents will be shared.

4.1 eFrailty Tool

Frailty in Scotland - Impact

- About 560,000 and just over 10% of the population.
- Vulnerable and mild frailty – 355,000 people
- Moderate frailty – 151,000 people
- Severe frailty – 50,000 people

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Cost of frailty across health in Scotland

	All frailty groups	mild	moderate	severe
Unplanned bed days	£1,172m	£396m	£482m	£293m
Community prescribing	£430m	£231m	£137m	£62m
Outpatient appointments	£412m	£240m	£118m	£54m
GP appointments	£394m	£212m	£127m	£55m
Community nursing	£138m	£84m	£44m	£10m

Extrapolated costs over 12 months for people 65 and over with frailty.

While severe frailty can be comparatively easy to recognise and diagnose, lesser degrees of frailty may be more difficult to differentiate from normal ageing. Early identification of need leads to early care planning and proactive intervention; this in turn can prevent further deterioration, resulting in avoidable hospital admissions.

The electronic Frailty Index uses existing GP data, groups it into frailty deficits and calculates the degree of frailty. It was developed in England and validated against a population group of 900,000 people. Health Improvement Scotland have tested and adapted it to the Scottish context and through working with ISD the system will be available GPs across Scotland who have access to SPIRE. As individuals interact with GPs, their GP records accumulate a list of read codes and community prescriptions. When the degree of frailty is identified appropriate

preventative measures can be put in place to reduce the impact of frailty as noted in the picture above. In GGC this will allows us to target, within a good evidence base, the 15% to 20% moderately frail population in the first phase, to whom we can provide interventions to manage their frailty, preventing decline and hospital admissions, risk of care home admissions, and mortality.

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Access to preventative support

Mild	Moderate	Severe
Nutritional interventions	Reablement	Bed based intermediate care
Exercise and physical activity	Polypharmacy review	Community-based geriatric services
Smoking cessation	Primary care MDT	Palliative care
Reduce alcohol	Falls management	Hospital at home
Reduce social isolation	Anticipatory care planning	Anticipatory care planning
Housing adaptations	Immunisation	Adult carers support planning

This case for change seeks to promote the systematic use of agreed tools and information sharing to support the introduction and ongoing development of Comprehensive Geriatric Assessment (CGA – supported by a Cochrane systematic review), an integrated plan for treatment, rehabilitation, support and long term care.

4.2 Active Clinical Referral Triage (ACRT)

This national programme, launched under the auspices of the Scottish Access Collaborative, encourages putting more resource into intensive triage of all outpatient referrals to ensure that patients are signposted to the most appropriate service, rather than defaulting to a secondary care appointment when their care needs are not acute.

ACRT Potential Outcomes are noted below.

Back to Referrer/ Advice to Referrer	• Information sent back to referrer with details of relevant self treatment options.
Opt In	• Patient sent self-care information, along with details as to how they can request an appointment if required.
Remote Follow Up	• Patient is offered a follow up virtually, by telephone or video consultation (NHS Near Me).
Straight to Treatment	• Patients are referred for treatment and/or tests prior to being appointed at an outpatient clinic.
Open Return	• Patient is kept on an open return waiting list. No appointment is created, however one can be requested within the given timescale if required.
Discharge	• Patients are discharged from outpatient care.

This approach has been extensively trialled within North Sector Orthopaedics and would have implications for all outpatient specialties across GGC. It forms a suite of tools (noted below) that will be developed into cases for change and progressed through the MFT process in the coming months.

ACRT	• Active Clinical Referral Triage
Advice Referrals	• SCI Gateway referral that can be generated from primary care asking for 'advice' on patient treatment. Can be responded to with an advice letter, which is sent back to the GP practice through EDT.
Emergency/ Clinical Dialogue	• SCI Gateway Clinical Dialogue to provide bi-directional communication regarding patient care which is stored as part of the patient clinical record.
Remote Consultations	• Software application that enables video consultations between patient(s) and clinician(s), or groups of clinicians.

4.3 Community-led care for people with coeliac disease

This project was initially funded as a national pathfinder site in South Sector as part of the national Modern Outpatient programme. Its aim is to redirect people with coeliac disease to

community dietetics and pharmacy support and advice, rather than annual monitoring visits in secondary care Gastroenterology.

4.4 Diabetes Local Care

The ***Scottish Diabetes Survey 2017*** stated;

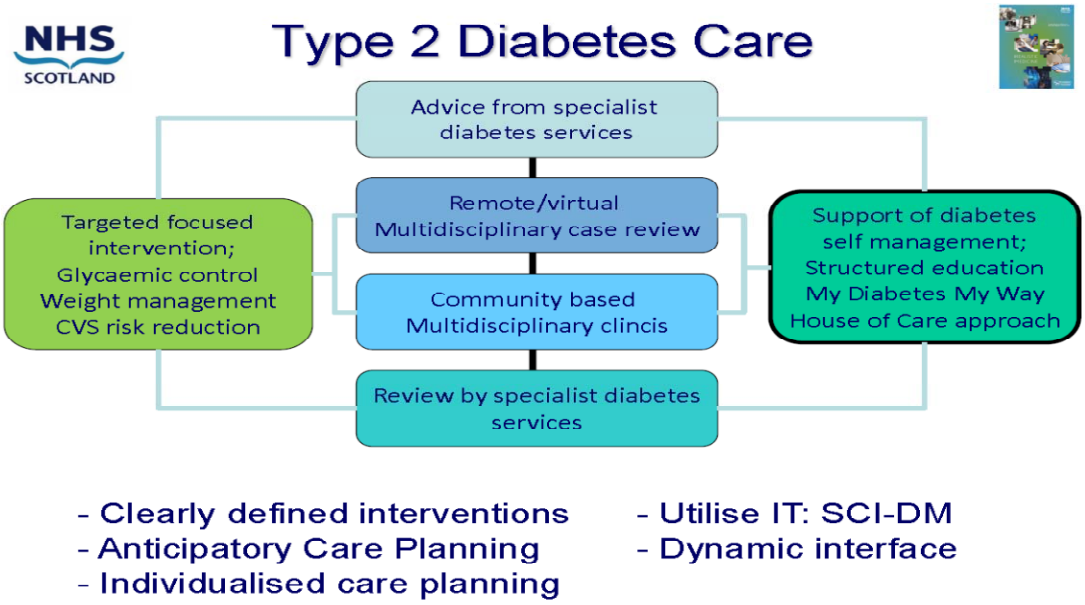
"There is a gradual decline in the delivery of all processes of care for those with diabetes in Scotland. Some of this relates to the change in the Quality and Outcomes Framework (QOF) funding for General Practice, but the specialist diabetes services in Scotland, not influenced by any change of primary care funding are also not delivering the 9 processes of care."

In recognition of this and in line with the principles of MFT, the diabetes MCN in GGC have developed a 'vision' for diabetes care that:

- Individuals with diabetes in Scotland will live longer and healthier lives.
- They will feel confident and able to self-manage their diabetes day to day.
- They will have equitable access to timely help and support from across the healthcare system and beyond when required.

In order to achieve the vision four separate but inter-linked elements of care have been identified as priorities (process summarised below).

- Delivery of 'monitoring appointments' at local chronic disease monitoring centres (health and wellbeing hubs)
- Lifestyle coach/self-help workers to support greater self-management
- Design and delivery of the MyDiabetes GGC app
- Delivery of a Primary care-based Integrated Diabetes Care Team [IDCT]



As this case for change is developed the implications for the management of other long term conditions will be identified and as the model of care is developed it can be assessed with other specialty groups e.g. COPD, with a view to system wide utilisation.

5.0 Future Cases for Change being developed

Three further initial cases for change have been identified for the May Programme Board, although more are expected once each of the six workstreams has confirmed the projects they wish to present:

- Cardiology Outpatient Transformation Models (engaging with Cardiology MCN)
- 'House of Care' Model for the management of long term conditions – this is an improvement framework developed to enable services to embrace care planning as an approach to support self-management of people living with Long Term Conditions
- Anticipatory Care Planning (Prototype under development)

6.0 Moving Forward Together: Public Involvement Update at end March 2019

Aim: Deliver a comprehensive programme of public involvement to engage with people about the Moving Forward Together Programme.

6.1 Programme Stakeholder Reference Group

a) Presentations to be developed for emerging Workstream PIDs to be delivered to PSRG:
   i) Systemic Anti-Cancer Therapy Case for Change
   ii) Trauma care
   iii) Active Clinical Referral Triage
   iv) Identifying Frailty in Older People
b) Group to meet with senior leadership on 29 May to engage in discussion and debate about the Programme their support for it and what they think are the key challenges
c) Membership continues to be developed to maximise geographic and demographic representation from across GGC

6.2 Public Involvement

Phase 1 of the Programme's strategic approach to public involvement set out to; raise awareness and hear initial feedback about need to change and direction of travel; understand what matters most to people to help inform future service delivery models; and to encourage future participation via an iterative process and ongoing conversations.

Following feedback at the Annual Review meeting work is underway to identify suitable dates, times and venues to hold evening engagement sessions to ensure equal opportunity is afforded to all members of the public to become involved in the Moving Forward Together programme. This applies equally to staff involvement opportunities and this is also being explored.

6.2.1 HSCP Locality Engagement Events

Programme is working alongside HSCP colleagues to develop and deliver a series of locality engagement events:

HSCP / Locality	Date	Time	Venue	Notes
Renfrewshire	18 Jan	09:30-12:20	Johnstone Town Hall	98 people – members of the public and community planning partners
West Dunbartonshire (Alexandria)	13 Mar	09:30-12:30	Alexandria Community Centre	26 members of the public
West Dunbartonshire (Clydebank)	19 Mar	09:30-12:30	Clydebank Town Hall	26 members of the public
Inverclyde HSCP	25 Mar	10:00-13:00	Tontine Hotel, Greenock	72 members of the public
East Dunbartonshire HSCP (East)	05 Apr	9:30-12:00	Bishopbriggs War Memorial Hall	
East Dunbartonshire HSCP (West)	05 Apr	13:30-16:00	Bearsden Community Hub	
East Renfrewshire HSCP	30 Apr	12:30-15:30	TBC	
East Renfrewshire HSCP	05 May	9:30-12:30	TBC	
Glasgow City	TBC	TBC		

The purpose of these events is to describe the HSCP's local strategic plans and priorities, to introduce MFT as GGC's strategic Vision for health and social care and to demonstrate alignment between the two.

Content has been developed based on the MFT tiered model of care to describe the Programme's underlying principles and concepts for each level with HSCP examples used to illustrate any local current / planned local activity aligned to this.

The format is a combination of presentations with Q&A and facilitated table-top discussion to hear and understand what matters most to people when developing new models of care; and how can we work together to meet challenges

HSCP and NHSGGC communication channels are being used to promote sessions and PSRG are being asked to share across their networks.

We are currently reviewing holding evening events and will pilot this approach in the near future.

6.2.2 **Community Engagement**

HSCP colleagues and PSRG have been asked to identify other local opportunities to present to community groups to raise awareness, develop links and have initial conversations about the Programme. This will be an ongoing process with each HSCP and community session providing more links and part of the planned networked approach to how we will reach into and engage with people. To-date the following sessions have been undertaken / are planned:

Group / Session	Date	Notes
North East Hub Development Engagement Session	09/01/2019	45 people - professional and public
Wheatly Housing: Registered Tenants Association	18/01/2019	10 members of the public
Levern Community Council	31/01/2019	11 members of the public
Glasgow South Locality Engagement Forum	26/02/2019	41 people – professional and public
Kirkintilloch Seniors Forum	28/02/2019	30 members of the public
Active Seniors / Knightswood Seniors Forum	13/03/2019	26 members of the public
Glasgow North West Locality Engagement Forum	21/03/2019	15 members of the public
Cardonald College HCSW	17/04/2019	
Glasgow City RTO Networking Event	29/04/2019	

6.3 **Feedback**

All feedback from public involvement sessions is being logged and will be analysed and used to inform future content such as FAQs, examples of transformation in practice and drive engagement so that it becomes and iterative process.
Early feedback from initial sessions is that the vast majority people recognise the challenges health and social care are facing and agree with the direction of travel set out by the Programme. The broad themes emerging when we ask what matters most to people are:

- Being treated with dignity, respect and well informed about and involved in decisions about care
- Education to improve knowledge and support people to access and use services differently is critical
    - The next generation are key e.g. in schools, further and higher education
- Recognise the need to use technology and support better information sharing
    - Disbelief that information is not already shared across those who need/should have access to provide joined-up care
    - Wherever possible provide patients and carers access to information to allow them to make better decisions
- Access and transport
    - Recognise there might be fewer specialist centres but question how will people and particularly the elderly access them
    - Concern that centralising service will have an impact on local hospitals
- Being open and honest with people
    - Transparent communication about current performance such as waiting times and challenges in delivering seamless care across settings
    - Tell people how much things cost – free at point of access but still needs financing
    - How is this going to be done with resources already stretched
    - Where is the workforce - who is going to deliver this and when if needs new roles

6.4 **GGC Third Sector Event**

A provisional date with Programme Board / senior leadership availability for a GGC wide Third Sector Event has been set for 19 June. Efforts to find a suitable central venue to meet capacity and accessibility is underway. When confirmed planning with Workstreams and the Equalities and Human Rights Team will progress to ensure inclusiveness.

The primary aim of the event is to provide a Greater and Glasgow and Clyde wide forum to engage with the relevant Third Sector organisations about Moving Forward Together

- Raise awareness about the Programme and the need to transform health and social care services
- Promote participation and encourage future joint working as part of a journey to help influence and shape future models of care
    - Find out what matters to Third Sector organisations in delivering care and support in our communities
- Create buy-in and develop mutually beneficial relationships that:
    - Enable more in-depth meaningful conversations to facilitate stakeholder informed redesign of health and social care services
    - Establish alliances and support for service redesign and transformation to reach those most affected and wider networks as part of any public facing campaigns

7.0 **West of Scotland Regional Planning Update**

7.1 The West of Scotland Regional Planning Team have commented on the strong alignment between the Regional Design and the overall MFT programme (e.g. Board approved report on SACT in December 2018); and the work being taken forward through the West of Scotland/Regional workstream (with PIDs prepared for cancer services and neurosciences).

7.2 The Model of Care proposed within the Regional Design seeks to reinforce the ambition and key elements of Realistic Medicine with respect to the West of Scotland health and care system.