NHS Greater Glasgow and Clyde

NHS Greater Glasgow & Clyde	Paper No. 19/41
Meeting:	NHS GGC Board
Date of Meeting:	20 August 2019
Purpose of Paper:	For Noting
Classification:	~~Official Sensitive~~/Board Official
Sponsoring Director:	Dr Jennifer Armstrong, Medical Director

Moving Forward Together (MFT): August 2019 Progress

Recommendation

The Board is asked to note progress in implementing the MFT vision and agree the next steps.

Purpose of Paper

- To update the progress in implementing MFT
- To note the next steps

Key Issues to be considered

- Priorities for MFT programmes, including progress in implementing Best Start recommendations
- Staff, public and stakeholder engagement
- Next steps

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. The Unscheduled Care work will progress the requirement from MSG to use set-aside budget to shape services. The Trauma Network in the West of Scotland has received £17m to implement the Major Trauma Centre and Trauma Units.

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. Individual projects within the MFT Programme will have workforce implications which will be brought to CMT, FP&P and GGC Board as appropriate.

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.
MFT has a risk register for the programme and individual workstreams are producing risk registers.

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
Fiona MacKay, Associate Director of Planning

Date 8 August 2019

Moving Forward Together:
Update August 2019

1. Background

Moving Forward Together (MFT) : Greater Glasgow and Clyde's Vision for Health and Social Care was approved by the NHS Board in June 2018 and subsequently at all six Integration Joint Boards (IJBs). The programme then moved into implementation phase, establishing a Project Management Office and governance structure. Six workstreams have been set up, each chaired by an HSCP Chief Officer, and with wide cross system representation. The workstreams cover:

- Planned Care
- Unscheduled Care
- Local Care
- Mental Health
- Older People's Care
- GGC Regional Services

The workstreams report through an Executive Group and a Programme Board, chaired by the Board Chief Executive. They are supported by a Stakeholders' Reference Group and a Workforce Reference Group. A programme for reporting has been set up, with a focus on two workstreams at each Programme Board.

2. Priorities

2.1 MFT Workstream Priorities

The six workstreams agreed a small number of priorities which are listed at Appendix 1, and are developing cases for change. The priorities emerged from the early work with the 31 clinical specialty groups, and contributors to that early work have been invited to participate in the workstreams. The Executive Group agreed to focus on some key high impact actions, recognising the need to balance progress towards the long term vision with the immediacy of meeting increasing demand and achieving in year targets. The workstreams are focussing on:

- Developing local care hubs to deliver services traditionally provided in hospitals. This will make use of existing and planned community facilities. The Planned Care workstream is leading this work.
- Developing a comprehensive framework for long term conditions, beginning with diabetes. eHealth is a key partner in this work. The Local Care workstream is leading this work. (The proposed clinical and long-term outcomes for the Diabetes self-care framework are included at Appendix 2 as an example of this approach.)
- Directing and redirecting people to the most appropriate service and establishing the Out of Hours Resource Hub model. The Unscheduled Care workstream is leading this work.
- Active public messaging in targeted areas. The project management office is leading this work with the Corporate Communications Team.

Each workstream is developing a project plan with clear timescales and milestones. The plans will describe the expected impact of each element.

2.2 National and Regional Priorities

In addition to these priorities, a number of national/regional plans are being progressed as part of MFT. These pieces of work fit well with the MFT tiered model of care which sees specialist services being delivered in a small number of centres and the aspiration to deliver other care as near home as possible. They include:

- The development of the West of Scotland Trauma Network which was approved at the June NHS Board meeting
- The emerging service model for Systemic Anti-Cancer Therapy (SACT)
- The implementation of Best Start, the national strategy for maternity and neonatal care

2.3 Best Start

Early Implementer experience of delivering Continuity of Carer for women (antenatal, intrapartum and postnatal) is progressing within the Clyde Sector. Adoption of the new model started with the Community Midwifery Team in the Barrhead, Hawkhead and Glenburn area in January. The second team covering Johnstone (Postcodes PA5, PA9, PA10, PA12) is to commence by the end of September. Learning from these teams combined with the learning from other Early Adopter Boards throughout Scotland is underpinning workforce projections for the full impact across NHSGGC. Until implementation of the final tested and approved model, midwifery teams across NHSGGC are focusing on improving delivery of ante and post-natal care. Further planning work is progressing to determine the optimum network of midwifery hubs in the community to provide comprehensive local outpatient care that is often currently based within GP premises. The Community Maternity Units at IRH and VoL will continue to provide maternity services to local mothers and their babies.

From the 19th August NHS Ayrshire and Arran (NHS A&A) and NHS Greater Glasgow and Clyde (NHSGGC) are implementing the Neonatal pathway recommendations in 'Best Start: The 5 Year Forward Plan for Maternity and Neonatal Care in Scotland'. This will see more of the smallest and sickest babies from NHS Ayrshire and Arran being cared for at the Royal Hospital for Children's Neonatal Unit and Maternity Unit on the Queen Elizabeth University Hospital site. Best Start aims to ensure that Scottish babies who need neonatal care benefit from safe, sustainable and high quality services. One of the Best Start recommendations is to concentrate expertise in the care of the most premature and unwell infants in fewer specialist centres. Women at high risk of extreme premature delivery will be transferred antenatally to QEUH for initial management, delivery, postnatal care and neonatal intensive care for their new born baby. Where a safe antenatal transfer is not possible, extremely premature infants will be transferred to QEUH as soon as safely possible after initial stabilisation at Ayrshire Maternity Unit. It will be supported by the introduction of Transitional Care at the QEUH to enable babies who require some medical or midwifery support (but not intensive care) to be looked after beside their mother. This will improve quality of care whilst releasing capacity in Neonatal care.

3. Staff, Public and Stakeholder Engagement

Between January and June 2019, the MFT Programme engaged with 649 people across 19 separate public and smaller meetings which included members of the public: MSPs, councillors and other political representatives; community planning staff; and Third Sector organisations. The PMO encourages and accepts invitations to speak to small groups and community organisations, which are promoted via its website and social media accounts.

There were eight joint public meetings held with five of the Health and Social Care Partnerships. These public meetings were promoted via the NHSGGC's Involving People Network mailing list with over 38,000 contacts.

In addition, two major meetings were held to take forward the formal engagement process:

3.1 Stakeholder Reference Group

This group met on 29 May 2019, and a series of presentations were given by the Chief Executive, Medical Director and Chief of Medicine. Topics covered in the discussion were the specific cases for change around:

- Major Trauma
- Systemic Anti-Cancer Therapy
- Identifying frailty and managing its impact on people
- redesigning outpatient services for both acute and long-term conditions by focusing on supported self-care at home and in the community

The SRG endorsed the work of the Programme and its specific workstreams.

3.2 Third Sector Event

The MFT Programme hosted an event on 19 June 2019 with 61 participants from across 34 Third Sector organisations plus 11 colleagues from Social Care, the Scottish Ambulance Service and Scottish Fire and Rescue.

Event commentary and content will be hosted online, but feedback has been positive. A full evaluation of the event has been undertaken by the Scottish Health Council, with whom the Programme meets on an ongoing basis to get advice and guidance on the engagement strategy.

3.3 Initial feedback

A full engagement report reflecting on the work over the past six months has been written up and once approved by the Executive Group and the Programme Board, this will be widely circulated and published on the MFT website.

The majority of people who participated in the engagement sessions recognised the challenges that health and social care services across Greater Glasgow and Clyde are facing in terms of rising demand, scarcity of resource and financial pressures. It was also widely accepted that there might be a need for people to travel to access some specialist services.

People indicated that what matters most to them was:

- Being treated as an individual with dignity and respect
- Being provided with all the information and being involved in and making informed decisions about treatment and care
- Patients and carers being treated as an equal partner in care with valuable knowledge and experience
- Having trusting relationships with people and continuity of care

Specific public comments included:

- "Digital disruption and technology will play a big role in this – need to plan for tomorrow's service users"
- "Don't make assumptions about what different groups need or want i.e. common myth that older people don't want or can't cope with services by tech – not true."
- "There is much more to do in terms of linking up the health services but people also need to work for themselves and look after their own health."
- "There needs to be more focus on self-care – people need to take more responsibility."
- "Communication with patients and carers is key. Information is kept secret. Patients should hold their own information. They can then make certain the right decisions are being made."

3.4 Staff engagement

One of the strengths of the MFT Programme's development has been the involvement of clinical staff in developing the future service models. To re-engage with this wider community, the MFT programme has written out to everyone who attended or put themselves forward for the original thirty-one clinical reference groups.

The clinical reference group members have been asked to consider:

- how the tiered care approach outlined in the Blueprint could best be implemented across their areas
- whether there were any specific ideas which they would like the MFT Programme to work up which could transform care within their area of practice
- whether there are existing or recent changes within their own area of practice which could be scaled up across all specialties

Initial responses have been strong, with expressions of interest in joining existing workstreams from across the medical, nursing and AHP communities.

4. Next Steps

4.1 Trauma

Following approval of the implications of establishing a Trauma Network in GGC, detailed planning for this is now being progressed. Planning groups for the Trauma Unit at the GRI and the RAH have been established reporting to the main Trauma Planning Group and a separate group for taking forward the children's Trauma work has been set up.

Discussions about the rehabilitation model are taking place with local Health and Social Care Partnerships. Staff engagement and public communication are prioritised in each part of this work.

4.2 Unscheduled Care

To complement the work of the Unscheduled Care workstream and to respond to the immediate pressures on hospital sites, HSCPs are working with acute colleagues to develop commissioning intentions. These intentions will describe how the health and care system will reduce demand for unscheduled care, manage the process at the front door of hospitals and improve safe and effective discharge. This will describe how we will work together to reduce the demand for unscheduled care by 5% and meet target waits.

Proposals to develop Urgent Care Resource Hubs have been developed by a cross-Board Project Board. These Hubs will support both achieving the patient-centred, transformational change proposed by the MFT Programme and meeting the recommendations of Sir Lewis Ritchie's review of Out of Hours Primary Care Services, which described a model for out of hours and urgent care in the community that is clinician-led but delivered by a multi-disciplinary team where patients will be seen by the most appropriate professional to meet their individual needs, whether that be a GP, a nurse, a physiotherapist, a social services worker or other key worker.

Progress to date has been fully endorsed and agreed by members of the Review of Health and Social Care OOHs Programme Board who oversee this work on behalf of the 6 HSCP Chief Officers. Operational planning continues and will inform the content and development of the Options Appraisal.

The Options Appraisal will:

- consider the number of UCRH(s) required and where they will be located
- confirm service and agency access and pathways to the UCRH
- determine if services should be co-located within the UCRH or virtual links established and how hosted services will be configured within the model

4.3 Local Care

A Diabetes case for change has already been proposed and agreed by the MFT Programme Board which is focused on developing a more person-centred approach to Diabetes care which is community-based and involves supported self-management via primary care based Integrated Diabetes Care Teams (IDCTs), self-help support workers and monitoring appointments at local chronic disease services.

NHSGGC has also been awarded funding to support the implementation of the National Diabetes (Type 2) Prevention Framework, which is focused on early intervention and support for weight management; healthy pregnancy and postpartum management of gestational diabetes; and better identifying patients for future case management. Proposals on this are due to be presented to CMT in September 2019.

Appendix 1: MFT Programme Priorities

Workstream	Title	Outline Description
Planned Care	OP Transformation	Focus on reducing the number of OP attendances in hospital via changes to referral criteria, review practices, the use of NHS Near Me and self-monitoring post-treatment
	Maximisation of Community Health Centres	Focus on providing OP consultations and follow up in a community health centre rather than an acute hospital and taking advantage of new H&SC Hubs
	Diagnostic One Stop Shop Model	Development of one stop shop specialist diagnostic services for clinically appropriate pathways at single centres of excellence in each sector
Unscheduled Care	ED Redirection and Alternatives to ED Attendance	Focus on providing and utilising alternatives to ED attendance in the community and supporting self-care
	Support to and interface with Care Homes	Focus on anticipatory and preventative interventions in care homes to avoid hospital admission
	OOH Provision	Taking forward the recommendations of the OOH review and establishment of the OOH Resource Hub Model
	Management of Frequent ED Attenders	Focus on developing local processes to support people appropriately in the community or at home in order to prevent avoidable attendance at ED
Local Care	Long Term Condition Management	Testing the principles of self-care, supported self-care and remote self-management using technology for people with long term conditions
	Palliative and end of life care	A comprehensive cross system review of palliative care and end of life care in primary, community and hospital facilities
	Health Literacy and Technology	A comprehensive cross system programme providing support and education to enable people to manage their own conditions and to utilise the opportunities presented by the use of self-monitoring technologies
	Anticipatory Care Planning	The expansion of anticipatory care planning across the system via a joined up shared care plan for people coproduced and maintained by the team across primary community and secondary care.

Workstream	Title	Outline Description
Mental Health	Unscheduled Mental Health Care	Implementation of the unscheduled care review developed as part of the MH strategy, working in partnership especially with EDs, Primary Care OOH and community alternatives. Effective use of Action 15 funding to meet patient need and support wider system.
	Mental Health in Primary Care	Work plans developed as part of the MH Strategy and Primary Care Improvement Plans need to align; redesign with a particular focus on responding to "stress and distress" as well as clinical conditions.
Older People's Care	Community Intensive Supports	Testing the emerging model for the maximisation of intensive community base support including geriatrician outreach into communities and use of frailty practitioners. A move to providing support and administering care in people's homes or in care homes.
	Early Identification of Preventative Frailty	A population health and intelligence-based approach to risk identification through risk stratification using frailty tools for anticipatory care to prevent avoidable admissions and promote community-based care
	Dementia Framework	An examination of a new approaches to delivering dementia care as an alternative to inpatient care with an investment in community-based facilities or using existing community facilities and infrastructure to provide locality based care.
GGC Regional	Comprehensive WoS Cancer Strategy	Working with WoS colleagues to develop a complex surgery model, to roll out the extant SACT Strategy and to provide a clear vision for all cancer services across WoS and provide context for the future configuration of the BWOSCC.
	Neuroscience Services	A comprehensive review of Neurosciences to develop a strategic plan including the development of a tiered model of care for Neurology which can be applied across all NHS Boards. The development of a new service model for Interventional Neuroradiology including Stroke Thrombectomy.
	Best Start	To implement the national Best Start Strategy in GGC and across WOS to improve maternity and specialist neonatology provision for all families

Appendix 2: Diabetes supported self-care outcomes

Outcomes

CLINICAL OUTCOMES

80% of patients with HBA1C<58 @ 1 year

The % of newly diagnosed patients who remain on universal support with well managed indicators at 1 year. e.g. HBA1C<58 @ 1 year / BP (<140/80mm/Hg) / cholesterol < 5mm/ltr

The % of newly diagnosed patients who attend structured education within 9 months of diagnosis

The % of newly diagnosed patients with a BMI > 30 who attend WMS and the % of those who attend WMS who lose>10% body weight

The % of newly diagnosed patients registered on My Diabetes My Way App

The % of patients who attend annual review and have a n agreed care plan

The % of patients who have 9 PoC measures completed

The % of patients who remain well controlled (maintain green pathway)

LONG TERM OUTCOMES

Individuals live longer healthier lives with diabetes

Individuals feel confident and able to self manage diabetes day to day/ Individuals know their status and have a patient centred care plan

Individuals have equitable and appropriate access to timely support from the healthcare system and beyond when required.

PATIENT CENTRED OUTCOMES

Self Care is Facilitated

Integrated diabetes care is provided