

MOVING FORWARD TOGETHER: NHS GGC'S HEALTH AND SOCIAL CARE TRANSFORMATIONAL STRATEGY PROGRAMME

Recommendation:-

The Board is asked to approve the plan and associated timescales set out below to develop a Transformational Strategic Programme for NHSGGC 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 NHSGGC population.

Purpose of Paper:-

To seek Board support for and approval of the development of a Transformational Strategic Programme for NHSGGC Health and Social Care Services: Moving Forward Together.

The paper also includes an Annex which highlights areas of transformational change already delivered across health and social care in NHSGGC.

Key Issues to be considered:-

The requirement for NHSGGC 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 NHSGGC'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 NHSGGC'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 NHSGGC'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 – Transformational Team

Tel No – 0141 201 4611

Date – 10 October 2017

MOVING FORWARD TOGETHER: NHS GGC'S HEALTH AND SOCIAL CARE TRANSFORMATIONAL STRATEGY PROGRAMME

PART ONE: NHSGGC Strategic Background and National Strategies/Plans and Requirements

NHSGGC strategic background

NHS services in general and NHSGGC acute services in particular have gone through a period of ongoing change since the millennium. The delivery of the Glasgow Acute Services Review first approved in 2002 and the South Clyde Strategy (2006) and the North Clyde Strategy (2009) have seen changes across services in what is now Greater Glasgow and Clyde. The achievement of the various infrastructure and service improvements embedded within these strategies culminated in the opening of the new Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children in May 2015.

In addition, in 2012 the NHSGGC Board commissioned a strategic review of clinical services to ensure their fitness for future demands. This work was completed and approved by the NHSGGC Board as the Clinical Services Strategy in January 2015. This Clinical Services Strategy was also adopted by the emergent Health and Social Care Partnerships as a framework for planning clinical services. That position remains extant.

National and regional strategic background

Since 2015 there have been a number of National Strategies published by the Scottish Government, including the National Clinical Strategy and Health and Social Care Delivery Plan as well as strategies for mental health, major trauma, cancer services, maternity and neonatal care, primary care, intermediate care and realistic medicine.

The Scottish Government have confirmed that by 2021 there will be Diagnostic and Treatment Centres (DTC) across the country, in addition to the enhancements to the current Golden Jubilee National Hospital. This investment is to build capacity for diagnostics and planned surgery away on dedicated sites away from the emergency and trauma centres and units. The precise configuration of these centres is yet to be fully defined but in planning for the future, it is essential that NHSGGC and West of Scotland plans influence and take account of this development.

The Health & Social Care Delivery Plan (HSCDP) reaffirms the need for planning regionally a range of clinical services on a population (cross geographical boundaries) basis. The West of Scotland Regional Planning Group is therefore developing its strategic planning programme in line with these requirements, with all component NHS Boards, including therefore, NHSGGC. This too must include forward planning towards establishment of the DTCs as well as within estates, capital and revenue planning.

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 within the NHSGGC Board area and each has in place a strategic plan and supporting commissioning intentions.

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.

In 2016, Audit Scotland set out a range of findings and recommendations for Scottish Government and for NHS Boards and Health and Social Care Integration Joint Boards, summarised (by Audit Scotland) as below.

“The NHS is going through a period of major reform. A number of wide ranging strategies propose significant change, including the National Clinical Strategy, integration of health and social care services and a new GP contract. These need to be underpinned by a clear plan for change. Some progress is being made in developing new models of care, but this has yet to translate to widespread change in local areas and major health inequalities remain.

Recommendations

The Scottish Government should:

- provide a clear written plan for implementing the 2020 Vision and National Clinical Strategy, including: – immediate and longer-term priorities, including a public health strategy to help NHS boards focus on preventing ill health and tackle health inequalities – support for new ways of working and learning at a national level – long-term funding plans for implementing the policies – a workforce plan outlining the workforce required, and how it will be developed – ongoing discussion with the public about the way services will be provided in the future to manage expectations*
- set measures of success by which progress in delivering its national strategies can be monitored, including its overall aim to shift from hospital to more community-based care. These should link with the review of national targets and align with the outcomes and indicators for health and social care integration*
- consider providing NHS boards with more financial flexibility, such as three-year rolling budgets rather than annual financial targets, to allow better longer-term planning*

The Scottish Government, in partnership with NHS boards and integration authorities, should:

- model the cost of implementing its National Clinical Strategy and how this will be funded, including the capital investment required*
- share good practice about health and social care integration, including effective governance arrangements, budget-setting, and strategic and workforce planning*
- in line with the national policy on realistic medicine: – work to reduce over-investigation and variation in treatment – ensure patients are involved in making decisions and receive better information about potential treatments*

NHS boards, in partnership with integration authorities, should:

- *take ownership of changing and improving services in their local area, working with all relevant partner organisations*

In response the Scottish Government published the Health and Social Care Delivery Plan (HSCDP) which is predicated on a “Triple Aim” of Better Health, Better Care and Better Value. It also described these aims in terms of reducing inappropriate use of hospital services; shifting resources to primary and community care and supporting capacity of community care.

It is against this national strategic background that this Programme – Moving Forward Together - is proposed so as to ensure NHSGGC health and social care services keep pace with best available evidence and ongoing transformational change nationally and regionally to meet the needs of the people of Scotland, ultimately delivering the Triple Aim set out in the HSCDP – Better Health, Better Care, Better Value.

The Aim and Objectives of the Moving Forward Together Programme

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 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 objectives are:

- 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.

A detailed description of the programme is set out in the accompanying paper. The Board is invited to consider and confirm its approval to proceed to develop Moving Forward Together as outlined. This will see the delivery of a comprehensive transformational change plan to come forward to the Board by June 2018.

MOVING FORWARD TOGETHER: A TRANSFORMATIONAL STRATEGY FOR HEALTH AND SOCIAL CARE SERVICES ACROSS NHS GREATER GLASGOW AND CLYDE

PART ONE: National Policy Strategic Context

The strategic landscape set for NHS Scotland in which NHSGGC must operate can best be described as an agreed and supported direction of travel which is founded on evidence based good practice and sound principles. Audit Scotland highlighted both the imperative to continue to pursue this direction of travel, but also recognised the challenges which face us in delivering the changes which are required to move us forward together.

The high level picture for our nation is one of changes to the demographic composition of our population and the challenges which that brings. It is to be celebrated that our people are generally living longer and healthier lives due to the range and quality of past and present prevention programmes and the care services that the NHS in Scotland has and is delivering.

It is also recognised, however, that these positive changes place increasing demands on health and social care services, who in turn work within allocated 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.

This changing and challenging environment drives a requirement to review and where necessary redesign our health and social care services for the future.

2020 Vision

The 2020 Vision remains the pinnacle of NHS Scotland Health and Social Care policy and it clearly has relevance beyond 2020.

The Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare 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

If the 2020 Vision is the pinnacle of the policy frameworks then the Quality Strategy is what underpins the frameworks.

The Quality Strategy (2010) is the approach and shared focus for all work to realise the 2020 Vision.

The Quality Strategy 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:

- **Safe**
There will be no avoidable injury or harm to people from healthcare and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all time
- **Person Centred**
Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision making
- **Effective**
The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit and wasteful or harmful variation will be eradicated.

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 Authorities now have responsibility for over £8 billion of funding across Scotland for the delivery of services which was previously managed separately by NHS Boards and Local Authorities. 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.

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 provides 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 brings closer together the range of services available to make them near seamless and more responsive to the people who use them.

Hospitals should and will 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 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 9 outcomes, which are monitored through a range of measureable 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
Outcome 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
Outcome 3	People who use health and social care services have positive experiences of those services, and have their dignity respected
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Outcome 5	Health and social care services contribute to reducing health inequalities
Outcome 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 well-being
Outcome 7	People using health and social care services are safe from harm
Outcome 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
Outcome 9	Resources are used effectively and efficiently in the provision of health and social care services

What does this mean for NHSGGC?

Metrics to monitor the delivery and impact of these nine outcomes have been described separately by Scottish Government. In terms of impact for NHSGGC, taking outcome 5 as an example, the Board will wish, in due course, to be able to define its contribution to reducing health inequalities across its population, particularly as there is continuing evidence of a widening gap in health inequalities within the City of Glasgow.

We will

- ensure that appropriate health inequalities impact assessments are a core component of the Moving Forward Together programme proposals for change

The National Clinical Strategy

The National Clinical Strategy (NCS) was published in February 2016. It is evidence based and sets out the drivers for the required transformational change in the delivery of clinical services. It follows an approach that looks across the whole patient pathway from primary care, community care, to secondary/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 available resource to consider the wider implications of those changes for NHS Scotland for the next 10 to 15 years and beyond.

The NCS lists the key drivers for transformational change as:

- 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 issues
- financial considerations
- changes in the range of possible medical treatments
- remote and rural challenges to high quality healthcare
- opportunities from increasing information technology (e-health)
- a need to reduce waste, harm and variation in treatment

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 NCS recognises the current challenges to the delivery of these changes in NHS Scotland which are reflective of those facing NHSGGC:

- increasing need for support for an ageing population with increasing levels of multi-morbidity
- multi-morbidity arising approximately a decade earlier in areas of deprivation

- A need to
 - improve care and outcomes via an expanded, multidisciplinary and integrated primary and community care sector, despite current workforce constraints
 - to increase co-production with patients and carers, create high quality anticipatory care plans and to 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 overtreatment and over medicalisation and at the same time prevent undertreatment 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, and
 - 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 NHS GGC will cut across the whole range of services from primary through community, acute care and beyond. This programme – Moving Forward Together – is aimed looking forward to the transformational changes that will be required for meeting the assessed future needs of our people. Taking as an example the principles of service planning, these will potentially significantly change in terms of both the “Once for Scotland” approach in, for example, shared diagnostic services 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 will likely lead to changes in the organisation of 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 NCS sets out evidence based examples of those services best provided locally, regionally and nationally. This evidence based configuration linked to population size will be a foundation principle for both WoS regional planning and Moving Forward Together.

We will

- maintain open dialogue with delivery partners, e.g. HSCPs, National Services Division, WoS Regional Planning leads and our workforce across all services and service sectors to ensure planning is joined up and cohesive across all relevant NHS Boards and partners.
- bring forward a forward plan that is developed together with all such partners and is agreed by them as a sustainable way forward.

Health and Social Care Delivery Plan

The Health and Social Delivery Plan (HSCDP) sets out in greater detail the outcomes required in the delivery of integrated health and social care services. It represents what Scottish Government expects NHS Boards, Local Authorities and IJBs to deliver in partnership with the voluntary sector, patients, carers, families and our wider population.

The HSCDP focuses on three areas, which are referred to as the “Triple Aim” -

Better Care

- ❖ To improve the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all

Better Health

- ❖ To improve everyone’s health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self management

Better Value

- ❖ To increase the value from and financial sustainability of care, by making the most effective use of the resources available to us and the most efficient and consistent delivery, ensuring that the balance of resource is spent where it achieves the most and focusing on prevention and early intervention.

The HSCDP goes on to describe how transformed Health and Social Care services will benefit individuals and communities and will impact on regional and national services.

National and Regional Approach to Service Planning

The National Clinical Strategy introduced the requirement to plan services on a population basis whether regionally or nationally (Once for Scotland) determined by evidence of those services that can best be delivered at local, regional or national level.

The West of Scotland (WOS) now has a nominated Chief Executive lead and the Director of WOS Regional Planning is building a team of co-opted senior executives from NHSGGC and other boards and seconded managers to take forward the WOS regional planning agenda.

The stated requirement is to develop a regional transformation plan by September 2017 which sets out how the region will support delivering the HSCDP with board local development plans setting out their contribution both to the regional and national plans.

By March 2018 each region is expected to have a plan setting out how services will evolve to deliver the NCS and further develop the efficiency of secondary care.

NHSGGC plays a full part in the leadership of and support to various work streams in the development of the West of Scotland planning process.

The plans will need to consider how services will be evolved over the next 15-20 years to support the transformation of health and social care and ensure the longer term investment in services and estate is committed to the right areas to deliver the aims of the national clinical strategy and HSCDP.

This WOS planning will run alongside the NHSGGC Moving Forward Together Programme and as it develops the interdependency and alignment will be continually monitored and necessary adjustments made through the maintenance of a close working relationship between the two teams.

Primary Care

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

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. Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of our services.				
HSCP OUTCOMES				
Services mitigate inequalities	People can look after own health	Live at home or homely setting	Positive Experience of Services	Services improve quality of life
Carers supported to improve health	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 better co-ordinated with community and secondary care	Our primary care infrastructure – physical and digital – is improved		Primary care better addresses health inequalities	

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*.

A new GP contract is under development with changes expected from April 2018. The contract, 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.

A key part of the vision is the establishment of clusters of GP practices. These are now in place across Scotland with a clear remit to provide leadership on quality improvement across practices and with wider services.

The Scottish Government review of Out of Hours primary care services was published in February 2017. It seeks to ensure that services are

- Person centred, sustainable, high quality, safe and effective
- provide access to relevant urgent care when needed
- deliver the right skill mix of professional support for patients during the out of hours period

Four theme based task groups were set up to examine workforce matters; how data and technology can enable improvements; explore new models of care and explore what a quality out of hours service would look like.

The Scottish Government also committed £1m to testing the Review Chair's recommended new model of urgent care with seven pilot sites throughout Scotland testing various aspects of this model.

The results of this Initial Testing Programme will inform the National Delivery Plan for the Transformation of Urgent Care, for which £10 million is committed in 2017. It is intended that this will deliver both national and local initiatives over the immediate and longer term towards enabling improvements in urgent care services.

We will

- continue to support the 39 clusters across NHS GGC as a cornerstone of future developments in primary care.
- work together with primary, community and secondary care partners to drive and support action to put in place the Review recommendations for urgent/out of hours care.

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-hours 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 multidisciplinary 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 eyecare in the community.

The Oral Health Improvement Plan currently under development will set out the steps to support NHS dental services to have an increasing focus on prevention.

Mental Health

The Scottish Government published a ten year strategy for mental health in March 2017. It is wide ranging and cross cutting across, for example, education, prison, secure care, children, young people and adults, including 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.

In terms of NHSGGC, it is not the purpose of this document to set out a range of specific actions required. That will take time given the complexity of the overall actions required, but it is vital that this programme considers and sets out the needs for people who need mental health and associated support services, whether provided by the statutory or the voluntary sector.

We will

- Work with health and social care partnerships and relevant sectors, including education and secure sector as required, to ensure that NHSGGC is prepared for and will deliver a range of services necessary to meet the needs of our population both in Greater Glasgow and across the WoS as required. These plans will be an important part of the final proposals to be brought forward to the Board in June 2018.

Maternity and Neonatal

The Review of Maternity and Neonatal Services in Scotland was published by Scottish Government in January 2017. Its aim was 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.

A summary of the recommendations:

- 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 co-located 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.

Implementation of these recommendations is overseen by a national Implementation Group chaired by Jane Grant, Chief Executive, NHSGGC.

As is the case with mental health services, the NHSGGC plans for the future in this area are being developed and it is intended that the Moving Forward Together Programme assesses the impact of these recommendations and necessary changes and brings forward appropriate actions to address any changes required in line with the national requirements both in terms of the women and babies within NHSGGC but also as required across WoS 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 QEUH. 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 WoS planning leads are working together to ensure the most appropriate configuration of trauma units and, along with Scottish Ambulance Service (SAS) and NHS 24, among others, to see necessary changes made so as to save more lives.

This work will continue to be driven by the Major Trauma Network and associated partners, however it is essential that the clinical needs of people with trauma are taken into account in determining the future patterns and pathways of care across NHSGGC.

We will

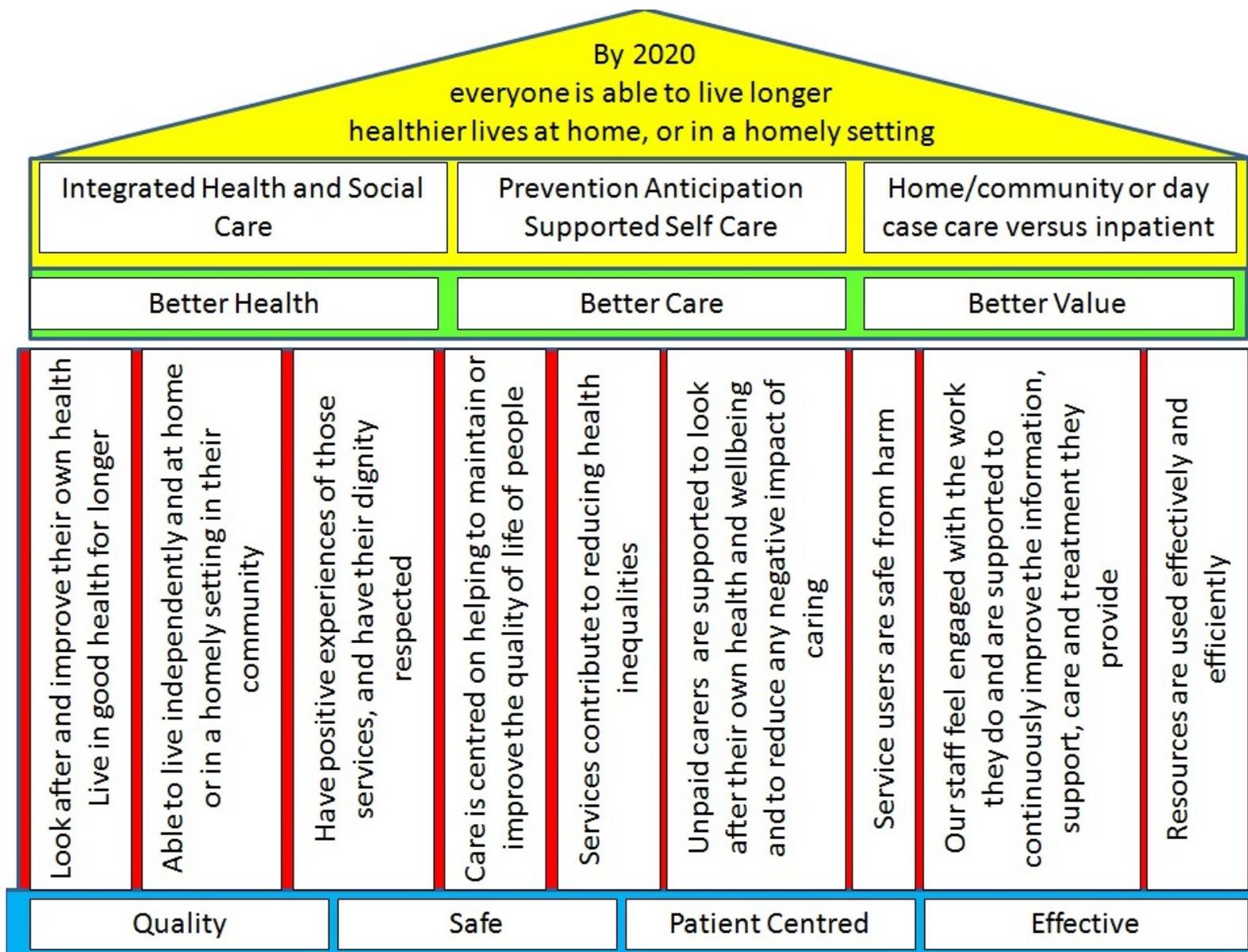
- ensure that the Major Trauma Network and planning for the appropriate configuration of Trauma Units is taken into account in planning for the future needs of our population.

Summary of the National Strategic Context

As highlighted in this section there are a number of national and regional policies, strategies and influences which will shape the NHSGGC Health and Social Care Transformational Strategy. However there is a coherent and clear direction set out across the documents. The diagram below seeks to summarise this direction.

The 2020 Vision is the pinnacle of the strategic framework. Its delivery for our population rests on the triple aim and the success of the integration agenda which is supported by the 9 pillars of the National Health and Social care outcomes and the Primary Care outcomes. Everything is underpinned by the Quality Strategy. Clinical services will be developed in line with the National Clinical Strategy and other relevant Scottish Government strategies.

Pictorially we are representing this as a “Cathedral of Care” – set out below.



PART TWO: NHSGGC Strategic Background and the Clinical Services Strategy (CSS)

NHSGGC Clinical Services Strategy

The 2015 CSS provides the extant 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 CSS Case for Change

As with the NCS the CSS 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 9 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.

CSS System Wide Challenge

The CSS 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 CSS proposed a new system of care showed a significant change focusing on providing care where it is most appropriate for the patient. This was based on strengthened 24/7 community services, acute services focused 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 face to face hospital visits.

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

Enablers

The CSS identified that changing the system at scale would require a series of enabling changes to support delivery of the new health care 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.

CSS projected benefits

It was anticipated that the successful achievement of the new system of health care 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's needs.
- Better patient experience and patient safety, and improved health outcomes with a particular improvement for patients with multi-morbidity.
- 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 focused on early intervention, better management of complex multi morbidity and a reduction in duplication of care.

Moving Forward Together – making it happen

The Moving Forward Together Programme will be delivered by a central hub of a core project team from across NHSGGC and with skills and experience covering all aspects of health and social care. The core team will work using the spokes of their various clinical and managerial networks in order to fully utilise the experience innovation and drive of the full range of staff who deliver health and social care services. The core team report into a cross system programme board populated by our most senior executives.

The Moving Forward Together Programme is not starting from first principles. Rather it builds on and drives forward known actions and commitments already recognised as necessary – but it will also update and supplement these in light of more recent evidence and national strategic needs.

The CSS Future Health System described a series of key characteristics of clinical services. These are also key features of the future for NHS Scotland and NHSGGC in particular in terms of the national strategic picture.

Much of the proposed change in the CSS 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 NHSGGC is to continue to meet the needs of our population, this Transformational Programme needs to take the CSS principles and the national context requirements on to a transformational delivery platform . It needs to describe transformational change in the context of integration and bring together health and social care to deliver a new health and social care 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. We need to develop the actions which will deliver the changes described in the National context but delivered locally, regionally and nationally for our population.

The actions that this programme recommends will need to:

- 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 world class 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, the West of Scotland

Delivery of the Moving Forward Together Programme will see improvements in care and outcomes for everyone.

What does the future look like?

➤ In Primary Care

A system underpinned by timely access to high quality primary care both in and out of hours, providing a comprehensive service that deals with the whole person in the context of their socio-economic environment:

- building on universal access to primary care.
- focal point for prevention, anticipatory care and early intervention.
- management where possible within a primary care setting.
- focus for continuity of care, and co-ordination of care for multiple conditions.

➤ In Community Care

A comprehensive range of community services, integrated across health and social care and working with the third sector to provide increased support at home as well as support for self management:

- single point of access, accessible 24/7 from acute and community settings.
- focused on preventing deterioration and supporting independence.
- multi-disciplinary care plans in place to respond in a timely way to crisis.
- working as part of a team with primary care providers for a defined patient population.

➤ In Unscheduled Care

Co-ordinated care at crisis/transition points, and for those most at risk:

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

Hospital assessment which focuses on early comprehensive assessment driving care in the right setting:

- senior clinical decision makers at the front door.
- specialist care available 24/7 where required.
- rapid transfer to appropriate place of care, following assessment.
- In-patient stay for the acute period of care only
- early supported discharge to home or step down care.
- early involvement of primary and community care team in planning for discharge.

➤ **In Scheduled (Planned) Care**

Planned care which is locally accessible on an outpatient and ambulatory care or day case basis where possible, with:

- wider range of specialist clinics in the community, working as part of a team with primary care and community services.
- appropriate follow up.
- diagnostic services organised around assessed individual needs.
- interventions provided as day case where possible.
- rapid access as an alternative to emergency admission or to facilitate discharge.

Aligned with regional and national direction our service planning will cater for the needs of our population, as well as for the wider regional or national population as required. In this planning highly specialised and complex care will be provided in relevant properly equipped specialised units with an appropriately skilled workforce. These services will be designed to meet the current and projected needs based on population and the planning will be shaped by clear evidence on the relationship between outcomes for patients and activity volume when delivered by colocated multi disciplinary teams.

➤ **In e-Health**

Since 2012 when the Clinical Services Strategic review was commissioned NHSGGC has already achieved considerable benefit from e-Health investment which has transformed many aspects of healthcare already. The main themes in the past five years have been:

- implementing board-wide cornerstone electronic health record systems (Trakcare, Clinical Portal and EMISWeb), including a single patient index across the Health Board using CHI as the main identifier.
- making a wide range of clinical and care information available for clinicians and social care practitioners at the point of need within and increasingly across social care and Health Board boundaries
- digitising incoming hospital and community referrals with SCI Gateway and sending return correspondence with EDT, replacing postal letters (2.5 million items annually)
- centralising laboratory and radiology information systems
- replacing paper notes in outpatient clinics with access to digital patient information
- digitising in-patient workflow and support services

NHSGGC eHealth has an ambitious work plan for the next 12 months which is focussed on patient safety and care integration.

- finalise Full Business Case and, subject to approval, begin implementation planning for a Board-wide Hospital Electronic Prescribing and Medicines Administration system
- implement a new medicines reconciliation system and discharge letter process, creating a single patient-centred medication list
- complete roll out of a single Board-wide maternity electronic record system
- complete data sharing in Portal between all HSCPs and health board
- improve interoperability between key EPR systems such as document sharing from EMISWeb into portal and GP data summary into Portal
- develop a Patient Portal proof of concept digital platform and associated business case that will inform national strategy

Strategic aims of e-health that will help transform care by 2025 include

- Improved healthcare safety for medicines and deteriorating patients giving better situational awareness for clinicians
- Better interoperability of and workflow between cornerstone systems right across community and primary care helping break down professional and organisational silos
- Support for virtual consultations and care coordination reducing need for patients to travel, improving oversight of long term conditions and maximising clinic utilisation
- Digital patient engagement including patient portals to help self care, multimodal access for patients with text or webchat
- Better use of smart informatics at the clinical front line to help decision making by summarising the large amount of health and care data that now exists on individuals
- Providing technology such as the Microsoft Office 365 collaboration suite that will enable more agile and flexible working

Our Starting Point and Transformation in Action

Although there has not been the transformational change since 2015 that would have seen the full implementation of the CSS new health care system, NHSGGC has not stood still.

There are a number of service reviews currently under way which will produce transformational change proposals which may be delivered during this programme or will be incorporated into the final change proposals in the new clinical and service models coming out of this programme and the wider West of Scotland regional approach to planning.

These reviews include:

- GP Contract Arrangements
- Out of Hours Services
- Mental Health Services
- Unscheduled Care
- Older People's Services
- Planned Care Capacity
- Beatson West of Scotland Cancer Centre
- Modern Outpatient Programme
- Stroke Services
- Orthopaedic Services
- Breast Services
- Urology Services
- Gynaecology Services

There are also a great number of changes which showcase the opportunities and benefits that can be realised if transformational change is achieved at scale across our health and social care services.

Annex A to this paper highlights small scale but transformational change that has been achieved and which clearly aligns to the direction set out by the CSS.

The challenge of the Moving Forward Together Programme is to take these advances from isolated demonstrations of success on to where they become common practice and then on to become business as usual across NHSGGC.

PART THREE: Proposed Approach: Moving Forward Together

Our Approach

The Moving Forward Together Programme takes a phased approach to delivery.

There is a central Core Team who have dedicated time each week to take forward the work of the Programme. It is composed of senior managers and clinicians from across the HSCPs and Acute Sectors.

The Programme plan has been divided into 4 phases which are described below.

Phase 1 – October to November 2017 - Establishing baseline and modelling known changes

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

We will

- Review the current range of relevant National and Regional Strategic Documents;
 - o 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
 - o Using the same methodology as WOS work with ISD to ensure alignment
 - o Work at a specialty and condition level using population based approach
 - o 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.

Phase 2 – December 2017 to February 2018 - Clinical discussion on principles leading to the development of plans to implement new models of care and the quantification of the impact of those changes

We will

- Prepare 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
- Prepare a review of all local and regional work on clinical services, as well as the GGC Clinical Services Review (CSR) and national strategies and model the predicted impact on the current services in GGC for discussion in clinical groups
- Commission either SLWG or current 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
- Model the impact of these proposed changes on the demand and activity profile to inform the options development
- Commission further evidence base reviews and review other service models as required to support the development of options

Phase 3 – March to April 2018 - Drawing together and quantifying the impact of predicted demand changes and new models of care to describe options for a new service configuration across primary community secondary and tertiary care

The Core Team will draw together all of the various pieces of work from Phase 1 and 2 and analyse the outputs of the commissioned work streams.

We will

- review current WOS planning, GJNH and other Health Board strategic intentions and assess the impact on GGC options
- describe the required changes, supporting and enabling work and outline delivery plans with options where relevant
- use this basis to prepare an outline of the strategic delivery plan with options 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

Phase 4 – May to June 2018) Amendments following engagement and Approval

The outcomes of the engagement process following the initial options proposal at the end of Phase 3 will be used to finalise proposals. The details of this Phase will be determined by the guidance given by the NHSGGC Board, IJBs and Scottish Government.

We will

- bring forward finalised proposals for the future of health and social care services delivered by NHSGGC for their population to the Board for approval in June 2018.

Communication and Engagement

It is proposed that during the programme there is a comprehensive and transparent engagement process with the widest possible range of stakeholders.

This will include wide spread staff and partnership engagement and inclusion through the hub and spoke methodology for clinical engagement following the principles of Facing the Future Together.

We will

- engage with and take advice from all the various Board advisory groups and committees
- work together with the WOS Regional Planning Team.
- engage with neighbouring health boards and national partner Boards including the Scottish Ambulance Service, NHS24 and the Golden Jubilee Foundation
- engage with patients and carers at the earliest opportunity and throughout the process by establishing a Stakeholder Reference Group with wide representation across the demography and the geography of our population.
- produce and implement an inward and outward facing communications programme which supports the delivery of our key messages to our staff, partners and population using the range of available effective means.

SUMMARY

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

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

The Programme will develop in cooperation and cohesion with the developing work in the West of Scotland for planning of a Regional basis.

The Programme will provide 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 it's recommendations.

The Programme will support 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.

NHSGGC Examples of Transformation in Action

The following section highlights small scale but transformational change that has been achieved and which clearly aligns to the direction set out by the NCS HSCDP and CSS.

The challenge of the Moving Forward Together Programme is to take these advances from isolated demonstrations of success on to where they become common practice and then on to become business as usual across NHSGGC.

Primary Care: Transformation in Action

<p>House of Care CSS New System Characteristic Building on universal access to primary care. Focal point for prevention, anticipatory care and early intervention. Management where possible within a primary care setting. Focus for continuity of care, and co-ordination of care for multiple conditions.</p>	
<p>Previous State: Disease specific task based review in primary care for patients with Long Term Conditions guided by former Quality and Outcomes Framework; limited patient empowerment.</p>	<p>Transformed State: Participating GP practices use the ‘House of Care’ process and framework when recalling patients for their annual review. The House of Care (HoC) ethos places the person at the centre of their care supporting a collaborative conversation between the individual and the professional. Changes in the process include a two-step review:</p> <ul style="list-style-type: none"> • The first is to gather information and carry out disease specific surveillance and to prepare the patient for the second appointment (carried out by the HCSW where possible). • The second, a longer time with the clinician to have a conversation about the impact of the condition and reflect on what matters to the individual (carried out by the Practice Nurse in most cases). <p>A further change is that the patient receives the results from their tests in between the two appointments. They also receive information and are asked to think about/note what matters to them and given prompts for discussion. The second appointment is then intended as a meeting of equals and experts to review how things are going; consider what's important; share ideas; discuss options; set goals; develop a care and support plan. A ‘More than Medicine’ approach is considered and local services to support this are identified.</p>
<p>Benefit Realised</p> <p>Patients being in control of their care and empowered to share decisions about it. The person is more likely to act upon the decisions they make themselves, rather than those made for them by a professional. Clinicians and other staff at all stages having the necessary information about the patient, with care better tailored to the patient's needs.</p> <p>Biomedical impact - in 19 trials involving 10,856 participants, care planning has led to:</p> <ul style="list-style-type: none"> • Better physical health (blood glucose, blood pressure) • Better emotional health (depression) • Better capabilities for self-management (self-efficacy) 	

New Ways Inverclyde – Transforming Primary Care Programme

CSS New System Characteristic

Building on universal access to primary care.

Focal point for prevention, anticipatory care and early intervention.

Management where possible within a primary care setting.

Focus for continuity of care, and co-ordination of care for multiple conditions.

Previous State
16 practices in Inverclyde working to standard national GMS contract within a context of significant pressures on primary care, including rising workload and complexity.

Transformed State

In September 2015, Inverclyde HSCP was approached to consider the opportunity to work in partnership with NHSGGC, Scottish Government and the British Medical Association (BMA) to explore new ways of working and inform the development of the new GP contract; and devise the future role of the GP, envisaged to be that of a senior clinical decision-maker in the community who will focus upon:

- Complex Care in the Community.
- Undifferentiated Presentations.
- Whole System Quality Improvement and Clinical Leadership.

Following initial engagement sessions led by Inverclyde HSCP, NHSGGC, Scottish Government and the BMA, all 16 Practices in Inverclyde (at that time) signed up to participate in the pilot.

A number of tests of change were developed:

- Aiming to reduce musculoskeletal presentations to the GP by making an advanced physiotherapist practitioner available.
- Introduced a Drop-In Community Phlebotomy (drawing blood for testing) clinic.
- Introduced Advanced Nurse Practitioners (ANP) working within the Community Nursing Service and responding to exacerbations of chronic illness and minor illness/injuries as well as undertaking Home visits.
- Having Specialist Paramedics to reduce home visits for GPs by using this role to deal with unscheduled requests.
- Piloting an extension of the Prescribing Team's clinical and medicines management activities to embed Pharmacists and technicians in GP practices doing pharmacist led clinics, the authorisation of special requests for prescribed medicines and review of immediate discharge letters from acute hospital and outpatient letters.
- Pharmacy First Pilot - Inverclyde Pharmacy First Service is a test service that extends the Minor Ailments Service (MAS) to all patients and adds a small range of common clinical conditions. The objective is to provide timely and appropriate assessment and treatment of these common conditions and identify patients who require onward referral to other services.

Benefit Realised

There is now an expanded multi-disciplinary team in primary care; conditions for further change, due to development of relationships and new ways of working; and increased resilience.

<p>GP Cluster working CSS New System Characteristic Building on universal access to primary care. Focal point for prevention, anticipatory care and early intervention. Management where possible within a primary care setting. Focus for continuity of care, and co-ordination of care for multiple conditions.</p>	
<p>Previous State: 238 individual GP practices across NHSGGC area, often working in isolation. Quality improvement approaches focused on contractual mechanisms e.g quality and outcomes framework and enhanced services.</p>	<p>Transformed State: 238 GP practices across NHSGGC area now grouped into 39 clusters each with a cluster quality lead. Clusters have a role in identifying and driving quality improvement both within clusters and practices and in the wider system. The roles are defined as:</p> <p><u>Intrinsic</u> Learning network, local solutions, peer support. Consider clinical priorities for collective population. Transparent use of data, techniques and tools to drive quality improvement - will, ideas, execution. Improve wellbeing, health and reduce health inequalities.</p> <p><u>Extrinsic</u> Collaboration and practice systems working with Community MDT and third sector partners. Participate in and influence priorities and strategic plans of IJBs. Provide critical opinion to aid transparency and oversight of managed services. Ensure relentless focus on improving clinical outcomes and addressing health inequalities.</p> <p>HSCPs have aligned several existing and new teams to clusters to improve co-ordination of care and multi-disciplinary working: for example neighbourhood older people's teams. Clusters are at an early stage of development and there is significant further potential.</p>
<p>Benefit Realised Supports better joint working between practices and with wider community services. Has enabled alignment of community teams to groups of practices.</p>	

Optometry First Port of Call and Acute Referral Centre CSS New System Characteristic Building on universal access to primary care. Focal point for prevention, anticipatory care and early intervention. Management where possible within a primary care setting. Focus for continuity of care, and co-ordination of care for multiple conditions.	
Previous State: Patient with eye problems routinely attending GP practices. For urgent care patients went to eye casualty and waited to be seen by ophthalmology staff.	Transformed State: Optometry practices now first port of call for eye problems including urgent issues. GPs signposting to optometrists, and optometrists can refer to secondary care using SCI gateway if required. Urgent care now triaged first by optometrist in the community and then by telephone triage by a specialist nurse at the hospital. The patient is then given a next day planned appointment or advised to attend the hospital immediately if triaged as urgent
Benefit Realised Patients going to the service with the most appropriate skills and equipment directly, resulting in a reduction in steps in the pathway and unnecessary referral though GP practice; faster appropriate response and treatment. Patients access care according to urgency on a semi planned basis. Optometrists are able to ascertain the status of electronic SCI Gateway referrals. Utilisation of existing systems (SCI Gateway) maximises benefit of previous investment in people, systems and equipment.	

Enhanced Anticipatory Care Planning CSS New System Characteristic Comprehensive Primary Care Service Community Services and care planning in place to respond to crisis	
Previous State: Anticipatory Care Plans should be in place for 30% of GP patients at highest risk of emergency admission.	Transformed State: Extension of anticipatory care planning to a larger number of patients than that required within target groups. Practices were paid an item of service for each ACP completed or updated. Additional work was undertaken to improve awareness and use of eKIS among health care colleagues involved in emergency care and home care, for example training junior hospital doctors and extending access to eKIS to Community Nurses
Benefits Realised <ul style="list-style-type: none"> • 700+ new KIS and 400+ updates performed on vulnerable groups. • Care homes, dementia and learning disabilities targeted. • Information in ACP supported decision making for patients admitted as an emergency 	

<p>Revised Heart Failure Diagnostic including direct access for GPs to BNP blood tests</p> <p>CSS New System Characteristic</p> <p>High Quality Primary Care</p> <p>Management where possible within a primary care setting</p> <p>Diagnostic services organised around patient needs</p>	
<p>Previous State:</p> <p>Patients with suspected Heart Failure were referred to the Heart Failure diagnostic pathway where they went through a series of investigations. Over 90% of patients referred were found not to have HF. The volume of patients referred into secondary care drove delays in patients with confirmed HF going through the diagnostic pathway and being given an appropriate treatment plan</p>	<p>Transformed State:</p> <p>There was a successful pilot, in the Renfrewshire area, in which GPs were given direct access to BNP blood tests for patients with suspected Heart Failure. It is now planned to roll out this access to all GP practices in the Greater Glasgow and Clyde NHS board area from September 2017. This will mean a change in the Heart Failure diagnostic Pathway that before referring a patient with suspected heart failure a GP will be able to request the relevant blood test from primary care</p>
<p>Benefit Realised</p> <p>Providing access to BNP blood testing in primary care improves the patient journey, immediately reduces delays in excluding HF as a diagnosis and reduces referrals and the number of secondary care attendances for these patients. It reduces waiting times for echo, cardiology diagnosis, improves the diagnosis of heart failure and other cardiac pathology for these patients and reduces the risk of emergency admission prior to commencing treatment</p>	

Community Care: Transformation in Action

West Dunbartonshire Care at Home CSS New System Characteristic:	
<p>Single point of access, accessible 24/7 from acute and community settings. Focused on preventing deterioration and supporting independence. Multi-disciplinary care plans in place to respond in a timely way to crisis. Working as part of a team with primary care providers for a defined patient population.</p>	
Previous State	Transformed State
<p>The traditional model of care at involved separate referral routes and care planning, contributing to unnecessary delays in the right assessment and service being provided, with a propensity for duplication of service provision.</p>	<p>West Dunbartonshire HSCP has established an integrated care at home service, bringing together the co-ordinated provision of Care at Home and District Nursing services to more timeously and effectively identify and respond to risk and avoid unnecessary admissions to hospital, both “in” and out-of-hours. This community service links directly to out-of-hours GP services and all HSCP-managed and independent sector care homes.</p> <p>The multi-disciplinary work together to ensure improved shared information and communication at an earlier stage. Single sharable assessments and information sharing leads to better targeting of resources, more skilled and confident staff working towards shared objectives.</p> <p>In addition, the innovative use of Technology Enable Care (TEC) and dedicated reablement services support better outcomes, by maximising the individual’s long term independence and quality of life; and appropriately minimising structured supports.</p> <p>The team consistently receives unsolicited excellent feedback from services users; and encourages a culture where all feedback is used to - including challenge - provides an opportunity to critically review and improve services.</p>
Benefit Realised	
<p>People living in West Dunbartonshire are better able to live independently at home, recover well from hospital stay or injury and are safer and more independent through the dedicated work of West Dunbartonshire’s Care at Home Team.</p> <p>The West Dunbartonshire HSCP Care at Home Service was awarded the Scottish Association of Social Work (SASW) Award 2017 for the ‘Best example of collaboration in an integrated setting’.</p>	

Reconfiguration of rehabilitation services in North East Glasgow CSS New System Characteristic Rapid transfer to appropriate place of care, following assessment. In-patient stay for the acute period of care only Early supported discharge to home or step down care.	
Previous State: Older people had extended stays in acute hospitals which were not seen as a homely setting. Patients attended day hospital for regular but infrequent appointments over long periods Patients attended for clinic appointments on sites without access to the full range of supporting services	Transformed State: Early intervention from specialists in the acute care of older people focussed on immediate multidisciplinary assessment of frailty and clinical need; Rapid commencement of multidisciplinary rehabilitation within acute facilities for patients who require immediate access to the full range of investigations and specialist advice; New HSCP inpatient and community services to enable patients who do not require care in a full acute hospital to:- Be discharged directly home after assessment or a short stay in a full acute hospital; Access local intermediate care in community rehabilitation beds provided in a homely local setting; Have rehabilitation at home with support from additional community rehabilitation services; Acute day hospital services, which deliver assessment and intervention on a more focussed and intense one stop basis, to enable the discharge of patients home or to the ongoing care of local HSCP services; Outpatient services in a setting where there is access to other clinical services enabling a one stop approach.
Benefit Realised Patients benefit from shorter periods in acute hospitals and a more focussed period of rehabilitation and re-ablement with a focus on returning them to their home. When they are not ready to return home but do not require acute care they can access community based intermediate care nearer to home and family	

Hepatitis C Outreach CSS New System Characteristic Planned Care Locally Accessible; Hospital Assessment – Right Time Right Place; Coordinated Care at Time of Crisis	
Previous State: Patients with Hep C Infection have high rates of non-attendance at hospital clinics	Transformed State: Community outreach clinic established at Bridgeton Health Centre combining Liver Clinics with Community Addiction Services and Opiate Substitution Therapy Prescription Management
Benefit Realised Better access to services, promoting better health through a joined up approach across relevant acute and community services supporting the patient. Higher levels of attendance at new patient appointments. Reduces barriers to healthcare for historically hard to engage patients	

East Renfrewshire Medicines Reconciliation and Support Service

CSS New System Characteristic:

Focused on preventing deterioration and supporting independence.
Working as part of a team with primary care providers for a defined patient population.

Previous State

Individuals and families/carers unclear about medicine failure to comply, leading to exacerbation of condition and re-admission to hospital.

Transformed State

The East Renfrewshire HSCP's Medicines Reconciliation and Support Service is a pharmacy technician led service which:

- Provides medication advice and support for patients and carers upon return home after hospital discharge to ensure any medication changes are understood and actioned.
- Assessed compliance with medication and offers support where compliance issues are known.
- Completes an enhanced medicines reconciliation liaising with relevant members of the multi-disciplinary team to ensure current medication is correct.
- Rationalises dosing times to minimise need for unnecessary homecare input for medicines prompts.

Benefit Realised

By understanding their medication better and by having interventions such as compliance aids and inhaler technique provided, patients have been able to get better results from their prescribed medication.

Reduction in additional medication prompts also supports other HSCP community services, as reduced homecare prompts consequently reduces pressure on the homecare service. The Medicines Reconciliation and Support Service has improved patients' healthcare journeys; promoted a joined up approach to patient care; and by close working with the voluntary sector, provided links to local community supports and opportunities.

East Dunbartonshire Health and Social Care Intermediate Care Unit (ICU) CSS New System Characteristic: Focused on preventing deterioration and supporting independence. Working as part of a team with primary care providers for a defined patient population.	
Previous State No opportunity for services users to have additional assessment and rehabilitation post discharge from hospital.	Transformed State East Dunbartonshire HSCP commissioned a pilot step down intermediate care unit within Westerton Care Home in November 2016. The pilot incorporated a model of GP provision, care management and rehabilitation. Eight beds were planned to allow service users to transition from the hospital setting when medically fit for discharge to a homely environment, allowing them time for additional recovery; rehabilitation; and to enable a comprehensive assessment of their longer term health and social care support needs. The skill mix for the unit comprised: <ul style="list-style-type: none"> • Social workers from the Hospital Assessment Team (HAT) and Allied Health Professionals from the Rehabilitation Assessment Link Service (RAL) who are part of the Community Rehabilitation Team employed from the HSCP. • A nursing/support worker component from the care home. • GP contracted to do 2-3 clinical sessions weekly.
Benefit Realised	
<p>There was improvement in delayed discharge figures against heavy demographic demands for admissions to hospital. The unit offered a new service for East Dunbartonshire HSCP's portfolio of services for people who had complex needs who required an opportunity for further interventions and time to reflect on future plans. The pilot consolidated the essential role of rehabilitation in the interface between the acute and the community.</p> <p>The unit has been very beneficial to clients and their families as it provides opportunities for further assessment and rehabilitation. The service helped to get people out of hospital whilst also giving them breathing space to make decisions for the longer term.</p>	

<p>Out of Hours Community In-reach Service: CSS New System Characteristic</p> <p>A comprehensive range of community services, integrated across health and social care Early supported discharge to home or step down care. Early involvement of primary and community care team in planning for discharge</p>	
<p>Previous State: The Rapid Response team of the Renfrewshire Rehabilitation and Enablement Service (RES) offered access to Physiotherapy Occupational therapy, nursing, dietetic and technical assessment and support to patients referred urgently by their GP or hospital. It operated 0830-1900 Mon-Fri.</p>	<p>Transformed State: The Out of Hours Community Inreach Service aimed to support key points of transition both in and out of hours. Community social workers coordinated a range of supports to prevent admission and support discharge, working alongside the Rapid Response team. Key additions were the provision of a transport and resettlement service (including transport of equipment) and the extension of hours of working (1330-2000 Mon-Fri and 0900-1700 weekends). The team worked within the multi-agency discharge hub following its establishment in Feb 2015.</p>
<p>Benefit Realised</p> <p>Provided assistance to Older Adults Assessment Unit, Emergency complex and wards with discharges. This was an essential component for OAAU in terms of facilitating early discharge and reducing length of stay. Consultant estimated reduction to length of stay for patients discharged from OAAU is 1.75 days. Delivered benefits of joint working between health and social care and co-location</p>	

<p>Renfrewshire Development Programme CSS New System Characteristic: Single point of access, accessible 24/7 from acute and community settings. Focused on preventing deterioration and supporting independence. Multi-disciplinary care plans in place to respond in a timely way to crisis. Working as part of a team with primary care providers for a defined patient population.</p>	
<p>Previous State: Traditional models of working and relationships between acute, primary and community care in Renfrewshire.</p>	<p>Transformed State: The purpose of the Renfrewshire Development Programme (RDP) was to develop and test new service models proposed by the NHSGGC Clinical Services Strategy. It involved Renfrewshire HSCP, the 13 GP practices in Paisley and the Royal Alexandria Hospital. Its aims were to:</p> <ul style="list-style-type: none"> • Improve quality, including patient experience. • Improve care at interface between hospital and community. • Reduce avoidable admissions. • Maintain/improve re-admission rates. <p>There were six component parts:</p> <ul style="list-style-type: none"> • Chest Pain Assessment Unit. • Older Adults Assessment Unit. • Out of Hours Community Inreach Services. • Enhanced Pharmacy Service. • Enhanced Anticipatory Care Planning.
<p>Benefit Realised</p> <p>There were reduced lengths of stay associated with Chest Pain Assessment Unit and Older Adults Assessment Unit, with fewer patients requiring overnight stay and high patient satisfaction.</p> <p>There were Increased numbers of Anticipatory Care Plans completed for patients in target groups.</p>	

<p>Glasgow City Home is Best CSS New System Characteristic: Focused on preventing deterioration and supporting independence. Multi-disciplinary care plans in place to respond in a timely way to crisis. Working as part of a team with primary care providers for a defined patient population</p>	
<p>Previous State Hospital facing social work and community health resources organised and managed separately across the NHS and Social Work and the 3 geographical localities within the city.</p>	<p>Transformed State Development of a singularly managed, multi-disciplinary hospital facing community health and social work team for the whole city, with separate hubs facing into north and south acute sectors. This team will have an unequivocal responsibility for improving HSCP performance in relation to diversion from admission (front door focus), delayed discharges (back door focus) and utilisation of HSCP beds management (e.g. intermediate care, former HBCC, and AWI). The team will co-ordinate activity across all relevant HSCP teams/ disciplines, including social work, rehabilitation and occupational therapy. Essential to its success will be effective interfaces with the Acute system at both front door and discharge points. It will also work closely with Cordia, HSCP integrated neighbourhood teams (as above) and independent service providers (such as care homes).</p>
<p>Benefit Realised</p>	
<p>More coherent and efficient deployment of hospital facing HSCP resources. A singular community health and social work team, managed by one Service Manager across the city (rather than multiple managers as at present). Simplified accountability and system performance management arrangements. Simplified interface with the HSCP for the acute system. Ultimately the intention is that this team will perform a key role in meeting whole system unscheduled care performance targets and further improvement in Glasgow's delayed discharge performance. It is also expected to lead to more efficient utilisation of expensive HSCP resources such as intermediate care.</p>	

Unscheduled Care: Transformation in Action

Dedicated Frailty Units and Comprehensive Geriatric Assessment CSS New System Characteristic In-patient stay for the acute period of care only	
Previous State: Elderly patients were admitted to emergency medical wards without routine access to geriatric assessment of their rehabilitation needs.	Transformed State: Dedicated frailty units have been established to deliver a consistent Comprehensive Geriatric Assessment to patients who have been identified as frailty positive using the standard ED Frailty triage tool. Early identification for appropriate patients provides fast track access to elderly care assessment nurses and geriatricians. With targeted specialist resource provided by the frailty team, which consists of Acute Community and Social Care services, can ensure that wherever possible the patients needs can be met and are returned home or to their place of care within 24-48 hours and avoid extended periods of inpatient care that can result in further deterioration for frail elderly patients.
Benefit Realised Patients gain rapid access to an integrated multi skilled specialist team focussed on supporting the patients safe return to home or a homely setting as soon as possible, thus avoiding unnecessary extended hospital stays	

Ambulatory Emergency Care Pathways CSS New System Characteristic In-patient stay for the acute period of care only	
Previous State: Patients presenting with conditions which did not require an extended stay were admitted in order to assess and access diagnostic tests as there was no appropriate alternative to admission. This resulted in short stays which took bed capacity and prevented patient flow through the emergency receiving beds.	Transformed State: A number of high volume pathways have now been established for ambulatory care pathways. For COPD the community respiratory team provides support at home to manage and respond to exacerbations and provide alternatives to hospital care. For chest pain there is now a consistent pathway which has been adopted by both EDs and AUs across all sites and enables streaming of patients based on clinical scoring algorithm to avoid unnecessary admission. There is a DVT clinic delivered by specialist nurses via an appointment based system triggered after first referral to complete the treatment plan and educate of condition management There is now a cellulitis pathway that reviews patients after first episode of admission and identifies those suitable to have their treatment converted to planned care delivered by the medical day units
Benefit Realised Patients avoid admission to hospital and are treated either on a planned basis or on an ambulatory basis through the hospital or in a day hospital or community based service	

Acute Assessment Units CSS New System Characteristic Senior clinical decision makers at the front door In-patient stay for the acute period of care only	
Previous State: Acute departments were not routinely manned by specialty consultants. These senior decision makers were available but on request and decisions were routed through junior staff.	Transformed State: The establishment of Assessment Units with access to professional advice either via senior nurse or specialty specific telephone systems. Work undertaken to improve access to specialty advice with the option to review management plan and/or defer patient attendance to the following day to a hot clinic.
Benefit Realised More rapid access to senior specialist opinion allows treatment plans to be established more rapidly	

Discharge Flow Hubs CSS New System Characteristic Better coordination of patient flow	
Previous State: The elements which are required for discharge; medicines, transport and care packages were not well coordinated and put pressure on ward staff	Transformed State: The Flow Hub concept brings together the combination of discharge lounges and transport hubs. The most advanced version of this is in the RAH with HALO (hospital ambulance liaison officer) supporting patient transport management and discharges, working alongside pharmacy service provision for patients awaiting medication/scripts which are provided in the hub rather than the ward areas. These hubs also manage outpatient transport services Pharmacy provision to the hub is being rolled out across sites.
Benefit Realised Discharge is better coordinated and is earlier in the day, improving patient flow and bed availability	

Exemplar Wards CSS New System Characteristic Better coordination of discharge planning	
Previous State: Patient discharge planning dependent on senior medical review. Decisions often taken later in the day resulted in delays.	Transformed State: More frequent and earlier decision making with the use of daily 'board rounds'. Discharge decisions delegated to nursing staff where appropriate. Better systems for coordination of Immediate Discharge Letters and Pharmacy.
Benefit Realised More patients discharged earlier in the day allowing beds to be available when needed for acute admissions	

Planned Care: Transformation in Action

Ortho Opt-in CSS New System Characteristic Hospital Assessment – Right Time Right Place	
Previous State: All patients referred by their GP with a specific range of joint related conditions would be sent a hospital outpatient appointment and seen in a consultant clinic.	Transformed State: Patients referred by their GP with that specific range of conditions go through an extended triage carried out by Specialist Nurses and Physiotherapists/ Podiatrists. Patients are sent information about their condition and asked to phone in for advice or to opt-into an outpatient appointment.
Benefit Realised	
To date 156 patients have been through this opt-in process. 67% made no contact with the department following the information being sent out. 30% requested a face to face clinic appointment and 3% called for advice in self care. This system reduces unnecessary outpatient appointments and empowers the individual to make a more informed decision about their referral into the department	

Virtual Lung Cancer Clinic CSS New System Characteristic Hospital Assessment – Right Time Right Place	
Previous State: All patients referred by their GP with Urgent Suspicion of Cancer (USOC) would be sent a hospital outpatient appointment for a fast track consultant clinic. A significant proportion of patients attending fast track clinic appointments were found to not have a diagnosis of cancer.	Transformed State: USOC referrals are now vetted by a Respiratory Consultant and directed to either a fast track outpatient clinic or to a Virtual Lung Cancer Clinic. In the Virtual Lung Cancer clinic referral information, lung functions test results and CT results are reviewed by two Respiratory Consultants resulting in either a routine clinic appointment or a fast track appointment, referral to another specialty or discharge. Written communication is provided to the patient after the virtual clinic.
Benefit Realised	
Of 354 patients referred for a USOC appointment, 144 were seen by Virtreduced clinic times, or required no physical appointment and were given early reassurance and discharge, allowing resource to be focused on the management of cancer cases. 81% of patients who responded to a questionnaire evaluation of the Virtual Lung Clinic were satisfied with receiving their results by letter. Benefits – timely reassurance of results; improved time to first face to face appointment for those needing one; better use of fast track USOC appointments for patients needing this type of service.	

Virtual clinics in Clyde Gastroenterology CSS New System Characteristic Coordinated care at crisis/transition points and for those most at risk	
Previous State: Inflammatory Bowel Disease Patients attended at regular interviews for Consultant Return appointment putting pressure on the return demand of the service	Transformed State: Virtual consultations - review of all 174 IBD patients on Biologics undertaken with Gastro Consultant, IBD Specialist Nurses over 3 x weeks resulted in an individual care plan in place for each patient on a Biologic drug
Benefits Realised No longer required to attend secondary care for appointment Individual care plan in place – shared with IBD specialist nurse team and General Practice Suite of patient self management support materials developed for use Biologic tapering / withdrawal – medicines review – not taking medicines unnecessarily IBD patients and relatives have telephone / email access to IBD Clinical Nurse Specialist Advice in event of a flare Protocols defined for CNS use – Nurse Led Return Clinics established for IBD IBD Consultant – aim is to see patient once then discharge with a clear care plan Reduced unnecessary OP returns to clinic Some require 2 or 5 Yearly scans – discharged in between Detailed Plan provided to GP for each patient Agreed pathway to enable quick access back into service if necessary	

Redesign of Bowel Screening Processes CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: Bowel screening (national programme) 3 samples required limited uptake	Transformed State: Introduction of more specific test requiring only 1 sample anticipated increased uptake (starting Oct 2017)
Benefit Realised Improved uptake for bowel screening therefore earlier diagnosis and better outcomes in bowel cancer treatment	

Access to Stroke Diagnostics CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: Limited ability/delay in patients receiving Imaging whilst attending a TIA clinic	Transformed State: Ring fenced slots for CT/MR where possible for patients attending TIA clinics
Benefit Realised Patients receive a diagnosis as part of a one stop clinic	

Primary Care Access to Lab Testing CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: Primary care did not order or receive test results electronically	Transformed State: Introduction of GP ordercoms (ICE) for Laboratory Medicine
Benefit Realised All Lab tests ordered electronically and reports available directly to GPs, faster response and more robust system.	

GP direct access to MRI CSS New System Characteristic Diagnostic services organised around patient needs	
Previous State: GP could not refer patients directly for MRI	Transformed State: GPs can now refer patients for MRI knee following the approved protocol
Benefit Realised Reduced need for patients to be referred to secondary care	

Mental Health: Transformation in Action

Redesign of Matched Care in Primary Care MH Teams CSS New System Characteristic Routine Patient Outcomes Monitoring	
Previous State: Primary Care Mental Health Teams are designed to provide brief, prompt care for people with common mental health problems. Patient “flow” in such systems is critical, but there was no agreed system for tracking care which patients required.	Transformed State: CORE-Net (Clinical Outcomes in Routine Evaluation) is an electronic patient outcome measure suitable for PCMHT use, and is completed electronically. Scores are entered by patients or their clinicians and the system visualises progress over time.
Benefit Realised Outcomes for patients, clinicians and teams can now be readily visualised, and support not only individual care plans, but also assist teams in managing overall demand, and team capacity. CORE-net is being rolled out to other community teams in MH.	

Redesign of provision of Cognitive Behavioural Therapy (CBT) CSS New System Characteristic Introduction of Computerised CBT (cCBT) across NHS GGC & Partnerships from Nov 2017	
Previous State: CBT is a fundamental mode of evidence-based psychological treatment in MH, but typically requires intensive therapist input. cCBT is recommended by NICE and SIGN and the program used (<i>Beating the Blues</i>) has a strong evidence base and has been proven to work in Scotland.	Transformed State: cCBT is used for the treatment of patients suffering from mild to moderate depression and/or anxiety. Treatment consists of 8 x 1 hour sessions completed weekly via the internet either in the patient’s home or at a community location such as a library.
Benefit Realised Referrals can be made via SCI Gateway from primary care with only minimal contact information required. Patients will typically be provided with access to the cCBT program within 5 working days from receipt of referral. NHS GGC/Partnerships has a target of 980 referrals in the first year, and this will increase treatment options for GPs, reduce referrals to secondary care MH services and support continued delivery of the Psychological Therapies HEAT target.	

E-health: Transformation in Action

West of Scotland Portal to Portal Development	
<p>The West of Scotland portal to portal project has provided a technical solution built in Clinical Portal to enable boards to launch their respective portal systems seamlessly without requirement to enter an additional username and password.</p>	
<p>Previous State:</p> <p>Patient care is increasingly being delivered in regional models across the West of Scotland. This is due to large populations located across NHS Board boundaries</p> <p>The viewing of patient records and clinical information across Health Boards within the West of Scotland involved accessing multiple sources of information from different systems, may have required telephone contact or even the transfer of paper case notes between Boards.</p>	<p>Transformed State:</p> <p>The project set out to make it simple for clinicians to find the information they wanted, while also addressing security and confidentiality issues.</p> <p>NHSGGC now has 2 way portal to portal with the following boards:</p> <p>NHS Lanarkshire</p> <p>Golden Jubilee National Hospital</p> <p>NHS Ayrshire & Arran</p> <p>NHS Dumfries and Galloway</p> <p>This functionality is available to all clinical staff in GGC and the participating boards. It will be extended to GGC administrative staff in November 2017</p> <p>Information governance and other key documentation was created once and then agreed by each of the health boards. A minimum data set was agreed that included demographics, GP details, lab results, encounter history and clinical documentation. A full audit trail is available of all user activity in each portal system.</p>
Benefit Realised	
<p>Data sharing is immediate and safe using the patient CHI number to identify and match the patient. Clinical risk is reduced significantly as up to date information can now be queried at source which further assists decision making.</p> <p>Obtaining patient information is efficient and simple, which is a significant time saving for clinical staff. Baseline analysis completed ahead of the project underlines this point. It found that doctors could spend 70 minutes per day looking for information about patients</p> <p>Feedback from clinicians is overwhelmingly positive, the regional portal is being well-used; already, clinicians are accessing 3-4,000 cross board records every week, and there have been more than 50,000 log-ons so far this year.</p>	

Community Nursing System Integration

Ability to view the following data sets from the community nursing information system (CNIS and EmisWeb) within Clinical Portal.

- Risks
- Allergies
- Open Referral Information
- Associated Professionals (GP, named nurse)
- Associated People (Next of Kin, Carer)
- Malnutrition Universal Screening Tool (MUST) data
- Summary of last 10 Visits
- Care Plans

The Community Nursing service will move to EMIS Web in 2018/19 this data will transfer from being viewed from CNIS to EMIS Web, further consultation will be undertaken to look at sharing additional fields.

Previous State:

District Nurses have regular contact with patients often seeing them on a daily basis this means the data they record in the electronic patient record is the most up to date. Previously this was not viewable to anyone other than Community Nurses.

When a patient was admitted to hospital there was a lack of information on any community care they were receiving.

These patients are often elderly and may be confused at the time of admission restricting their ability to provide accurate medical information.

Transformed State:

With the above data fields now being viewed in Clinical Portal other directorates can view important data relating to community nursing patients.

The ability to see contact details for patient's district nurse and next of kin is particularly useful when patients cannot provide this information themselves or for when a patient being discharged from hospital and will require district nursing care.

GP's can view when the patient was last visited by a district nurse rather than contacting the district nurse in person.

Other Specialist Nurses, eg Tissue Viability nurses can see view care plan data relating to any pressure ulcers the patient may have.

Benefit Realised

Improved sharing of patient information and more effective communication between primary, secondary and community care staff leading to patient safety benefits and improved care.

Community Care HSCP Partnership Information

Access across partner agencies to patient/client information via an adapted version of Clinical Portal.

<p>Previous State:</p> <p>No electronic means for two-way sharing of shared patient/client information between social work and NHS staff.</p> <p>Their only option was to phone round/message often multiple partnership colleagues to get what they needed.</p> <p>Clear impact on efficiency, and potential impact on patient/client safety.</p>	<p>Transformed State:</p> <p>Portal links created for each of the two social work IT systems in use.</p> <p>Depending on the access rights of a user, information accessible can include demographics, key contact details, alerts/ concerns, encounter summary and a variety of assessments.</p> <p>Piloted and now live between NHSGGC and West Dunbartonshire.</p> <p>Good early reviews from users. Feedback is that they want to implement wider.</p> <p>Roll-out now underway, plus planning for possible future extension.</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Benefit Realised

Availability and sharing of information between partner agencies leading to improved patient safety and quality of care benefiting patients and carers. More efficiency for staff involved in patient's care as information is available and relevant.

Neurology Advice Only Headache Pilot

Pilot of advice referral using SCI Gateway from Primary to Secondary care.

<p>Previous State:</p> <p>Patients presenting to GP's with symptoms routinely referred to Neurology and placed on waiting list until seen by the Service.</p>	<p>Transformed State:</p> <p>Early intervention with the service via the Advice referral highlighted 25% of the pilot referrals were dealt appropriately through this process which negated the need for the patient to attend an outpatient appointment.</p> <p>16% of referrals resulted in an urgent referral being made to the patient.</p> <p>While the project was taken forward as a pilot, the system and process has been left on, with wider communication to GP practices due to the potential benefits to patients and to the service.</p> <p>Further work will be undertaken to assess what developments are required to support a full scale implementation for other services.</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Benefit Realised

Primary care clinicians in requesting advice for patients to decide on best treatment plan, and if a referral is required to secondary care.

Secondary care clinicians in being able to vet an advice only referral and upgrade this to an outpatient appointment if appropriate, therefore reducing the number of appointments required.

Copy of advice message placed into the EPR to form part of the patient record. Structured advice message within SCI Gateway utilising agreed terminology, allowing appropriate triage. Patient benefits from triaged advise and avoiding an unnecessary appointment.