Maximising Independence (MI)
Glasgow City Integration Joint Board

Programme Storyboard

29th June 2022

MI Work Streams

- Changing the Nature of Care
- Communities
- Maximising Health & Wellbeing
- Workforce and Culture
- Communication and Engagement
- Governance established and financial envelope agreed

Covid-19 Impact

- Limited progress made as a result of ongoing service demands
- Service responsiveness increased to deal with the pandemic
- Innovation around service delivery was observed across the system
- Adapting to the pandemic has increased organisational learning
- Limited ability to deliver practical change in 2021

Current Position for 2022/23

- Reenergised and refocused MI Transformation Programme
- Governance and assurance delivered through a Programme Management Approach
- Adopting and adapting revised care and support models
- Programme of prioritised project work now in progress at various stages of development

Maximising Independence Programme

Vision

Glasgow will be a city where everyone will achieve their potential for health, wellbeing and independence

Mission

Working alongside individuals, carers, communities, local organisations and partners we are moving on from traditional ways of providing services with the intention of enabling people to live the best lives they can by sharing decision-making about their care. Reducing inequalities in health and well-being outcomes

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Maximising Independence Strategic Alignment

Making connections, identifying interdependencies and opportunities for joint working – building productive relationships

- Unscheduled Care Joint Commissioning Plan
- Primary Care Strategy and Improvement Plan
- Mental Health Strategy
- Realistic Medicine (national and local)
- National Urgent & Unscheduled Care Collaborative

NHS Greater Glasgow and Clyde

Glasgow City Council

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Health and Social Care Partnership

MI Organisational Change Model

Purpose

Developing Glasgow's Communities' Health, Well-being and Resilience

Vision

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Strategy

Changing the nature of care through a cultural shift towards: Investing in, and supporting self-management approaches, coproduction and whole system collaboration to achieve better health and wellbeing outcomes in a targeted way, proactive engagement to develop the 'right' support for families and carers and prevention and early intervention initiatives via community and neighbourhood-level intervention that builds capacity and shared responsibility

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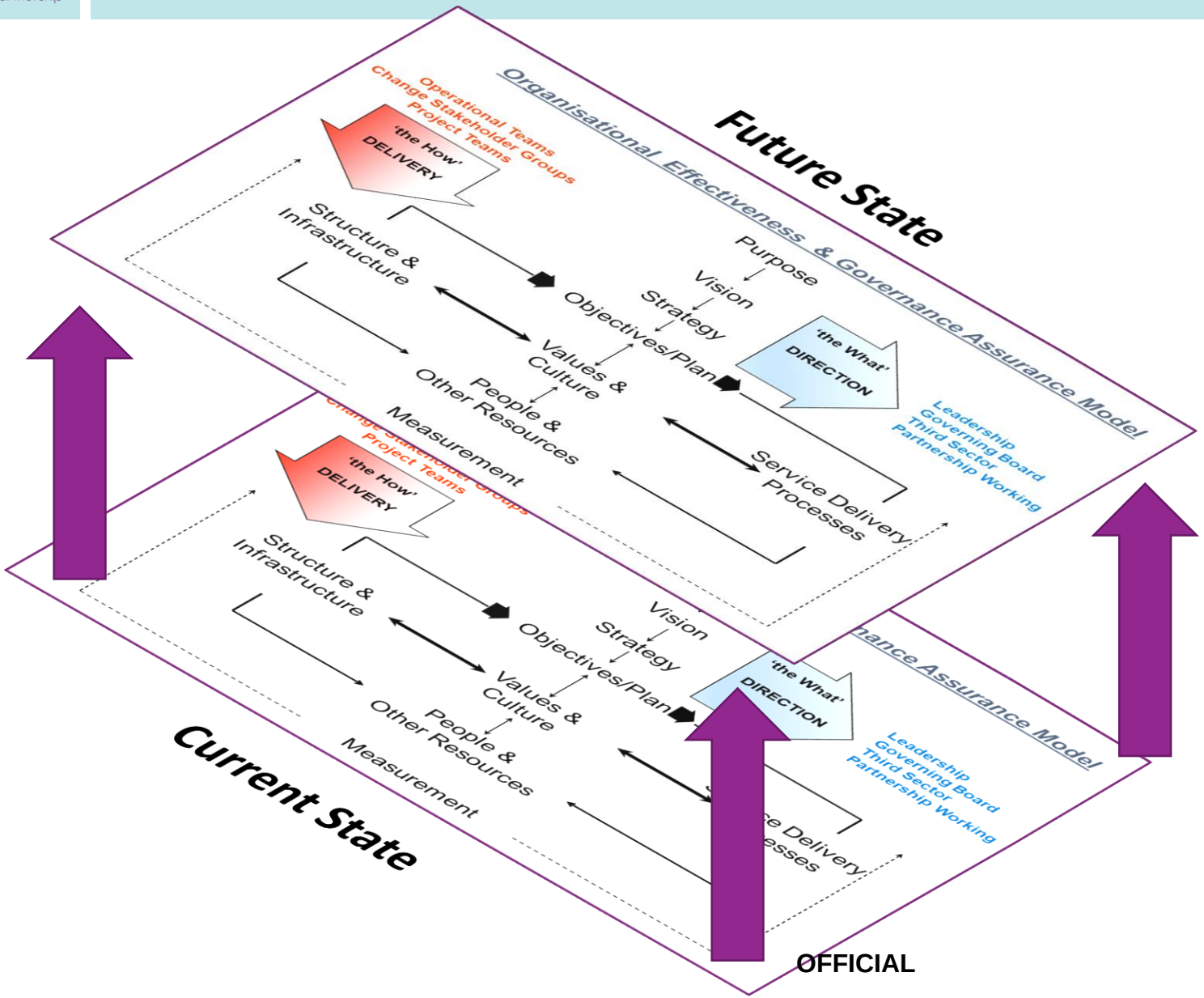
Innovate from Current to Future State



Define where we are now, describe the baseline 'As Is'

Innovate to describe the outcomes that will demonstrate success 'To Be'

Develop a change transition action plan that describes how we're going to get there

Use the outputs and outcome measures to confirm delivery and evaluate to evidence improvement

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MI Projects in Progress

Communities
- Asset Mapping
- MI Engagement Workshops
- Haghill & Carntyne Pilot

Changing the Nature of Care
- Single Point of Access
- Family Group Decision Making
- Development and Evaluation Process

Workforce and Culture
- Workforce and Culture Development
- Strengths Based Practice
- Trauma Informed Practice

Maximising Wellbeing
- Wellbeing for Longer Fund
- Mental Health & Wellbeing fund
- Community Mental Health Strategy
- Mental Health Hubs

Communication and Engagement
- Branding % Narratives Development
- Stakeholder Mapping
- Communications Delivery

Digital Enablers
- Carers Virtual Centre
- Carers digital referral
- Activity Monitoring Pilot
- TEC Clinic

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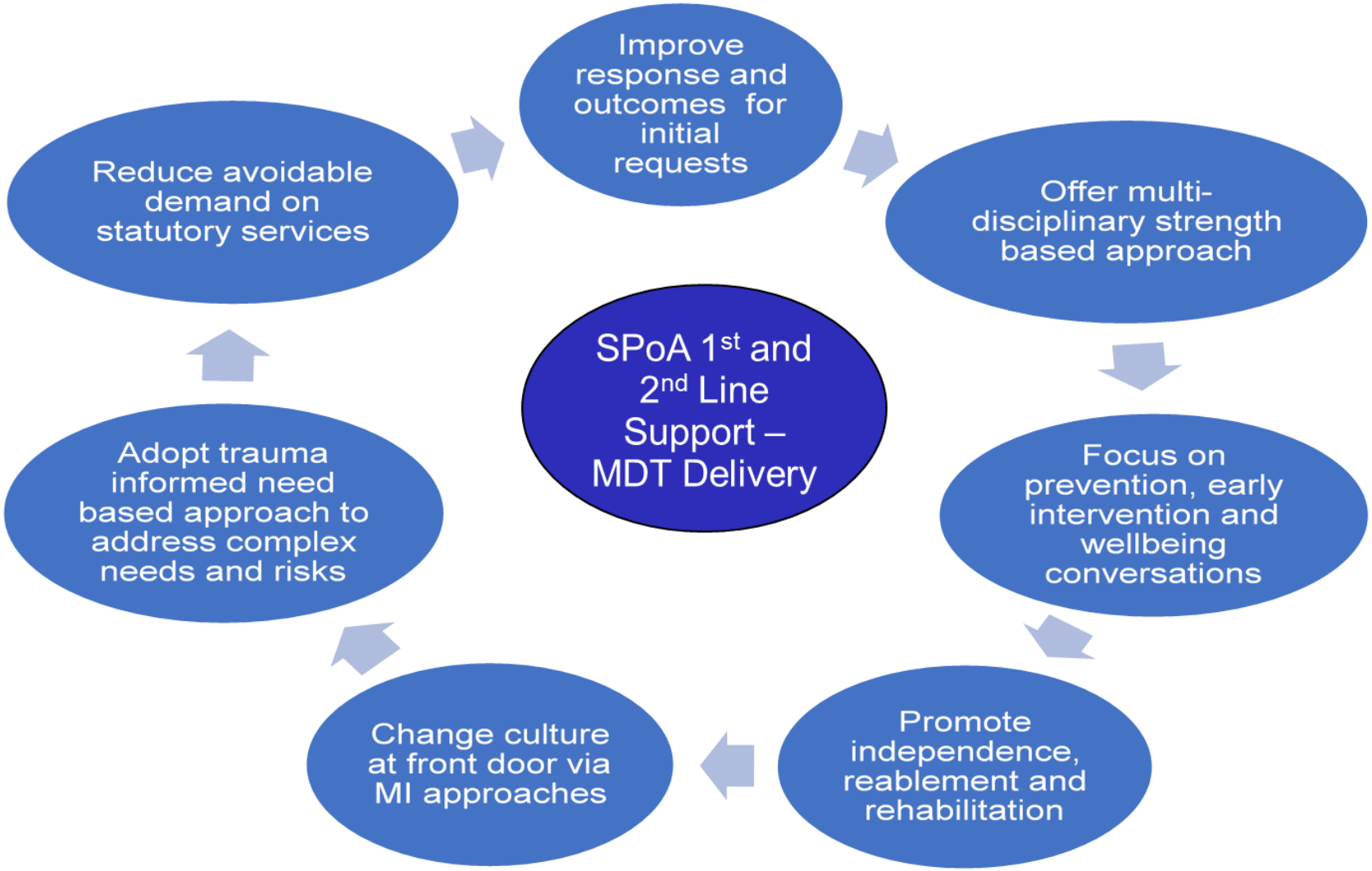
Single Point of Access Strategy (SPoA)



Understanding GC demand profile

- Link to SPoA and MH Hubs
- Analysing Waiting Lists
- Audit to inform resource modelling
- Common high volume themes
- Potential for targeted development with third sector organisations
- Investment in a multidisciplinary team
- Focus on delivering timely outcomes and reduced onward referrals

Single Point of Access Progress

- Developed at proportionate assessment for staff included in Phase One
- Built ‘Eclipse’ assessment tool aligned to strength based principles
- Developed the workforce plan and multi-disciplinary team investment proposal with ambition to significantly reduce waiting lists
- Source and agree a Strength Based Approach Framework for Glasgow City HSCP to support whole system transformation (options appraisal)
- Communities sub group established to link with interface work – workshop held 12th May with HSCP, third sector and partner agencies
- Ambition to develop a ‘cooperative of resources’ with rich expertise and a shared objective to build on strengths and community capacity
- Informed by analysis of high volume unallocated waiting list referrals
- Commitment to commission external evaluation of the SPoA service six months post implementation

National Guidance : Mental Health and Well-being Primary Care Service (MHWPC)

- Fully implement a new MHWPC services by 2026 using the Scottish Government financial allocation awarded for that purpose, and potentially supplementing with other local funds. Investment will increase annually with an expectation of over £4m pa by 2026 in Glasgow City
- New service will be designed around groups of GP practices
- The new service will provide assessment and support to the individual to access appropriate levels of advice, community engagement, treatment or care
- Anticipate combined teams of clinical and other professional staff from within and beyond the NHS. Clinical staff may include mental health nursing, clinical psychology, occupational therapists and other allied health professional groups. Every GP Practice must have access to a Community Link Worker and other staff may include third sector, financial advice and others
- Open to all patients on the practice list, with no age criteria
- Patients referred through General Practice or self-referral

MH Hubs 2022/23; initial development year

Aim

- **Improve access (journeys into and through) to mental health and wellbeing support**
- **Increase primary care and mental health system capacity**
- **Deliver integrated responses to promote good mental health**

1. Services respond to local need and demographics – **working with local residents** and agencies to develop the model
2. **Whole system collaboration** – pathways, planning and delivery - connecting existing services (HSCP and community)
3. **Working out the journeys into and through the hubs**– how will people arrive and be supported appropriately for their issues – including onward access to specialist mental health services if required
4. **Team leader recruitment** – 3 will be recruited initially for the three pilot areas
5. **So what?** – Glasgow Centre for Population Health will work with us to inform learning and help capture the differences generated through this investment to peoples lives.
6. **Working with 23 practices** initially, 3 clusters covering 102,000 patients initially (Dumbarton Road Corridor, Springburn area and Govanhill/Pollokshields)

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Family Group Decision Making

- Family Group Decision Making can help an individual's wider family to come together to agree on a family plan to support that individual, before decisions are made about their future.
- Families are often experts about themselves and their situation and have a right and responsibility to be active decision makers, the model is based on independent coordination to bring people together
- The model has been successfully implemented in Children & Families, our plan is to deliver for Adults & Older People
- Evidence of use in adult services in England and Wales from 1990s and in Scotland
- Working with Edinburgh to inform strengths based approach and to import learning, evidence of improved outcomes and benefits realisation post implementation
- FGDM Coordinators are a key component, in addition to a designated FGDM team the model will consider early intervention resource potential including local area coordinators and third sector

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Family Group Decision Making Progress

BMJ - Hillebregt CF,Scholten EWM, Post MWM,et al. Family group decision making interventions in adult healthcare and welfare

FGDM Progress Update

- Project team established, reviewing national learning to define model options
- Developing GC implementation plan (with support from Lothian)
- Define resources required to progress implementation and produce options appraisal
- Define and agree KPI's for Family Group Decision Making

Interdependencies identified and work in progress to understanding Glasgow profile?

- Link to SPoA and MH Hubs
- Analysing Waiting Lists
- Model Audit to inform resource modelling
- Common high volume themes being developed from demand, public health and independent reports
- Ambition for targeted coproduction and service development with third sector organisations

MI Carers Strategy Priorities

- Carers digital referral
  - Develop Eclipse system to automate referrals to carers team to create a proactive in reach service model
  - Aligned delivery to Single Point of Access Phase One
  - Test of change to automate referral with new Homecare packages
  - Ambition to identify other opportunities aligned to life changing diagnosis
- Virtual Carers Centre
  - Expand Your Support Your Way Carers Website to include training modules
  - Review modules/guides currently available across care group areas
  - Develop training catalogue alongside Carers Centre 'in person training delivery'
- Short Breaks Bureau
  - Early concept stage development in line with national guidance
  - Develop alternative and innovative support solutions for unpaid carers
  - Review current delivery process to ensure timely decision making

Reablement – Maximising independence

Additional 10 Occupational Therapists funded through Maximising Independence.

- **Introduction of a multi disciplinary approach (MDT)**
  - Increasing Occupational Therapy capacity for the reablement model, focusing on all referrals and supporting people to regain as much independence as possible
  - Occupational Therapist lead on screening and assessment in 25 service areas. , average of 40 referrals a day
  - Maximise reablement ethos for all service users including 404 service users with complex needs where the care package exceeds the equivalent of Residential or Nursing Care
  - Overnight home care focused currently on palliative and continence assistance to prevent avoidable admissions

Despite working through pandemic conditions, the reablement service is delivering increasingly effective care plans that support individuals to transfer safely into mainstream services.

Following Covid recovery, the plans for the project are:-

- **Focusing their expert resource in MDT meetings to incorporating**
  - Identify where service user care plans have increasing resource requirements to better understand and respond to service user needs
  - Review of care packages that exceed the equivalent of residential care to ensure support needs are met whilst acknowledging that this may not always be most effectively delivered by a statutory service
  - Increase the use of overnight homecare to prevent avoidable hospital admissions and maintain service users at home for longer where appropriate to do so

Community Asset Mapping

- Community asset mapping project now at commissioning stage led by GCVS
- Pilot project to engage with Haghill & Carntyne Community developed and now at commissioning stage
- Working with Knightswood Connects and Nan McKay Hall to scope existing community models and develop options for shared learning to inform the communities plan
- Workshop held with staff operating at the interface between statutory and third sector services on 2th May to develop a ‘co-operative’ service innovation model
- Early scoping of a ‘place’ based project with the Glasgow Helps Service focused on food poverty, income optimisation and social isolation
- GCVS establishing a Health & Social Care Network to increase and improve MI third sector engagement

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Maximising Independence
Key Enablers

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TEC Clinic Vision –to provide a service that

- Service Users, Family and professionals can utilise to help identify appropriate technologies to support Health and Social care needs.
- Offers face to face appointments and virtual appointments Via NHS Near me or Teams
- Includes information on technologies available through Health and Social Care, and also the wide range of technologies available on the consumer market.
- Is skilled to support service users, families and professionals to understand and use digital technologies
- Can link in with 3rd sector organisations (such as Ability.net) to visit a service user in their home and assist with the set up and training of digital technologies
- Can support service users to find available funding to support the purchase of digital technologies on the consumer market
- Helps to close the digital divide across Glasgow City (estimate 20% digitally excluded)

TEC Clinic Progress

- Engagement with Scottish Government and 3rd Sector Partners Alzheimer Scotland
- Support agreed from both partners and working across all care groups to develop pilot options
- Agreement other 3rd Sector Partners will be involved
- Potential funding stream
- Scottish Government recognise value on a National basis through shared learning.

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Communication & Engagement

- Working together with our partners in a new way, to transform Glasgow into a city where everyone can achieve their full potential for health, wellbeing and independence
- Our aim is to develop a positive program of change built on the principles of coproduction across the whole system to improve outcomes and increase service effectiveness
- Conducted extensive independent research to understand key stakeholder groups' responses to the MI Programme, acting on their recommendations including current programme branding work
- We recognise the risk of perceived anxiety and that building trust takes time, we have developed the groundwork for positive and effective multi-agency relationships
- We're developing narrative, content and approaches with GCVS and partner agencies through discussion and proactive engagement
- Reaching out to other programmes and interdependencies to have a consistent and coherent message that will support service change and transformation

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Draft MI Values

Trust and Trusted

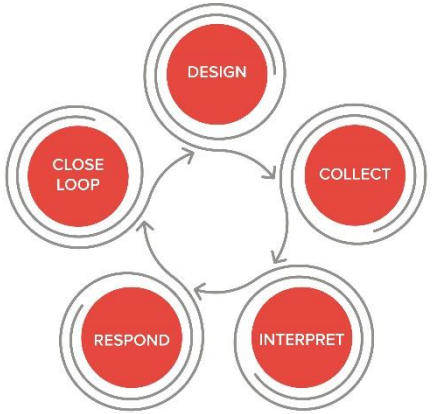
Collaborative

Kind, compassionate and supportive

Inclusive

Safe

Empowering and Empowered



Responsive to feedback

Innovative and creative

Respectful of individual choice and diversity

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MI core values (working draft)

Empowering and empowered so that people who are frail or living with disabilities or long term conditions, can live safely at home or in a homely setting in their community as long as possible, and those who care for them are empowered to do so in ways that maintain their wellbeing

Inclusive so that everyone who uses health and social care services are able to look after and improve their own health and wellbeing as much as possible, so that they live in good health for longer

Kind, compassionate and supportive so that people who use health and social care services have a positive experience of those services and have their dignity maintained at every contact with the service

Trusting and trusted so that we build positive relationships with the people we work with and support

Collaborative so that health and social care services are designed with, and centred on, the people who use the services

Safe so that people using health and social care services are safe from harm

Respectful, so that conversations with people who use health and social care services centre around their strengths, choices, human rights and diversity

Innovative and creative in how we use technology to support and improve service design and delivery

Responsive to feedback so that we learn, improve and change