Glasgow City HSCP
Older People's Services

Transformation Programme

February 2019

Strategic direction

- Strategic direction:
  - early intervention, prevention and harm reduction
  - providing greater self determination and choice
  - enabling independent living for longer
  - shifting the balance of care away from “institutional care” towards community provision
  - improving quality of life
- Context of significant demographic, demand and resource challenges
- Continued pressure to improve performance and deliver value for money

Why change is necessary?

- People are living longer e.g. in Glasgow those aged 85 and over set to increase by 10% over next three years
- There are huge health inequalities in Glasgow
- As a result many more older people are going to require care and support than is the case now
- We therefore need to find new ways of providing care to older people

What changes will people see?

We want to change our care system so that much more is done to prevent people becoming unwell and to support them to stay at home for as long as possible

Glasgow City HSCP
Health and Social Care Partnership

What will this look like?

- A shift away from long-term care with people being supported to remain longer in their homes
- More high dependency palliative/end of life care and short-term rehab care
- Intermediate care (step up/step down) as alternative to hospital admission
- More respite care
- More specialist dementia provision

NHS Greater Glasgow and Clyde

Glasgow City Council

Transformational programme

- All aspects of health and care system subject to change
- Residential and day care modernisation
- Home care – re ablement
- Intermediate care – new model & improved performance
- Integrated neighbourhood teams based on GP clusters
- Technology enable care programme
- Extending supported living

Glasgow City HSCP
Health and Social Care Partnership

Priorities for Older People's Services

- Reduction in care home places
- Shift towards a supported living models of care at home
- Increased support to families and carers
- Increased use of day care to support those with more complex needs
- Increased use of community based resources provided by third sector
- Range of telecare and responder services
- Multi disciplinary input from SW, Rehab, Nursing and OPMH working closely with GP practices or "Clusters" of practices
- Increasing prevalence of dementia - need for early recognition, diagnosis and support. Staff / carer education key to this agenda

NHS Greater Glasgow and Clyde

Glasgow City Council

Priorities for Older People's Services

- Implementation of "Neighbourhood" delivery model with Service Managers covering specific geographies within a Locality
- Implementation of the OT Review recommendations
- Review how we use Residential & Day Services – development of large unit presents an opportunity to review GP registrations & clinical input
- Implement the HSCP 's Palliative and End of Life Care Plan 2018-2023 which includes actions to improve identification & use of the national framework for staff education
- Improve the use of Anticipatory Care Plans

Glasgow City HSCP
Health and Social Care Partnership

Integrated Community Supports

Christine Murphy
Service Manager, SE Locality
Glasgow City Health and Social Care Partnership

February 2019

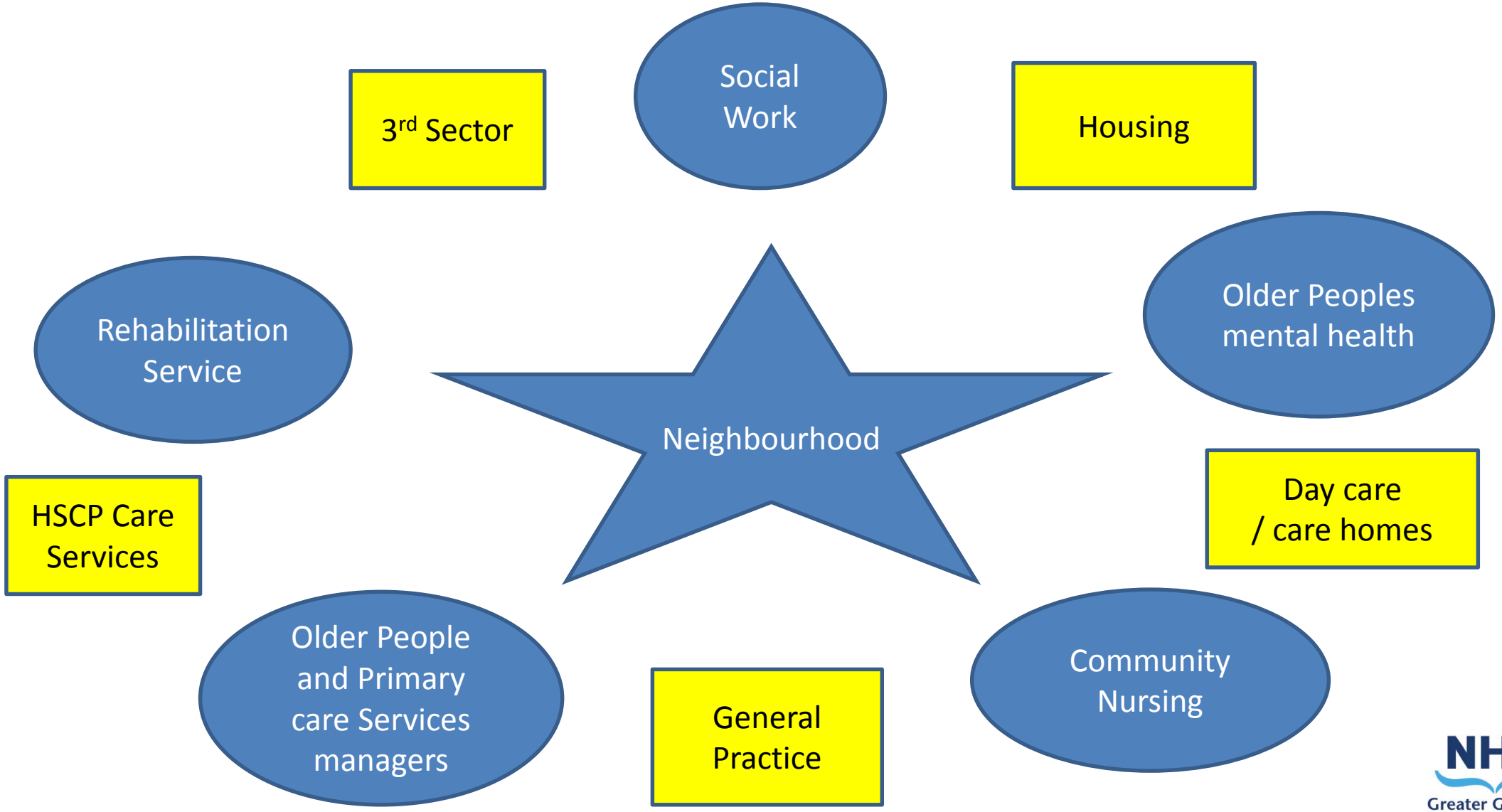
NHS Greater Glasgow and Clyde

Glasgow City Council

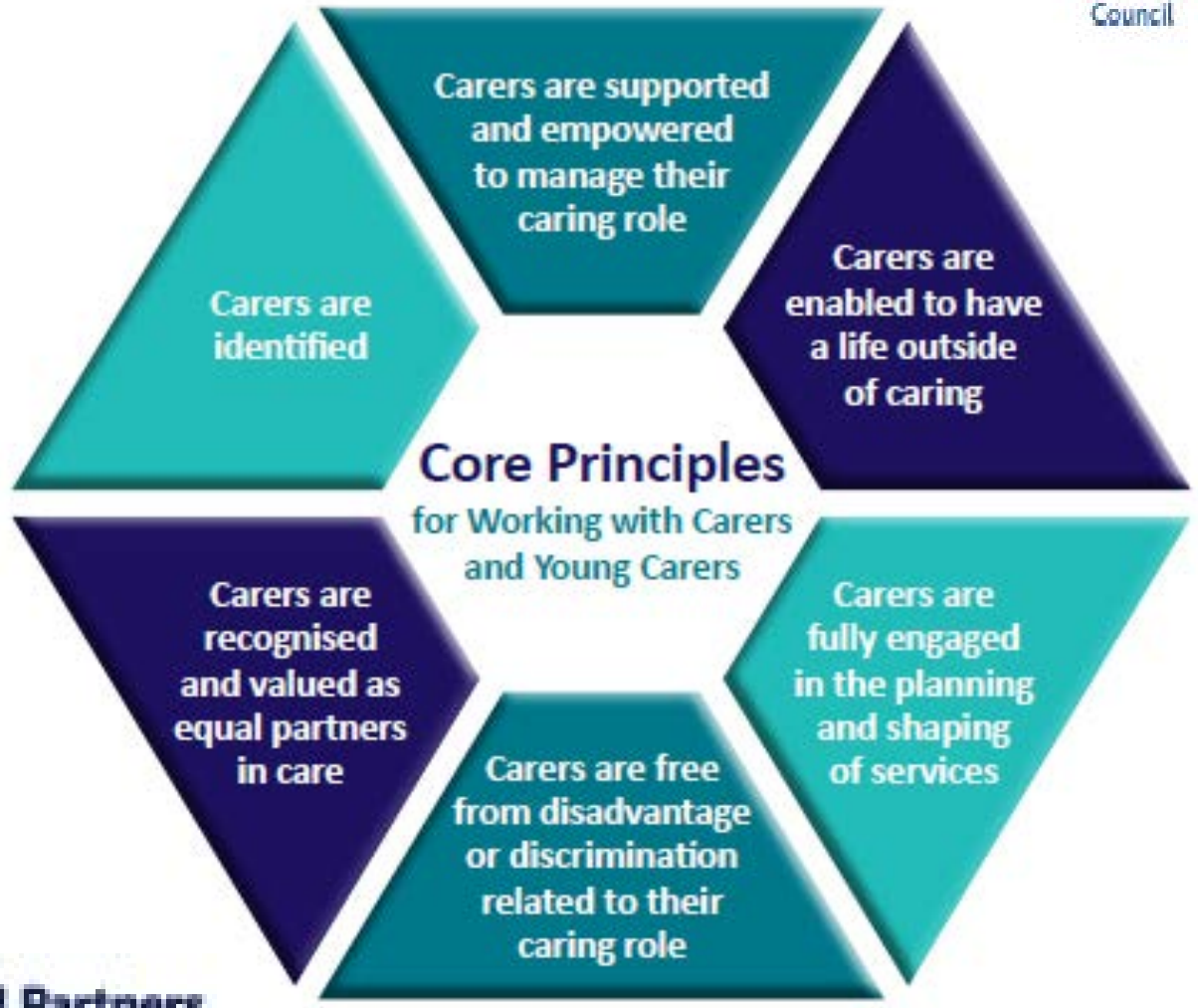
Home is Best- a few examples

- Neighbourhood Teams
- Carers Strategy
- Supported Living Developments
- Housing Options for Older People
- Home is Best Team

What services are part of the Older Peoples system of care in the neighbourhood



Glasgow City HSCP Carers Strategy



Glasgow City HSCP
Health and Social Care Partnership

Patients Journey

NHS Greater Glasgow and Clyde

SOCIALW(i)RK SERVICES
INCLUSIVE • SUPPORTIVE • PROTECTIVE

Carer's Journey

GLASGOW CITY CARERS PARTNERSHIP

NHS Greater Glasgow and Clyde

Glasgow CITY COUNCIL

Supported Living & Housing Options for Older people

- Supported Living service developments – continue to reduce number of care home admissions
- Housing Options - small team of Housing Staff funded by Glasgow HSCP
- Co work with health / social work colleagues housing partners (7 Hospitals / 6 SW offices / 6 Intermediate Care Units to help:

  Older People whose discharge is affected by Housing Issues

  Prevent Older People's Admission to Hospital where there are Housing Issues

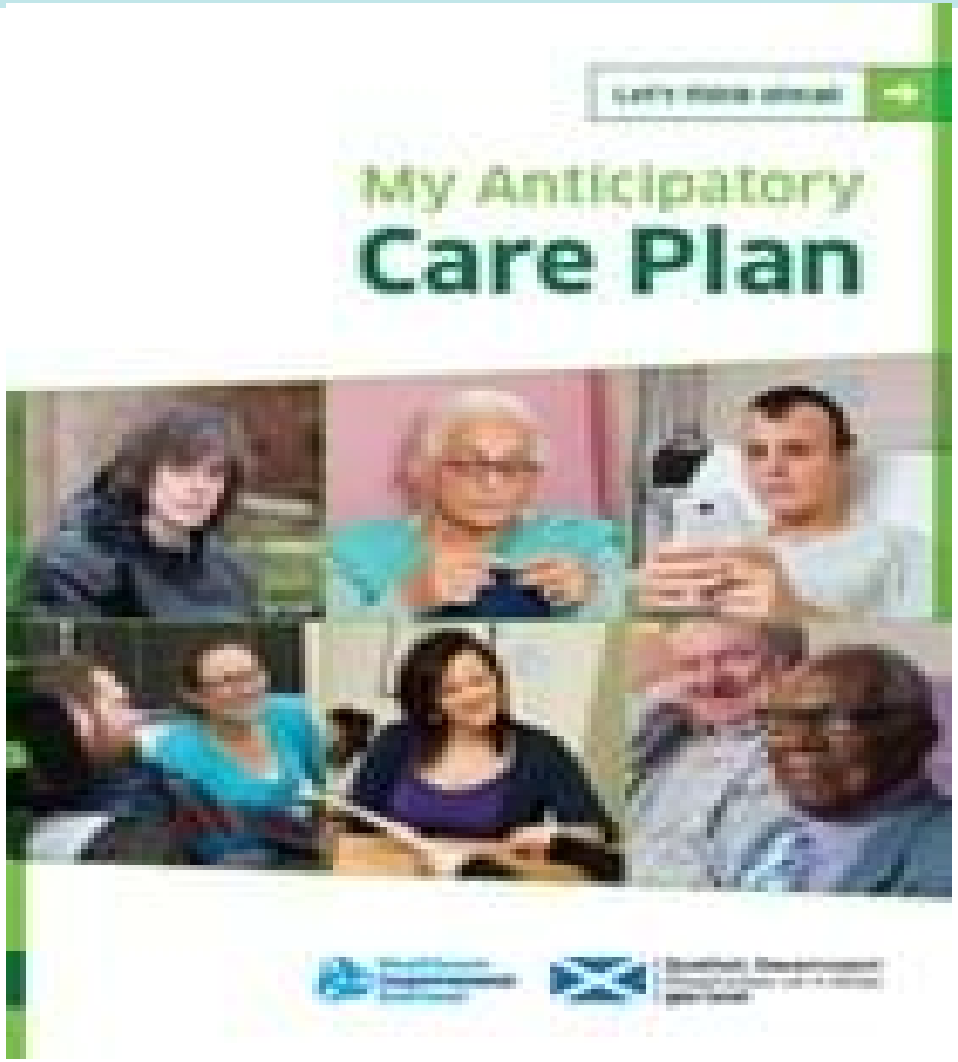
  Older people make informed housing choices along with their families
- We work closely with RSLs (60+) in Glasgow to optimise access to available stock (allocation policies /tee up HOOP customers / minimise void rents)
- Share our data base to help future proof the city's new build programme proof: GCC DRS

Home is Best Discharge Team

- **A single hospital discharge team for the HSCP , with a clear identity and a visible management team**
- **Staff will mainly be based in the two main Acute Hospital sites & operate as a single team allowing team to flexibly respond to demand – potential to co-locate with Discharge Team**
- **Staff will work to a single set of Operating principles and to a single consistent process.**
- **Opportunities to streamline the current process and to move to a ‘’paper lite’’ if not paper free system**
- **Already building relationship with ward staff**

Anticipatory Care Planning

Frances Millar
Change and Development Manager
South Locality
Glasgow City Health and Social Care Partnership



In this presentation ….

- ✓What is Anticipatory Care Planning
- ✓When and who needs a plan
- ✓Why it’s helpful to have an Anticipatory Care Plan
- ✓How can you start your own plan
- ✓What to do with a plan when you have one…

What is Anticipatory Care Planning?

- Anticipatory Care Planning is a process that can empower you to make choices and decisions about current and your future care needs

- It can support you to have conversations with your family, carers, friends and health and social care professionals about what is important to you, who the important people in your life are, and in some situations what you wish to happen to you.

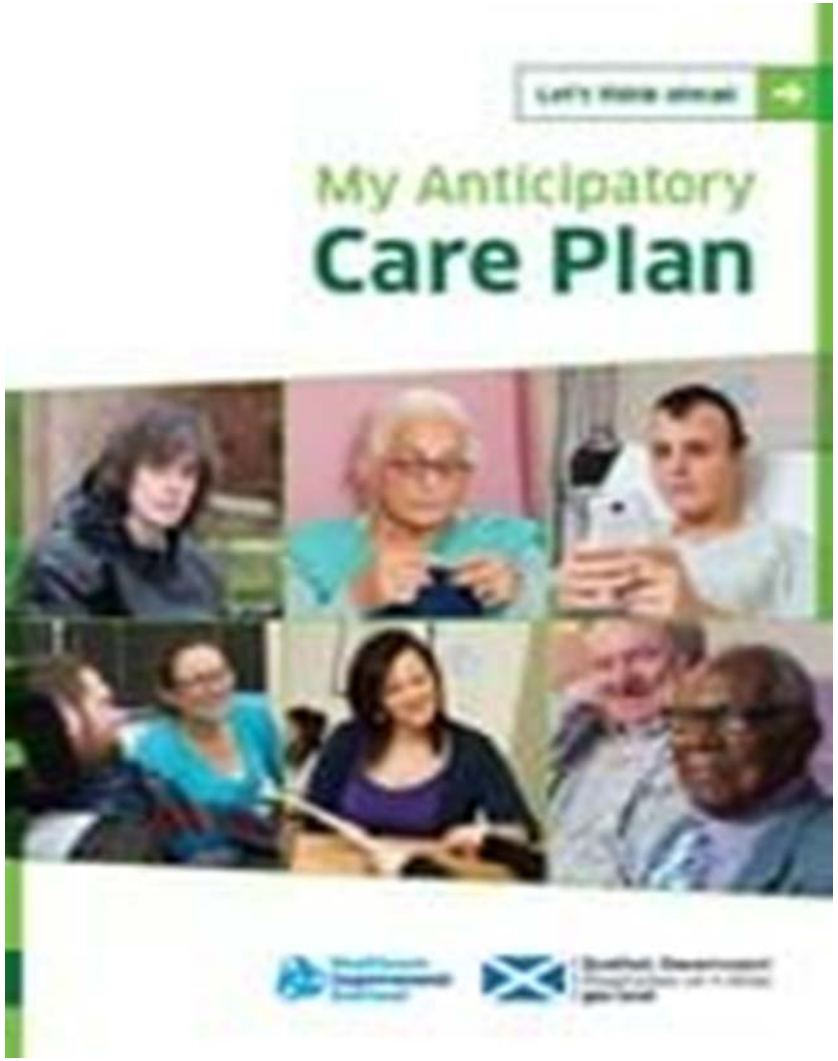
When and who needs a plan

- Not everyone needs (or wants) an Anticipatory Care Plan
- They can be useful for people who have complex health and social care needs
- If there is a change in your condition, e.g. if it becomes more complex or your circumstances change it may be a good time to put a plan in place.
- If you have a plan it can be very helpful to people who, particularly at times of crises, may be looking after you but do not really know who you are as a person, what is important to you, and how you wish to be treated.

Why is it helpful to have a Plan?

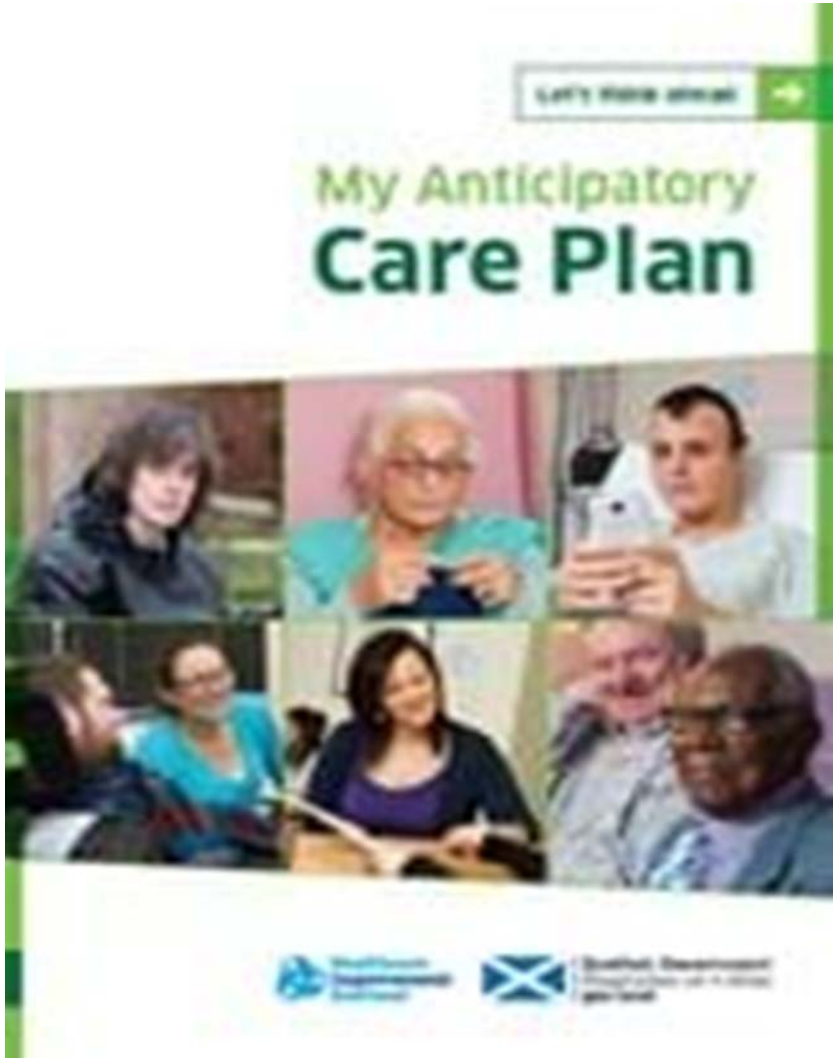
- It can help you feel more aware of the options and choices available to you, it can help you take control of these options
- It can help you have conversations with family members, carers friends and all those involved in your care about what is important to you and what you would like to happen in the future.
- It is a written record of who you are as a person, what is important to you and your wishes.
- It can be shared with others.

How can you start your own plan?



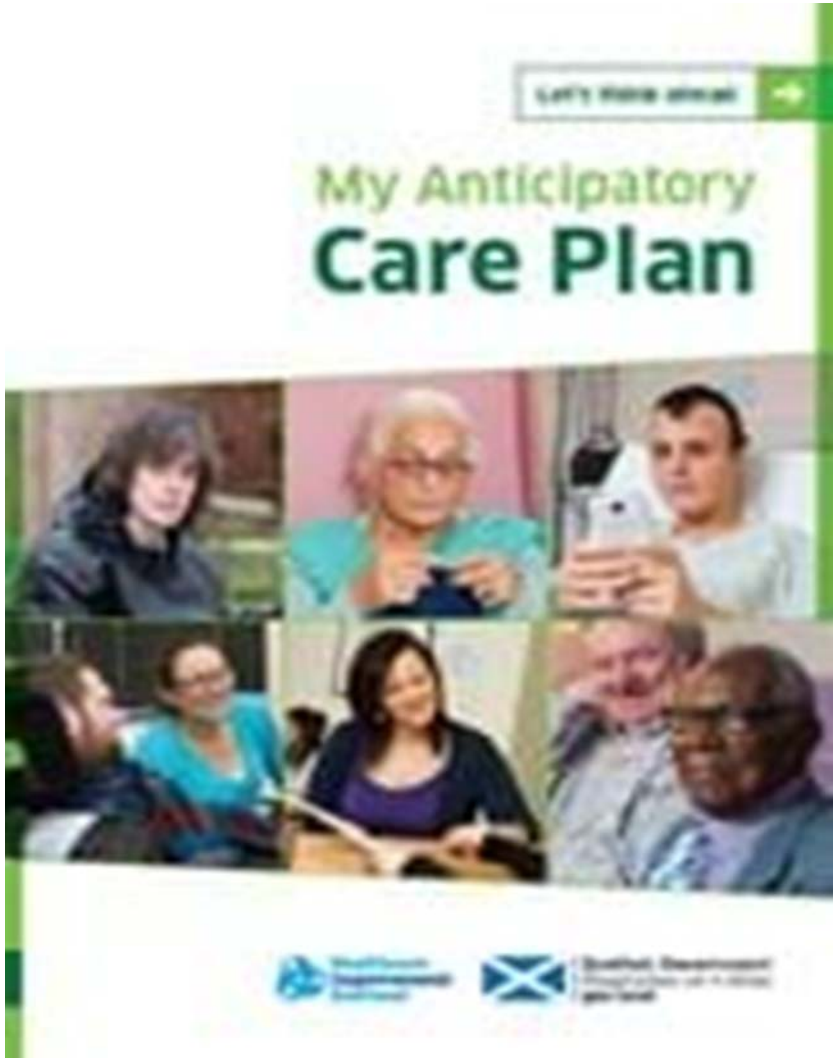
Anticipatory Care Planning App
[Anticipatory Care Planning Application – YouTube]

What to do with your Plan



- Share your Plan
- Tell people where it is
- Share it with your GP and other Health and Social Care Professionals, take it with you to appointments
- Remember to update it if things change

Useful Links



[Anticipatory care planning | NHS inform]

[Anticipatory Care Planning - Anticipatory Care Planning Toolkit]

Moving Forward Together.

Moving Forward Together

Programme Overview

Welcome

Today:

- Describe the programme to transform health and Social care services across Greater Glasgow & Clyde- Moving, Forward, Together
- Explain why we might want to make changes to services
- Describe what this might look like at a high level
- Let you know where you can get more information and stay involved
- Hear what people think and listen to staff converstions about what matters to most people

Introduction to Moving Forward Together

What is Moving Forward Together

- Moving Forward Together is a **Vision** to transform **healthcare** and **social care** services
- It describes **new ways of working** that provide safe, effective, person centred care to:
  - **Deliver improvements in care and outcomes for all patients service users and carers by:**
    - Maximising available resources
    - Making best use of innovation and technology
- The **Blueprint** for change was approved by NHSGGC Health Board and noted by the six Integration Joint Boards
- Sets a **strategic direction** of travel for the next **3 to 5 years** and beyond to meet future needs of the **whole population**
- It is aligned with **Scottish Government** strategy and plans

Why we need to transform services?

There is increasing demand across the whole system

- Advances in medicine and effective public health interventions are helping us all to live longer
- As more of us live longer the demands on health and social care services are also increasing
- Nature of illness has changed, people are now living with diseases and conditions that previously would have been fatal
- Health and social care system is struggling to keep pace with extra demands

What this means

Our **current models** of care are facing a number of challenges

The current **'fix and treat' approach** to healthcare doesn't focus on prevention, self-management and reablement

Increasing reliance on hospital care is simply not in the best interests of people

The **increasing demand** will simply **not be met** unless we change how services are accessed and used

There is a **limited** budget to spend on health and social care, and we need to use our resources to provide services that are **realistic, affordable and sustainable**

What we want to do?

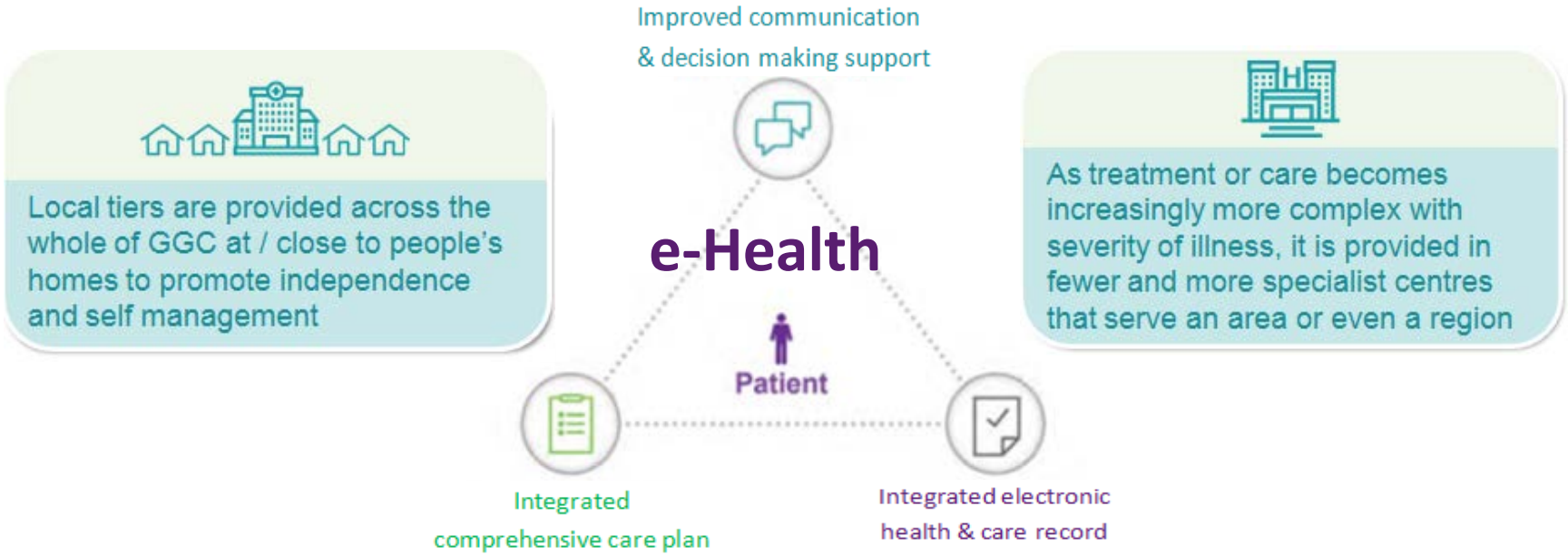
Deliver an integrated and seamless **tiered system of care** that**:**

- Puts the Person at the Centre
- Supports people to live longer healthier lives at home or in a homely setting
- Provides more care in or close to people's homes in their community
- Provides more specialist care in a community setting
- Provides world-class specialist hospital care for our whole population

What will it look like?

Tiered models of care working across the **whole system** to:

1. Maximise Primary, Community and Virtual Care Opportunities
2. Align with West of Scotland Regional Plans
3. Optimise our Hospital Based Services



We need to work with people on concepts to **hear what matters most to them** to develop more detailed plans

Older People's Care

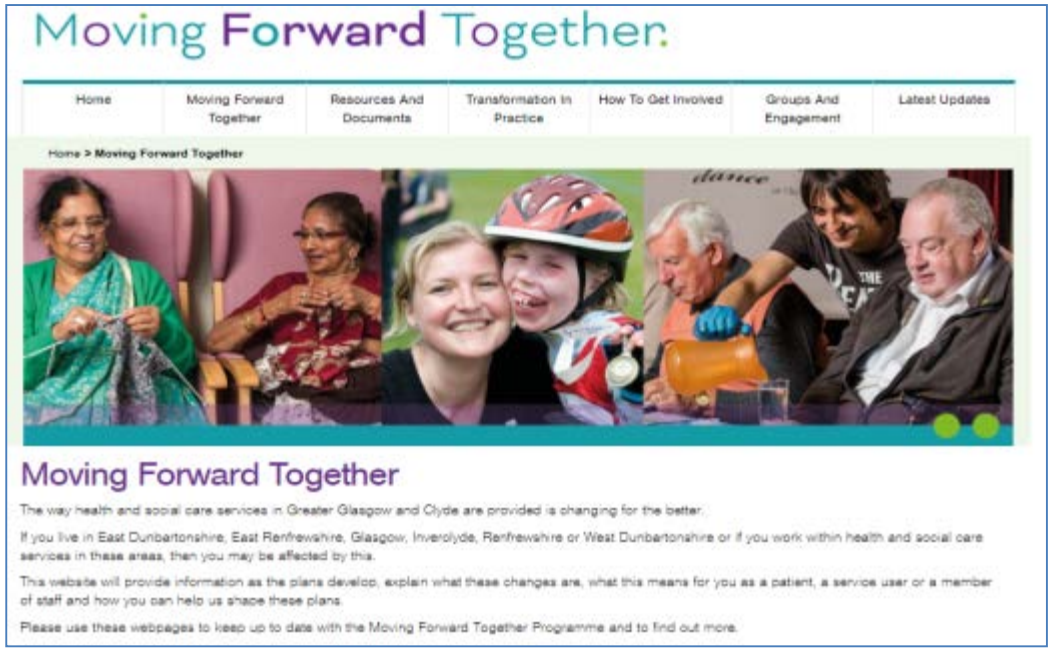
- The initial priorities for Older People's Care are:
  - Intensive support in people's homes or care homes with geriatricians and other specialists providing 'hospital at home' services via outreach into the community
  - Identifying frailty earlier to intervene and actively support people to improve function to reduce falls and prevent avoidable hospital admission
  - Look at new approaches to community based dementia care as alternatives to inpatient hospital care

It's not just services that need to change...

- To help reduce pressure on the system people need to access the **right care**, in the **right place** at **right time**?
- To do this we need to:
  - Support people to access and use services differently
  - Improve knowledge of and trust in new models and alternatives
  - Promote greater self care and health improvement with the community networks to support this
  - Work collaboratively with the Third Sector, community planning partners and importantly people

To **Move Forward Together** we **all** need to **think**, **work** and **act differently!!**!

Find out more and stay involved



For further information

Visit: **www.movingforwardtogetherggc.org**

Call: **0300 123 9987 (free phone)**

Feedback and Questions

- Do you recognise the challenges we face and the need to change
- Do you agree with the direction of travel and how we want to:
  - **Empower people** to be healthier, manage their own care and be the **key decision makers**
  - Provide services across a **tiered network** with more care and more support **closer to home**
- **What matters most** to people when using services