Moving Forward Together.

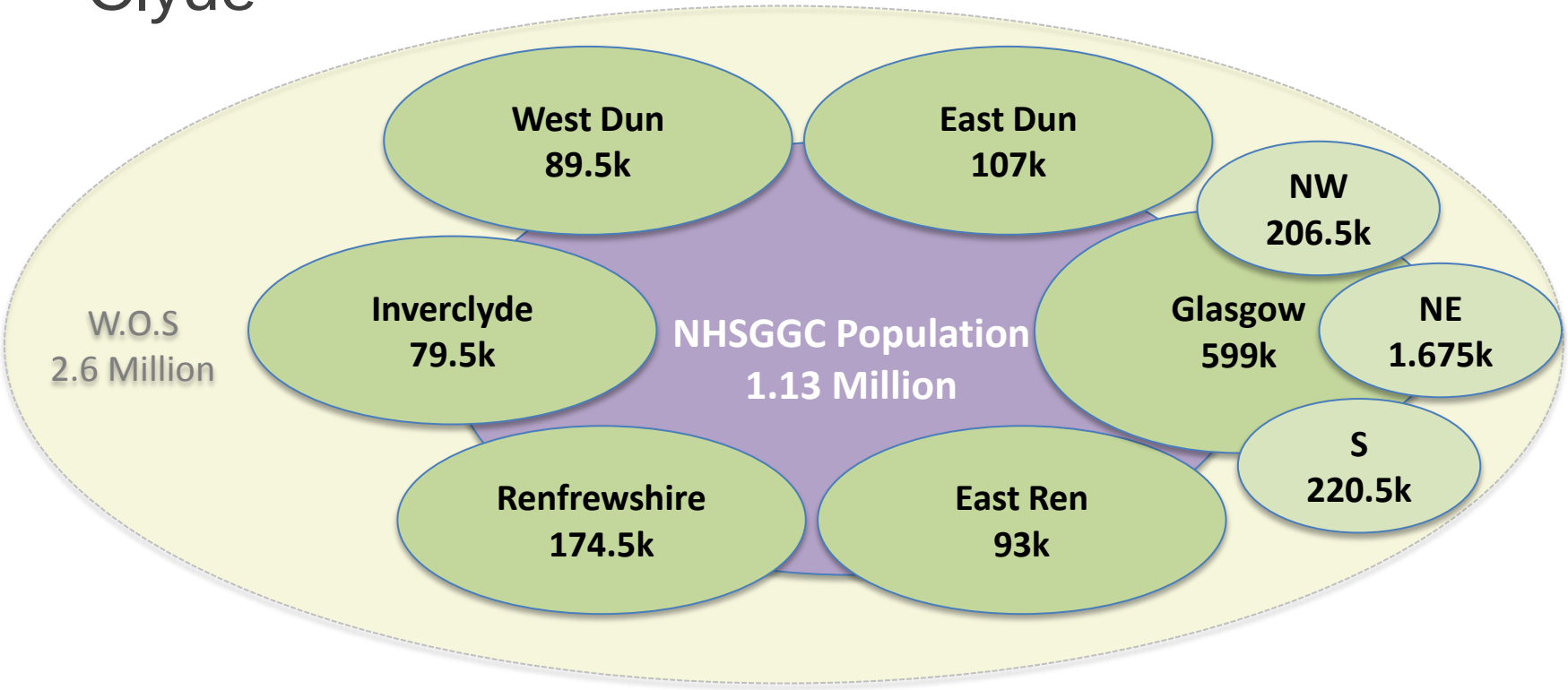
Moving Forward Together

Tiered Model of Care

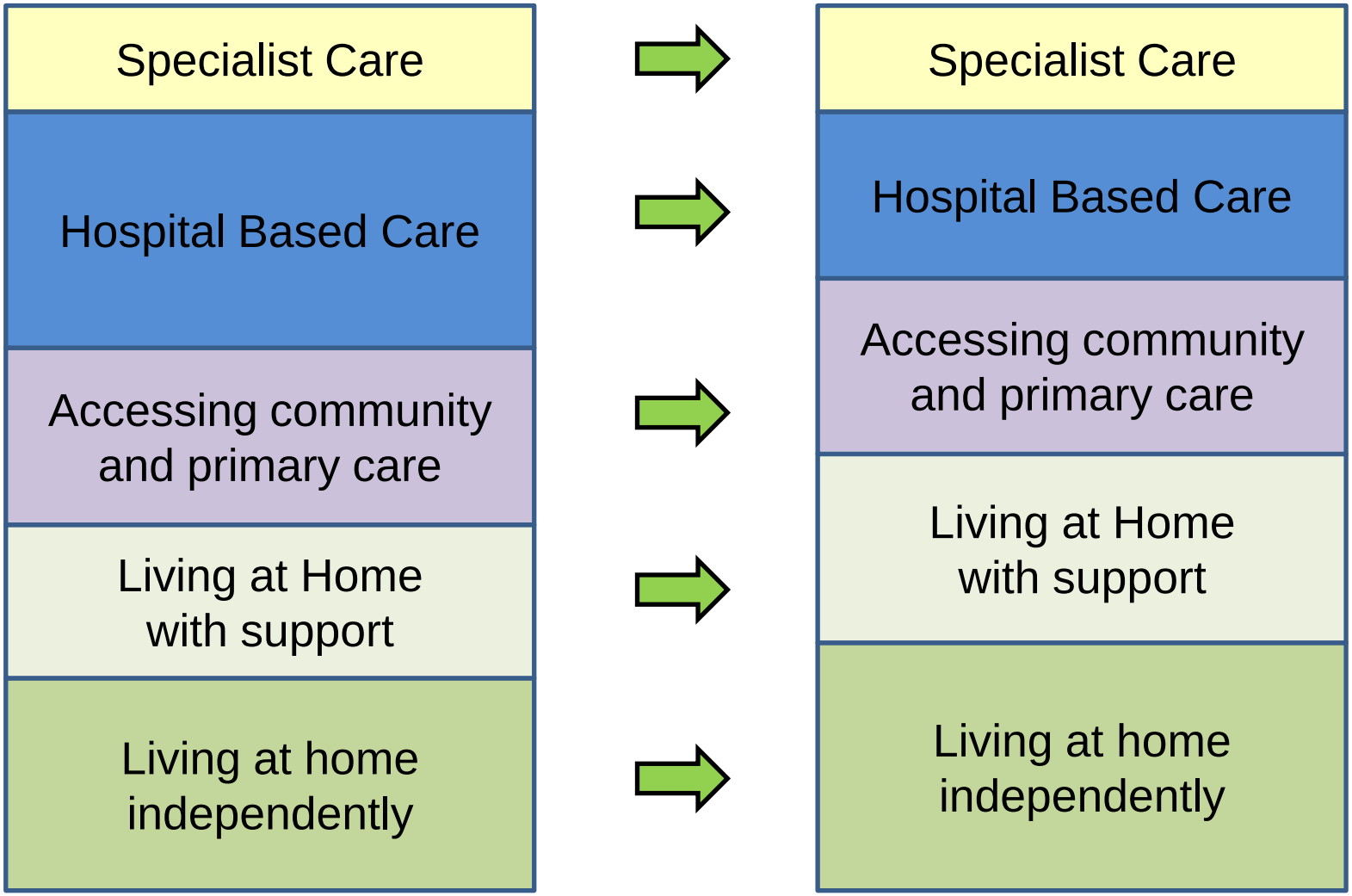
Dr David Stewart
Lead Director for Acute Medical Services
December 2017

Moving Forward Together

- Programme to transform healthcare and social care services for the future for all of Glasgow and Clyde



Transforming Care Delivery



Programme Phases

- Phase 1 (Completed)
  - Review National, Regional and Local Strategy and Delivery Plans
  - Update the population projections for Greater Glasgow and Clyde to 2025
  - Develop the principles that the Transformational Strategy will be based upon:
    - Safe, Effective and Person Centred

MFT Principles

By 2020 everyone is able to live longer healthier lives at home or in a homely setting

1. People can look after and Improve their own health and live in good health for longer
2. People are able to live independently and at home or in a homely setting in their community
3. People have positive experiences of those services, and have their dignity respected
4. Care is centred on helping to maintain or improve the quality of life of people
5. Services contribute to reducing health inequalities
6. Unpaid carers are supported to look after their own health and wellbeing and to reduce any negative impact of caring
7. Service users are safe from harm
8. Our staff feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9. Resources are used effectively and efficiently

Programme Phases

- Phase 2 – Current
  - Prepare and present case for change, projected demand and evidence to facilitate discussion with specific clinical groups across primary, community and hospital settings
  - Task speciality groups to review predicted service demand and propose new ways of working, based on the Programme Principles
  - Work with clinical groups to look at interdependencies to inform options and plans that enable change and describe future models of service delivery
  - Review options and models against evidence and Programme Principles

Tiered Model

- What is a tiered model of service delivery?
  - System based on increasing level of complexity
    - The lower tiers are low complexity and lower acuity (severity of illness / treatment) and can be provide at or close to home
    - The upper tiers are higher complexity and acuity and provided in a hospital setting

Tiered Model

- Why plan using a tiered approach
  - System can be designed to fit the needs of the population
    - Develop and organise the fundamental facilities and systems to provide safe, effective and person centred care
    - Whole system approach to health and social care can be taken across primary, community and social care into scheduled and unscheduled hospital care

Unscheduled Care Tiers

- **Tier 1**
  - Major Trauma Centre
  - Population base: 2-3M
  - Service Model: 24/7 Access to major trauma services
- **Tier 2**
  - Trauma Unit
  - Population Base: 400-600K
  - Service Model: 24/7 access to the full range of emergency services below that only provided in the MTC
- **Tier 3**
  - Local Emergency Hospital
  - Population Base: 100-200K
  - Service Model: Consultant led A&E with access to a range of emergency services and transfer arrangements to MTU and MTC
- **Tier 4**
  - Emergency Care Centre
  - Population Base: 50-100K
  - Service Model: GP led emergency care centre with access to a range of assessment and treatment services and transfer arrangements to MTU and MTC
- **Tier 5**: Community Based Services

TIER 1
24/7 access consultant delivered A&E,
Neurosciences, Cardiothoracic ,
Hyper Acute Stroke, Vascular
Full range of emergency surgery and acute Medicine
Full range of support services, ITU/HDU etc

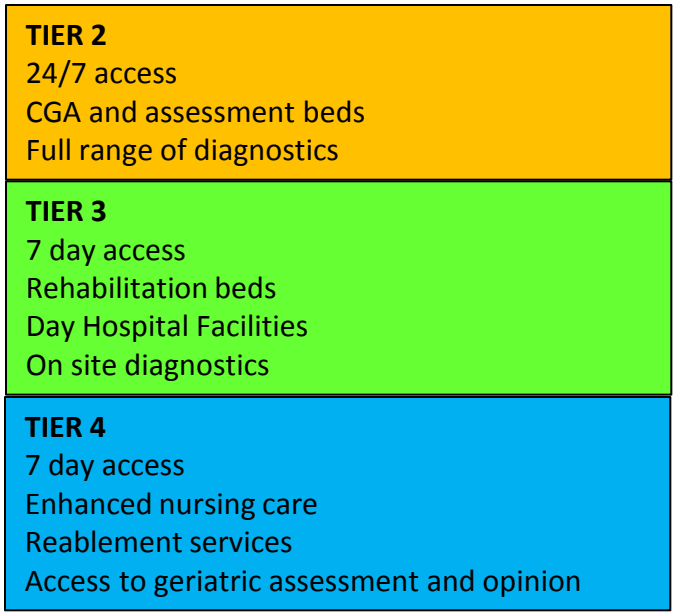
TIER 2
24/7 access
Moving towards 24x7 consultant delivered A&E
Full range of emergency surgery and acute medicine,
Full range of support services,
ITU /HDU,
CGA and assessment beds
Access to intermediate care network

TIER 3
Front door services with Acute medicine
No onsite emergency surgery,
Access to critical care/HDU and
surgical opinion via network,
Outpatients and diagnostics

TIER 4
18/7 Access GP-led urgent care incorporating OOH
GP and community based services
Access to community based step up/step down
beds possibly with 48 hour assessment unit
Outpatients and diagnostics

Older People's Care Tiers

- Tier 2
  - Trauma Unit
  - Population base: 400-600K
  - Service Model: Complex Geriatric Assessment and inpatient assessment beds
- Tier 3/C
  - Rehabilitation Hospital
  - Population Base: 400-600K
  - Service Model: Inpatient rehabilitation beds and access to day hospital and on site diagnostics
- Tier 4
  - Intermediate Care
  - Population Base: 100-200K
  - Service Model: A network of step up and step down beds or community services designed to care for people not ready for home but not requiring the level of care in a hospital setting
- Tier 5
  - Community Based Services
  - To be defined



Scheduled Care Tiers

- Tier A
  - Regional Centre
  - Population base: 2-3M
  - Service Model: Centralised high complexity low volume services extending to National and Regional Services
- Tier B
  - Complex Inpatient Centre
  - Population base: 400K-3M
  - Service Model: Medium to high complexity services requiring extended inpatient stay or access to critical care
- Tier C
  - Ambulatory Care Hospital
  - Population Base: 400-600K
  - Service Model: Low to medium complexity services requiring access to short stay beds but no access to critical care
- Tier D
  - Local Planned Care Centre
  - Population Base: 100-200K
  - Service Model: Low complexity services delivered on a day case basis
- Tier E
  - Community Based Services
  - To be defined in specialty

TIER A
7 day access
Regional service for complex low volume surgery
Full range of complex elective surgery and medicine
Full range of support services, ITU/HDU
24/7 interventional radiology
On site laboratory services
Research infrastructure

TIER B
7 day access
Full range of elective surgery and medicine
Full range of support services, ITU/HDU

TIER C
7 day access
Range of elective surgery and medicine
Access to on site support services excluding ITU/HDU
Access to ITU/HDU in emergency via network

TIER D
Limited range of elective surgery and medicine
Limited support services
Access to ITU/HDU in emergency via network

Cancer Care Tiers

- Tier α
  - Regional Cancer Centre
  - Population base: 2-3M
  - Service Model: Comprehensive range of cancer assessment and treatments, follow up and palliative care, including National Services and Paediatrics
- Tier β
  - Treatment Unit Networks
  - Population Base: 1.2M
  - Treatment Unit Service Model: A network of satellite cancer units offering consultation and local access to less complex treatments, palliative care and follow up
- Tier γ
  - Community services
  - Population 50-100K
  - Model—community dispensing of appropriate SACT and long term follow up and palliative care

TIER α
Clinical Trials
Acute Oncology Assessment
Inpatient beds
Outpatients
Medical Oncology
Clinical Oncology
Haemato-oncology
Clinical Apheresis Unit
Chemotherapy
Brachytherapy
Radiotherapy
Pharmacy
Full range of labs and diagnostics; MRI CT PET-CT
Access to critical care facilities
Palliative Care

TIER β
Access to consultation and less complex treatments, palliative care and
Outpatient follow up

TIER γ
Diagnostics to support treatment and follow up
Hormone/Immunotherapy
Chemotherapy

Methodology

- Work with clinical and multidisciplinary teams to develop and agree a tiered level of service delivery and supporting infrastructure
- Step One - Top down approach
  1. Agree initial tier with wide clinical engagement
     - Sharing tiered approach with GGC clinical modelling groups
     - Revise tiers as required
- Step Two - Bottom up approach
  1. Working tiers used as a basis for primary care, community service, social work and acute specialty level engagement to develop tier stratified services
     - Stratified services used to populate detail of tiers in terms of collocation and dependencies
- Step Three - Joined up approach
  - Infrastructure allocated to tiers and services aligned into infrastructure
  - Population access to tiered services correlated for each HSCP locality
  - Revision of allocated infrastructure where identification of gaps in infrastructure as required

Phase Two Service Modelling Groups

- Cardiology
- Endocrine/Diabetes
- ENT
- Gastroenterology
- General Surgery
- Geriatrics
- Respiratory
- Rheumatology
- Orthopaedics
- Urology
- Haemato-oncology
- Breast Cancer
- Dermatology
- Vascular
- Diagnostics
- Upper GI Cancer
- Colorectal Cancer
- Lung Cancer
- Head and Neck Cancer
- Urological Cancer
- Gynaecological Cancer
- Critical Care
- Palliative Care
- Infectious Diseases
- Tier 3/4 Unscheduled Care
- ACH OOH Model Group

Phase 2 so far; emerging themes

- Tier 4/D services
  - All specialty groups have identified service provision that could be moved from the hospital base to local or community delivery models
  - Each specialty groups have identified a need for more and better supported specialist nurses and AHPs to deliver this transformation
  - Models could be based on physical community or local assets or virtual teams with no fixed infrastructure
  - Support links into the acute consultant body and also into GP clusters enhance this model and are enabled by e-health solutions

- Access to Comprehensive Records and Improved Cross Sector Communication
  - This has long been a desire but now there are e-health solutions that can make this a reality

Phase 2 so far; emerging themes

- Working to the top of a licence
  - All specialty groups have identified service provision that could be done by other less qualified staff at a lower level which would allow each practitioner to send more time doing only the work that they can do

- Cross System Team Working
  - Many of the specialty groups have already shown areas of good cross system working but there is a real enthusiasm that this could be expanded and rolled out to be universal practice

- The opportunities of integration
  - Most of the specialty groups felt that the gap between primary community and acute service delivery had closed and that the transformational programme was an opportunity to bring about a much more integrated health and social care system

Discussion