Moving **Forward** Together.

Local Care

Workstream Overview

What is the Local Care Workstream

Local Care is described under Moving Forward Together as:

The complete range of services that can be provided within people's communities and homes to support self-management and maximise individual health and wellbeing, or to support people to live how they want until death

It will optimise General Practice, Primary Care Teams and develop networks of community based services. Wherever possible there will be a focus on innovation, using technology and digital solutions to develop new models of care and ways of working.

What are our priorities

The Local Care Workstream is going to initially focus on these areas to transform health and social are services:

1. **Long-term condition management** and testing the principles of self-care, supported self-care and remote self-management
2. **Palliative and end of life care** system that supports people to make choices at the end of life the same way it has during their life
3. **Self-management health literacy and technology** to support and educate people to manage their own conditions
4. **Anticipatory Care Planning** via a joined-up, co-produced and shared plan that works seamlessly across the whole system

Example: Improving Self-Management of Type-2 Diabetes

This project will develop new ways of working to shift from hospital focussed care to greater self-management and more community-based services

Based on the principles and concepts set out in Moving Forward Together and in consultation with the Diabetes Managed Clinical Network we have identified four key areas to transform current diabetes service delivery:

I. Monitoring appointments at local chronic disease monitoring centres located within health and welling hubs
II. Lifestyle coaching/self-help services to support greater self-management
III. Design of a Greater Glasgow and Clyde specific ‘MyDiabetes’ app
IV. Delivery of a primary care based Integrated Diabetes Care Team

Learning from this project will be applied to other long-term conditions

Chronic Disease Monitoring Centres

I

This concept for new ways of working would see a range of services traditionally delivered in the hospital setting to monitor a long-term condition being delivered in community venues. Those without complex care needs would visit their local centres and expert staff would make use of flexible multipurpose treatment rooms to carry out assessments, take bloods etc. Results will be reviewed by a multidisciplinary team and care will be coordinated by a senior clinician. This will prevent unnecessary travel to hospital for what can be multiple appointments and lets hospital teams and consultants manage the most complex cases.

Lifestyle coaching and self-help services

II

These are a range of services that people can access to improve and maintain health, prevent and deal with illness. They are usually thought of as things like advice and support to become more physically active, to eat healthier, cut down on smoking or alcohol. However, Moving Forward Together also recognises that environmental and socioeconomic factors also contribute to a person's wellbeing and advice and support on housing, maximising income and other community and peer support initiatives will play an equally important role in the future.

My Diabetes App

III

We want to develop an app that enables people to have greater control over their diabetes. It will let people manage and prepare for any appointments they have and will provide a personalised ‘dashboard’ with easy to understand information on test results and treatment advice. This will be linked to a ‘my management plan’ with information about current medication, priorities and risks e.g. not taking medication. It will support healthier lifestyles with tools and tips to improve diet and exercise and provide links to peer and expert support and advice.

Integrated Primary Care Diabetes Team

IV

This multidisciplinary team led by a GP would review test results, monitor treatment and propose individual management plans based on a ‘traffic light’ system. A nominated person will work alongside an individual to determine the best course of action depending on a person’s needs. There will be a range of expert support and advice available from dieticians, podiatrists, mental health professionals and consultant diabetologists.

Current diabetes care model

Mr Smith has type-2 diabetes and gets sent a letter with a date for an appointment to attend for a diabetes review with the Practice Nurse at his GP practice. He manages to arrange time off work, but this is not always easy.

When he attends the nurse does some physical tests, takes blood and goes through a list of questions about his treatment and lifestyle. An appointment is made for him to discuss the results in a couple of weeks time when he again needs to take time off work.

When he attends they discuss that he is not achieving his personalised glycaemic target. He says that work has been difficult lately and he is finding it difficult to get into a good regime.

The nurse discusses his care with the GP and Mr Smith is referred electronically to the diabetes clinic at the hospital. He gets another letter to attend there were he will be monitored and a new care plan discussed.

Local diabetes care in the future

Mr Smith has type-2 diabetes and receives a reminder on the MyDiabetes app about his upcoming review appointment that he booked. He answers some questions about his current treatment regime and his overall wellbeing.

A week later he attends his local monitoring centre where they do some physical tests and measurements and take some blood. A day later he looks up his test results on the app dashboard and can see his diabetes is better controlled, but that he is not meeting recommended levels for physical activity. The app asks if he would like to be contacted by someone for advice on this and suggests turning on the activity monitoring function to give him daily goals and prompts.

A few days later he receives a message to book a video call appointment with his practice nurse as the Integrated Diabetes Care Team had reviewed his care. He makes the call during a lunchbreak at work and they congratulate him on getting his diabetes under control and that he has moved from the amber to the green pathway.

However, they said that one of the questions he answered suggests his mood is low and on discussing it with him he says he is under some stress at work. Its agreed that they will send links to some online tools to help him with mindfulness and resend him the questions in a months time to see how he is doing.

The benefits we expect to see

- A person centred collaborative approach to treatment and care that allows people and staff to best use their knowledge skills and experience
- People being empowered and supported to make better decisions about self-managing their own health and overall wellbeing
- People and teams being able to easily access a range of expert support and advice to provide more holistic joined-up care
- A more flexible individual approach to treatment and care that's not 'one size fits all'
- Treatment and care that can easily be escalated up or down depending on induvial needs and circumstances
- Better outcomes and experience for those that use and those deliver services
  - All the care that people need without intruding on their lives
  - Experts 'working to the top of their licence' supporting complex patients

Tell us what you think

What are your thoughts about the 4 priority areas that we have initially chosen to transform local care services?

What do you think about being able to access information and services using technology

What areas do you think we need to focus on to transform local care services?

How could we better coordinate local care services for people with multiple long-term conditions?

Any other feedback or comments