

MODERNISING HEALTH CARE

Integrating hospital, community health care and social care more closely will help us deliver safe and sustainable services

How we publicly launched the strategy process in 2012.

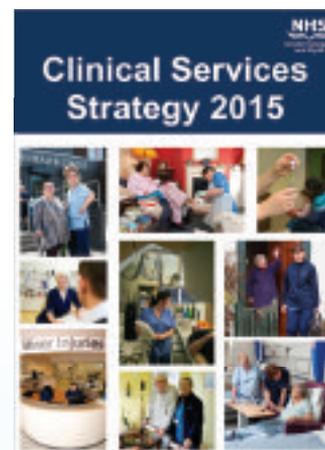


Medical Director Dr Jennifer Armstrong

Back in 2012 NHSGGC began a Clinical Service Review. We identified a real need to re-examine the way we do things to ensure our services were fit to meet the rapidly changing needs of our population.

We published a special edition of our public facing Health News newspaper entitled "It's Our Future" and invited our staff, patient groups, the public, third sector organisations and other key stakeholders to get involved.

Led by our Medical Director Dr Jennifer



Armstrong this has been an innovative and engaging process producing many new ideas and partnership approaches. It aimed to deliver a direction of travel for the successful development of services to drive up quality and effectiveness and better meet patient needs and expectations beyond 2020.

It is a blueprint for the future and one that will evolve and develop alongside technology and population changes.

The Clinical Strategy sets out high quality models of care from better prevention and self management right through to highly specialised hospital care and is evidence based with learning on what works across the UK and beyond.



Our key aims:

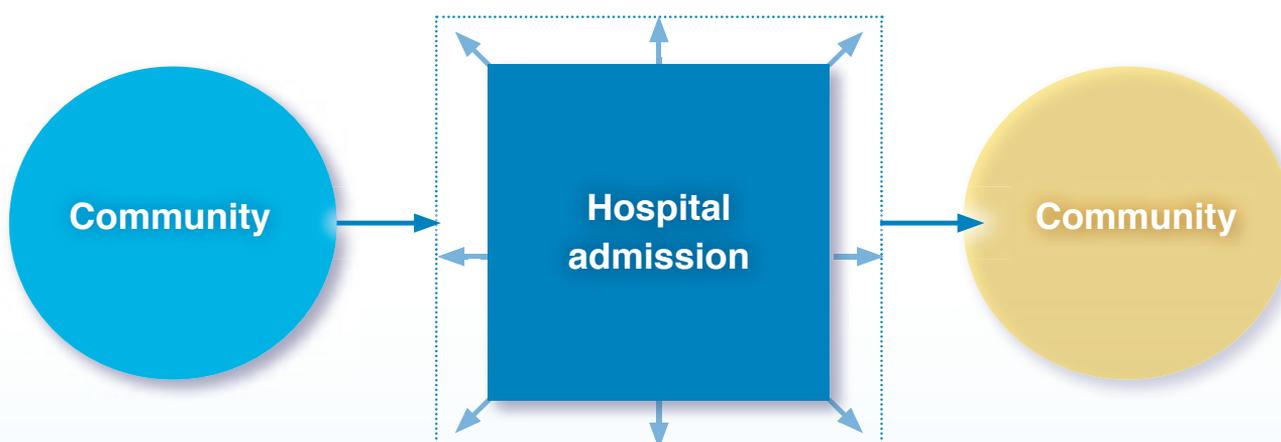
- care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements
- sustainable and affordable clinical services can be delivered across NHSGGC
- pressures on hospital, primary care and community services are addressed

We set out to achieve:

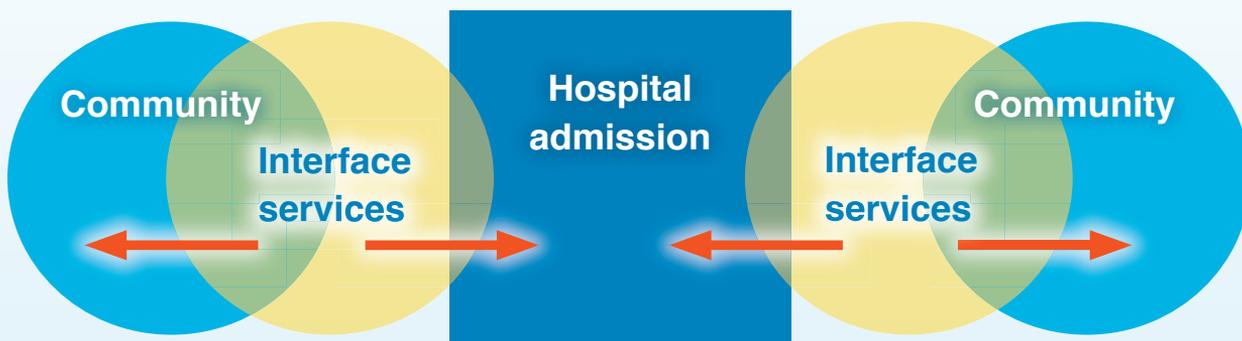
To achieve a balanced system of care where people get care in the right place. This means:

- thinking beyond artificial boundaries of "hospital" and "community"
- focusing on patient pathway and needs at each stage
- changes to delivery of acute care: assess and direct to appropriate place of care
- changes to provision and accessibility of community services
- different ways of working at the interface

Moving from this



To this



Clinical Strategy in action: **THE RENFREWSHIRE DEV**

A unique project is underway in Renfrewshire as part of NHS Greater Glasgow and Clyde's Clinical Services Review which sees NHS and social care teams working as one to test better ways of delivering patient care.

The 'Renfrewshire Development Programme' (RDP) is working out the best ways to join up the services provided by hospitals, GPs and community services to ensure that:

- people are seen by specialists sooner and important decisions about their care taken earlier
- the right services are in place so people aren't admitted to hospital if they're okay to go home
- people only attend Accident and Emergency if they really need to
- we reduce the time people actually have to spend in hospital
- and where we can, stop a person's health from deteriorating at an early stage to prevent complications.

NHSGGC Medical Director, Dr Jennifer Armstrong, said: "The programme is a template which will influence how people are cared for in future, not just in Renfrewshire but across the whole of NHS Greater Glasgow and Clyde.

"It is being delivered in partnership between patients and their carers, clinicians at the Royal Alexandra Hospital, GP practices, Community Health Services, Renfrewshire Council Social Work Services and the third sector.

"In addition to the services already in place in Renfrewshire four key developments have been put in place at the same time as part of the programme to test their collective impact."

Here we take a look at these four new developments...

A new In-Reach team at the Royal Alexandra Hospital

Sometimes older people and people with disabilities get admitted to hospital after they've been treated at A&E. Often there isn't any medical reason for them to stay in hospital but they get admitted because their injuries mean they could have problems coping on their own at home.

The new Community In-Reach Team at the RAH is quickly arranging the help and support patients need such as transport, the provision of meals or the installation of equipment so it's safe for them to go home and they don't have to stay in hospital unnecessarily.



In just two months the team were able to prevent 89 unnecessary admissions by putting in place the necessary support required for patients to remain either at home or in a homely setting in the community.

A new Older Adults Assessment Unit at the Royal Alexandra Hospital

Hospitals can be a difficult environment for people who are older and more frail. We've set up a new unit to make the experience easier, by making sure that when older people come to A&E they get the right care, at the right place, at the right time, from the right people.

A full assessment of the older person is carried out by a Geriatrician when they come into A&E which ultimately helps cut the length of time people have to stay in hospital, prevents future admissions to hospital and can stop existing medical conditions from getting worse.

Since its opening this unit has received very positive feedback from patients,

their carers and hospital clinicians alike.



DEVELOPMENT PROGRAMME

A new Chest Pain Assessment Unit at the Royal Alexandra Hospital

We are also trying out a new service for patients who come to A&E suffering from chest pains. At the moment the RAH sees more than 3000 patients every year who attend as an emergency with chest pain.

It can take up to 12 hours to carry out a full assessment on someone with chest pains. The assessment can also involve an overnight stay in hospital. Yet many of these patients don't actually have heart problems.

Our new Chest Pain Assessment Unit is staffed by heart specialists who can provide a quick, clear diagnosis allowing patients to go home sooner, often without having to stay in hospital overnight.

An early audit looking at the impact of the new unit has shown that from the sample of patients looked at some 87 per cent were able to be discharged home from the unit without onward admission into a hospital bed with their average time in the unit being just four hours.



'Anticipating' the care someone in the community may need in future

If you have complex health needs, after you and your family, it's your GP who knows most about the care you need. But what happens if there's an emergency when the doctor's surgery is shut?

A&E or NHS 24 might not know all the medication you're taking, the full range of conditions that affect you or any relevant information about your social circumstances. This is where having an anticipatory care plan prepared in advance comes in.

This plan is designed to support you and is drawn up with you, your family and your GP. It sets out what should happen if you have a health crisis out-of-hours. This way, what you want and what's best for your health is all down

in black and white.

This also means you won't get rushed to hospital if all you need is some help at home or a change in your medication for example. Central to this plan is the aspiration for the patient to be supported at home or community and not admitted to hospital inappropriately.

All 13 GP practices in Paisley are working with their patients who have complex needs to put anticipatory care plans in place for them as part of the RDP and more than 168 of these important plans had been developed within just two months of this work getting underway.



Find out more about the RDP

Effective two-way communication with our patients and partners is central to the success of the RDP and as such there are a number of ways you can find our more information and get involved in the programme. You can visit a dedicated website www.nhsggc.org.uk/rdp where you can also watch a short film about the programme and download a special information brochure.

You can also contact Sylvia Morrison on 0141 618 7640 if you would like the brochure or a DVD posted out to you.



**Renfrewshire
Development
Programme**