



The Renfrewshire Development Programme

Leading the way in bringing together better ways to deliver patient care

Renfrewshire
Community Health Partnership

NHS
Greater Glasgow
and Clyde


Renfrewshire
Council

 Renfrewshire
Development
Programme

ABOUT THE RENFREWSHIRE DEVELOPMENT PROGRAMME

A UNIQUE project is under way in Renfrewshire which sees the whole NHS and social care community working as one to test more effective ways to deliver patient care in hospitals and community settings.

Across NHS Greater Glasgow and Clyde, our teams are constantly developing new ways of working. However, the idea behind the Renfrewshire Development Programme (RDP) is to bring a number of these schemes together in the same area, at the same time, to test their collective impact. The outcome of the RDP will influence the way health and social care is provided in future – not just for Renfrewshire, but for the whole of NHSGGC.

Dr Jennifer Armstrong, NHSGGC Medical Director, said: “The fundamental principle of the project is the creation of better joined-up links between hospital and community services and ensuring that senior decision makers and specialists are available early in any patient’s interaction with health and social care services. By achieving this, we believe that we can ensure the right packages of care for our patients in the right place with the aim of improving their outcomes.

“The programme has been developed as part of the larger programme of work under the Clinical Services Review taking place across NHS Greater Glasgow and Clyde, to develop the strategic direction to meet the national 2020 vision for NHS Scotland.

“The RDP is a partnership between the Royal Alexandra Hospital, GP practices, Community Health Services, Renfrewshire Council Social Work Services and the third sector. The programme also involves the Public Partnership Forum in its work and is looking at opportunities to work with the third and independent sectors in the area.”

Local doctors are involved in leading this work along with managers and front line staff to test and develop ways to improve the provision and accessibility of community health and social care services, ensure that only people who need to attend A&E do

so, prevent unnecessary hospital admission, reduce the time patients actually have to spend in hospital and support people to stay at home or in a homely setting for as long as possible.

Here we take a look at four key developments the project has now put in place...



Dr Jennifer Armstrong



Dr Chris Johnstone

ANTICIPATORY CARE

Patient plans will share GPs’ detailed knowledge

Thinking ahead

OTHER than patients themselves and their loved ones, the person who knows most about a person’s complex and often multiple health problems is their GP. GPs are aware of a person’s medical needs as well as their social circumstances. But what happens when a crisis occurs in a patient’s condition out of hours and they are not seen by their GP? Out-of-hours services or A&E are not as aware of the full complexity of their circumstances, and often they are admitted to hospital. Sometimes this is entirely appropriate, but sometimes it’s not. And that’s where anticipatory care planning comes in.

Dr Chris Johnstone, a Renfrewshire GP from the Barony Practice in Northcroft Medical Centre, explained: “An individual’s anticipatory care plan is developed with them and their carers by their GP, with input from other health and social care services. It sets out what should happen in the event of a ‘crisis’ in and out of hours. This way, those coming into contact with the person for the first time will know

what the patient’s circumstances are and can follow the agreed plan. Central to this plan is the aspiration for the patient to be supported at home or in the community and not admitted to hospital inappropriately.

“As part of the Renfrewshire Development Programme, all 13 GP practices in Paisley are working with their patients who have complex needs to put anticipatory care plans in place. New electronic systems have been developed to ensure that plans are shared with out-of-hours GP and A&E colleagues. A hard copy will also be in the person’s home or care home so that health and social care professionals supporting the patient can refer to the plan as necessary to ensure that the actions agreed are carried out in line with the wishes of the patient.

“Anticipatory care planning is about sharing the detailed knowledge that GPs have about their complex patients with other health and social care professionals so that the best possible care and solutions can be put in place day or night.”

IN-REACH

New in-reach team

A NEW health and social care community in-reach team, embedded within the emergency department, is now in place at the Royal Alexandra Hospital. The team’s role is to prevent unnecessary admission to hospital following A&E treatment by ensuring that patients – particularly older people and those with disabilities – receive the right community health and social care they need at home as soon as they leave hospital. This new joint service will build upon the existing work already under way at the RAH by the NHS Rehabilitation and Enablement Service.

Lorna Muir, Renfrewshire Care at Home Service Manager, said: “At the moment, a patient may attend A&E, receive appropriate treatment and be perfectly fit to go home but is admitted unnecessarily because they require immediate support at home. They might, for example, be unable to prepare food because of a sprained wrist, require minor equipment or need help with personal care. This is where the



community in-reach team kicks in. They can rapidly arrange the appropriate support a patient needs in their home – such as the provision of meals; installation of equipment; and care at home or nursing services, including overnight support – all enabling patients to be safely discharged and supported at home.

“Crucially, the team also works closely with the patient’s GP and other health and social care professionals in the community to ensure that the care plan put in place by the A&E team for follow-up is enacted. This very significant measure will ensure the patient gets the continued care they need and may well prevent a repeat trip to A&E.”

Right care, right place

A dedicated unit for older patients attending A&E will help reduce hospital stays

A NEW Older Adults Assessment Unit at the Royal Alexandra Hospital has been established to ensure that older people attending hospital get the right care, at the right time, in the right place, by the right people.

Where clinically appropriate, older people attending as an emergency (referred to the hospital by their GP or who self refer) are taken from A&E directly into the dedicated unit, which is open between 8am and 8pm.

The unit is best placed to provide the most appropriate care for this group of patients because it is staffed by a multi-disciplinary team made up of dedicated clinical specialists in elderly care. The unit is led by geriatricians Dr Janice Murtagh and Dr Oona-Mary Lucie.

Dr Janice Murtagh explained: "Hospital can be a challenging environment for frail older patients especially if they have dementia or a history of confusion. By being taken rapidly into our new unit, senior specialists in elderly care can very quickly carry out a 'Comprehensive Geriatric Assessment'.

"This specialist assessment looks at the immediate medical condition which brought the person into hospital, as well as their mental wellbeing, what social and community support they have or what they need, their functional abilities and the medication they are on.



The team performs comprehensive assessments on elderly patients, identifying the community support they need

"Having specialists in elderly care carry out such a comprehensive review so early in the patient's hospital journey allows us to get the right care in place as fast as possible and in very many cases will significantly reduce the length of time a patient needs to stay in hospital."

Dr Oona-Mary Lucie added: "The aim of the unit is to formulate a care plan for the patient which takes into account all their health and social care needs – not just for the medical issue which has brought them to the hospital but going forward to prevent

future admission or a deterioration of any underlying conditions.

"Through our early comprehensive assessment of the patient, we can rapidly identify which community support is required. And by working with our colleagues in the community, we can get that in place so the patient can go home – often on the same day – and be supported at home in a much more comfortable and familiar setting.

"It is for these reasons that our links with community and social care colleagues are so vital to the unit's success."

CHEST PAIN ASSESSMENT UNIT

Faster diagnosis allows patients home quicker

THE Renfrewshire Development Programme is testing a new model of service for patients with chest pain which aims to avoid unnecessary hospital admissions.

Chest pain remains one of the most common reasons for admission to hospital and the Royal Alexandra Hospital sees more than 3000 patients every year who attend as an emergency with chest pain.

Many of these patients will not actually have heart problems but at the moment it can take up to 12 hours before the appropriate assessments to rule that out are complete.

For many patients, this will involve an overnight stay in hospital and, naturally, this waiting period can be a stressful time for both patients and their families.

Dr Iain Findlay, Lead Cardiologist at the RAH, explained: "Our new Chest Pain

Assessment Unit is staffed by specialist cardiology nurses, with support from senior cardiologists. The aim of the unit is to streamline the journey for patients in whom the diagnosis is not clear and ensure specialist cardiology input into their care at the very earliest opportunity.

"The targeting of patients with a low likelihood – and, more importantly, low risk of complications from a possible heart attack – will allow a diagnosis to be made more quickly. This means that patients without heart problems can be back home much sooner than is currently the case and do not need to be admitted to hospital unnecessarily.

"Furthermore, for those who require follow up, the dedicated staff in the new unit can have these tests carried out either the same day or arrange for return the next day, thus enabling earlier treatment if patients need it."



The new assessment procedure aims to avoid unnecessary overnight stays in hospital, according to Dr Iain Findlay, right





Patients are at the heart of the RDP

Engaging with the community is key to success

Patients and partners have helped shape the RDP and we'll make sure they're kept up to date with progress

CENTRAL to the success of the Renfrewshire Development Programme (RDP) is effective and two-way engagement with our patients and their representatives, as well as other partners such as the third sector and the Scottish Ambulance Service.

To launch the RDP, a major event was held in Paisley. More than 160 people and key groups attended, including patient and public representatives, staff from the RAH, community healthcare teams, GP practices, Renfrewshire Council, allied health practitioners, mental health care staff, pharmacy staff, the Scottish Ambulance Service, third sector and NHS 24.

The purpose of the event was to inform our stakeholders as well as to get their views on the current service provision in Paisley and on what the most effective areas for change could be.

All of the information gathered from the event has been used to shape the work of the

programme and the services that have now been put in place.

Throughout the programme we will continue to work closely with Engage Renfrewshire – a single point of access for community action, volunteering and social enterprise in Renfrewshire – to ensure that our patients and the wider community can learn more about our work and feed back their views.

>> If you would like more information on the project or if you are part of a community group and would like someone from the project team to come out to talk to your organisation, please contact Sylvia Morrison, Head of Primary Care and Community Services, Renfrewshire Community Health Partnership, on 0141 618 7640 or email sylvia.morrison@ggc.scot.nhs.uk We will also provide regular updates on our website www.nhsggc.org.uk/rdp

Renfrew Development Programme timeline



April 2014	Project team established and communication and engagement plan agreed
April to November 2014	Service developments agreed and implemented
November 2014	Baseline data and Evaluation Framework available
November 2014 to September 2015	Services delivered supported by tests of change
September 2015 to December 2015	Final evaluation and reporting