Clinical Services
Strategy 2015 Summary
1. Introduction

Dr Jennifer L. Armstrong
Medical Director, NHS Greater Glasgow and Clyde

In April 2012, as part of planning the delivery of the Scottish Government’s 2020 Vision, we launched a Clinical Services Review to consider how best to deliver services to meet the changing needs of patients beyond 2015 to 2020.

The review was led by NHS clinicians with substantial involvement from patients and special interest groups, the third sector and with wider public engagement.

Together all of these interests analysed the changing population needs, the modernisation of approaches to care and technological developments and how best to deliver sustainable, safe and effective services going forward.

The review has been approved and the final Clinical Strategy is now available on our website at: http://www.nhsggc.org.uk/about-us/clinical-services-fit-for-the-future/

The key aims of the Clinical Strategy are to ensure that:

- 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

The Clinical Strategy is the blueprint to develop innovative and redesigned services to meet future demands of the population we serve. It provides the opportunity to engage with the six new Integration Joint Boards (local authority social care and NHS community care integrated boards) across Greater Glasgow and Clyde to adopt this as a shared clinical strategy to work together on planning services changes as we go forward from 2015 to 2020.

In addition, the innovative new approaches being trialled in the Renfrewshire Council area to integrate community health services, social care and the acute hospital teams will influence a new approach for our entire Board area.

The Clinical Review Report 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 from what works across the UK and beyond. The work that has gone into this intense and crucial Review is the bedrock of how we will plan to deliver and plan clinical services to meet all of our hospital and community health needs.

On behalf of NHSGGC I would like to thank everyone who has been involved in leading and shaping this work. The input from staff in hospitals and in the community along with patients and public representatives, special interest groups and charities has been invaluable.
2. Clinical Services Fit for the Future

Looking at 2015 and beyond – how do we design our services and the resources available in a way which will support us all in the future? The clinical strategy sets out the context and background to the review of clinical services, details the high level population position, it sets out the case for change and core components of the future healthcare system and details service models and implementation challenges.

3. Case for change

The case for change was developed based on the views of a wide range of clinicians on what is currently affecting clinical services and what is the likely impact on services in the future, as well as the opinions of patients of what they value in the current service and what they would want of future services. Following extensive engagement with stakeholders 9 key themes were identified.

- The health needs of our population are significant and changing
- We need to do more to support people to manage their own health and prevent crisis
- Our services are not always organised in the best way for patients.
- We need to do more to make sure that care is always provided in the most appropriate setting
- There is growing pressure on primary care and community services
- We need to provide the highest quality specialist care.
- Increasing specialisation needs to be balanced with the need for co-ordinated care which takes an overview of the patient
- Healthcare is changing and we need to keep pace with best practice and standards
- We need to support our workforce to meet future changes


4. Developing Future Services

Building on the work on the case for change service models were developed and are set out in the clinical strategy.

The overarching aim of this clinical strategy, based on this work, is to provide a balanced system of care where people get the right care in the right place from people with the right skills, working across the artificial boundary of ‘hospital’ and ‘community’ services.

At the heart of this approach is the requirement to understand our population and provide care at the most appropriate level. Getting this right will enable more intensive support for those most in need, and supported self management with rapid access into services when required for the majority of the population.

This approach relies on a strong emphasis on prevention. It is therefore important that as part of the strategy we continue to emphasise the importance of health improvement and disease prevention.
We need to encourage the population to improve their health and prevent disease, recognising that lifestyle choices and modifiable behaviours are responsible for around 80% of our current long term condition disease burden. This requires all health care professionals to promote healthier lifestyles and to support the population to take responsibility for improving their own health by adopting healthier lifestyles. It also requires patients and the public to work together to support each other in managing their health and health care needs.

The key characteristics of the clinical services required to support this approach are:

Timely access to **high quality primary care** providing a comprehensive service that deals with the whole person recognising their home circumstance:

- Building on universal access to primary care.
- Focused on prevention, anticipatory care planning with early intervention.
- Care where possible within a primary care setting.
- Focus for continuity of care and co-ordination of care for patients with multiple conditions.

A comprehensive range of **community services**, integrated across health and social care and working with the third sector to provide increased support at home:

- Single point of access, accessible 24/7 from acute and community settings.
- Services focused on preventing deterioration and supporting independence.
- Multi-disciplinary care plans in place to respond in a timely way to crisis.
- Working as part of a team with primary care providers for a defined patient population.

**Co-ordinated care at crisis / transition** points, and for those people **most at risk**:

- Access to specialist advice by phone, in community settings or through rapid access to outpatients.
- Jointly agreed care plans with input from GPs, community teams, specialist nurses and consultants, with shared responsibility for implementation.
- Rapid escalation of support, on a 24 / 7 basis.

**Hospital assessment** which focuses on early comprehensive assessment driving care in the right setting:

- Senior clinical decision makers at the front door.
- Specialist care available 24/7 where required.
- Rapid transfer to appropriate place of care, following assessment.
- In-patient stay for the acute period of care only
- Early supported discharge to home or step down care.
- Early involvement of primary and community care team in planning for discharge.

**Planned care** which is locally accessible on an outpatient / ambulatory care basis where possible:

- Wider range of specialist clinics in the community, working as part of a team with primary care and community services.
- Appropriate follow-up.
- Diagnostic services organised around patient needs.
- Interventions provided as day case where possible.
- Rapid access as an alternative to emergency admission or to facilitate discharge.

**Low volume and high complexity care** provided in defined units equipped to meet the care needs:

- Driven by clear evidence of the relationship between volume and outcome.
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, for example, comprehensive assessment and inreach from community teams to prevent admission to hospital.

**MOVING FROM THIS**

![Diagram showing traditional hospital-centric care model]

**TO THIS**

![Diagram showing integrated care model]

5. **PUBLIC AND PATIENT ENGAGEMENT**

There has been extensive engagement informing the development of this Clinical Strategy. As we develop specific change proposals engagement will continue to be fundamental. We will continue to ensure the approach taken is in line with Scottish Health Council guidance in relation to engagement, pre consultation and consultation, where this is indicated.

6. **WAY FORWARD**

The Clinical Service Review has enabled us to develop this clinical strategy to provide a basis for the development of detailed service change to deliver the Government’s 2020 Vision.

As we go forward we will engage with the new Integration Joint Boards of the Health and Social Care Partnerships to adopt this as a shared clinical strategy and to work together on planning service changes.

We will develop implementation plans, including delivering changes to reflect the results of the Renfrewshire Development Programme, which is testing new ways of working at the interface, across the Board area.

We will engage with GPs, wider primary care contractors and with the new Health and Social Care Partnerships to refresh the Board’s Primary Care Strategy and plan the further development of primary and community services.

We will continue the dialogue with stakeholders on the delivery of care and the models we use.

If you require further information or would like to comment on the strategy summary please email Community.Engagement@ggc.scot.nhs.uk or contact Community Engagement Team on 0141 201 5598.

April 2015

This publication has been produced in line with NHS Greater Glasgow and Clyde’s “Clear to All” Policy. This publication is available in large print, Braille, easy read or on audio-CD. We can also provide this in any language including British Sign Language or any format you may require. Please contact 0800 027 7246

This publication has been produced in line with NHS Greater Glasgow and Clyde’s “Clear to All” Policy. This publication is available in large print, Braille, easy read or on audio-CD. We can also provide this in any language including British Sign Language or any format you may require. Please contact 0800 027 7246

This publication has been produced in line with NHS Greater Glasgow and Clyde’s “Clear to All” Policy. This publication is available in large print, Braille, easy read or on audio-CD. We can also provide this in any language including British Sign Language or any format you may require. Please contact 0800 027 7246

This publication has been produced in line with NHS Greater Glasgow and Clyde’s “Clear to All” Policy. This publication is available in large print, Braille, easy read or on audio-CD. We can also provide this in any language including British Sign Language or any format you may require. Please contact 0800 027 7246
This publication was prepared in accordance with the policy of readability for all NHS Greater Glasgow and Clyde.

This publication is available in a larger font, Braille version, simplified version, and audio CD. We can also provide it in any language, including British sign language, or any format you require.

Contact us on 0800 027 7246