GREATER GLASGOW AND CLYDE HEALTH BOARD

BOARD MEETING **Board Paper No 14/53**

MEDICAL DIRECTOR PAPER

CLINICAL SERVICES FIT FOR THE FUTURE: Clinical Services Review Paper

Recommendation:

The NHS Board are asked to note the progress report on the Renfrewshire Development Programme.

1. Introduction

In August 2013, as part of the ongoing work of the Clinical Services Fit for the Future Programme, a paper on Service Models was presented to the NHS Board for consideration. This paper was developed by the Clinical Groups in response to the earlier paper setting out the Case for Change in December 2012, which set out nine key themes that NHS Greater Glasgow and Clyde required to consider and address as it plans services for the future.

The Case for Change

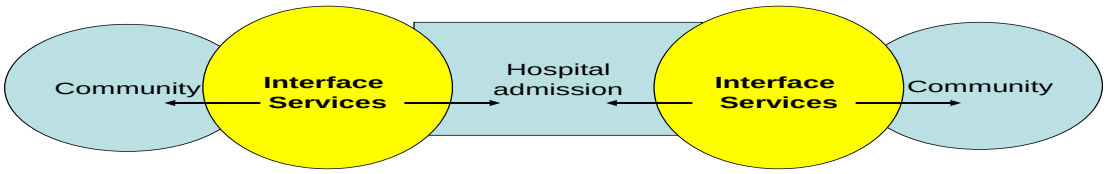
1. The health needs of our population are significant and changing;
2. We need to do more to support people to manage their own health and prevent crisis;
3. Our services are not always organised in the best way for patients; we need to ensure it is as easy to access support to maintain people at home, when clinically appropriate, as it is to make a single phone call to send them to hospital;
4. We need to do more to make sure that care is always provided in the most appropriate setting;
5. There is growing pressure on primary care and community services;
6. We need to provide the highest quality specialist care;
7. Increasing specialisation needs to be balanced with the need for coordinated care which takes an overview of the patient;
8. Healthcare is changing and we need to keep pace with best practice and standards;
9. We need to support our workforce to meet future changes.

These issues set a context which recognised that health services need to change to make sure that they can continue to deliver high quality services and improve outcomes. The Case for Change recognised that in the years ahead there will be significant changes to the population and health needs of NHS Greater Glasgow and Clyde, starting from a point where there are already major challenges in terms of poor health outcomes and inequalities.

The overarching aim of the service models set out in the CSR Service Models document is to encourage the development of **a balanced system of care where people get care in the right place** from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services.

It recognised the need to work differently at the interface (represented by the yellow circles below); extending existing services; creating new ways of working through in-reach, outreach and shared care; evolving new services; as well as changes to the way we communicate and share information across the system if we are to address the case for change.

Figure 1



Evidence from the emerging service models suggests that getting the basics right – integrated, multifaceted and coordinated primary, secondary and social care - are much more important than any single tool or approach.

In December 2013, the NHS Board supported the proposal to progress a Development Programme to test the whole system approach and effectiveness of the interface service models. It was agreed that this should be undertaken within Renfrewshire, focused on the Paisley population.

2. Testing the Service Models

The aim of the Renfrewshire Development programme is to assess the approach and support more detailed planning to both develop the confidence that the model can deliver the future position described and to allow costing of the approach to ensure that this approach is affordable and deliverable.

The development programme brings together a range of components of the emerging services models to further develop and assess their cumulative impact. It builds upon any relevant service developments being progressed through other initiatives, including On the Move, the Unscheduled Care Programme and the Change Fund initiatives. The development programme approach also considers the underpinning requirements and ways of working which will be important to support the effective delivery of the programme.

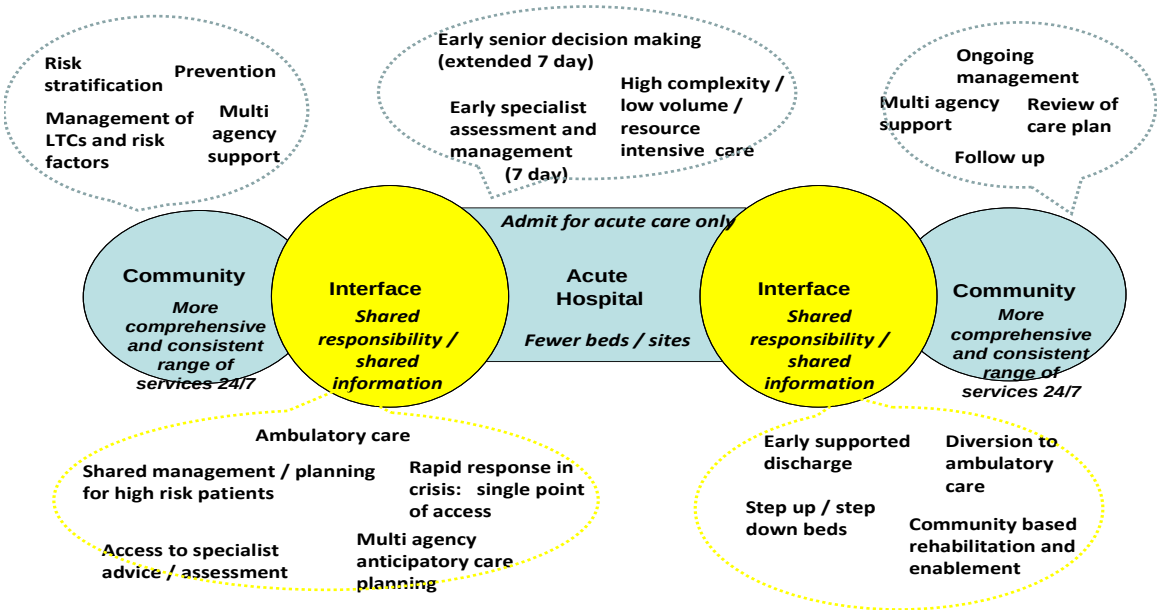
2.1 Core Elements of the Model

The programme is focused on developing the interface services further, particularly on areas with greatest impact on demand and capacity:

- Timely access to **high quality primary care**
- Comprehensive range of **community services,** accessible 24/7 from acute and community settings
- Coordinated care at **crisis / transition** points, and for those **most at risk**
- **Hospital admission** which focuses on early comprehensive assessment driving care in the right setting: inpatient stay for acute period of care only.

The key areas underpinning the CSR for testing are shown on the diagram below

Figure 2



This paper provides a progress report on the work of the Renfrewshire Development Programme to date.

3. Progress Report on the Renfrewshire Development Programme

3.1 Establishing the Programme Team

The Renfrewshire Development Programme (RDP) is now well underway. The clinical leads are in post with Dr Chris Johnstone leading from primary care and Dr Iain Findlay and Dr Alistair Dorward jointly leading from the Royal Alexandra Hospital (RAH). Along with service managers and front line staff they are developing 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 and reduce the time patients have to spend in hospital.

3.2 Stakeholder Event

To launch the RDP 163 stakeholders attended an event in May 2014 including staff from the RAH, community healthcare teams, GP practices, Renfrewshire Council, allied health professionals mental health staff, pharmacists, patient and public representatives, the Scottish Ambulance Service, third sector and NHS 24. The event was to both inform stakeholders of the background of the CSR and the RDP and to get stakeholder views on current service provision in Paisley and on what the most effective areas for change could be, bearing in mind the overarching objectives of the CSR and the RDP.

A range of areas were discussed with a number of key themes emerging including the need to integrate services (including the third sector); shared responsibility for care; need to develop the approach to support the management of older people by improving the frailty pathway by the use of comprehensive geriatric assessment and joining up care between acute and community services; extending the availability of services; increasing the understanding and awareness of the range of services available and where to turn to (both for practitioners and the public).

Other key messages included strengthening communication between different staff groups and organisations and encouraging more joined up care through the use of anticipatory care planning; improving accessibility of information through better use of IT to create more integrated systems and effective working practices to support patient care and sharing of information.

All of the information gathered from the event and from bringing the team together to undertake detailed mapping of the current service provision and challenges has been used to shape the work of the programme.

3.3 Understanding the Needs of the Population

Led by Dr Anne Scoular, a comprehensive review of the population needs is being undertaken. The needs assessment is a systematic approach which aims to ensure that resources are used in the most efficient way to improve the health of the population. For the purpose of this, needs are defined as those that can benefit from health care or wider social and environmental changes. A holistic population health profile of multiple care inputs and their interactions will build a picture of need from multiple perspectives, following individuals and groups over time and capturing multimorbidity and other indicators of need.

Information has been collected at individual patient level for the 13 Paisley GP practices. Using the CHI register the information obtained will be linked from the different data sets to create a description of the health status and use of services, on an individual basis. The information will be stored within Information Services in line with the data protection governance arrangements. The linked dataset will be fully anonymised before release by Information Services for analysis by Public Health in accordance with Data Protection principles. This position has been approved by our Caldicott Guardian. All data will be used only for the explicit purpose described above. The following data items have been collected to allow this picture to be built:

- Age, sex, SIMD quintile
- Health status at individual level – QOF codes for selected LTCs
- Ethnic group
- Outpatient attendances, by specialty
- A&E attendances
- NHS 24 and GEMS contacts
- Day cases, by specialty
- Elective admissions, by specialty
- Readmissions, by specialty
- Acute bed days, by specialty
- Mental health services utilisation
- Prescribing information by BNF chapter
- Utilisation of chronic medication service
- Community rehabilitation services utilisation
- Diagnostic services utilisation (imaging initially, other services to follow)
- District nursing service utilisation
- Social work services utilisation

In addition, aggregated Census data are being collected, using best fit method. The needs assessment is almost complete, and will be presented when QOF disease codes have been added to complete the picture. This work will create a multivariate report on the population. This detailed review will form the basis for the future monitoring and evaluation of the programme.

3.4 Establishing the Components of the Programme

Four key projects are underway as part of this programme to cover gap areas identified to support the test of the model. These are summarised below:

1. Anticipatory Care Planning

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. Anticipatory care planning will allow sharing of the detailed knowledge that GPs have about their complex patients with other health and social care professionals who may come into to contact with them in the future so that the very best possible care and solutions can be put in place when required in or out of hours.

To ensure that these plans are used in the most effective way new electronic systems have been developed to ensure that they are shared with out of hours GP and A&E colleague. A hard copy will also be in place in the person's home or care home so that health and social care professionals supporting the patents can continually refer to the plan as necessary to ensure that the actions agreed are carried out in line with the wishes of the patient.

This project is expected to:

- Increase the number of ACPs to cover the intended population.
- Improve shared knowledge and skills (GPs, community and acute service).
- Improve communication and information sharing between patients, health and social care staff.
- Increase patient / carer satisfaction.
- Improve quality of care.
- Significantly reduce unplanned hospitalisation for a cohort of patients with multiple morbidities.
- Reduce 999 calls to SAS.
- If admitted to hospital, enable a proactive approach to discharge patients into the community.
- Increase in expected deaths at home and in Care / Nursing home sector.

2. Access to Comprehensive Geriatric Assessment

A new Older Adults Assessment Unit at the RAH is being created to ensure that elderly patients get the right care, at the right time, in the right place, by the right people.

Where clinically appropriate, elderly emergency patients referred to the hospital by their GP or who self refer will be fast tracked from A&E directly into the new dedicated unit between 8am and 8pm. The unit is supported by a multi-disciplinary team made up of dedicated clinical specialists in elderly care, including Consultant Geriatrician, Elderly Care assessment nurses (ECANs) and Allied Healthcare Professionals (Physio and Occupational Therapist).

The unit will allow patients to be fast tracked to senior specialists in elderly care, who can carry out 'Comprehensive Geriatric Assessment.' This specialist assessment looks at the patient's immediate medical condition which has brought them into hospital but also their general mental wellbeing, what social and community support they have in place or what they need and what medication they are on etc.
Having specialists in elderly care carry out such a comprehensive review so early in the patient's hospital journey enable the right care to be put 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.

The aim of the unit is to formulate a care plan for the patient, taking 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. Early comprehensive assessment of the patient will identify which community support is required and, working with colleagues in the community, this can be put 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. This programme links closely with the in reach programme outlined below.

It is proposed to also incorporate the rapid access outpatient service into the Frailty unit. Follow up would be arranged by the community rehabilitation team as appropriate with any outstanding medical issues being picked up by the day hospital for elderly or the GP.

This redesign of services is expected to ensure:

- Better initial patient assessment with perhaps an increased proportion of patients being discharged home on the day of assessment.
- Improved access to specialist care from geriatricians and the Elderly Care team.
- Reduction in length of stay, with focused inpatient care and then ongoing management via the community / interface services.
- Increased number of older people in specialist beds.
- Reduced number of moves for older people.
- Better care for patients with dementia and delirium.
- Increase the prevention of deterioration / crisis care through more proactive management of at risk patients – supported by shared ACPs.
- Improved communication between teams.

3. New Chest Pain Unit

The 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. The RAH will see more than 3000 patients every year who come to the hospital as an emergency with chest pain. Many of these patients will not actually have heart problems but currently it can take up to 12 hrs before the appropriate assessments are completed to rule this out. As such for many patients this will require an overnight stay in hospital and with a waiting period which can be a stressful for both patients and their families.

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 when they present at the RAH. 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.

For those patients 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 the patients needs it.

This redesign programme is expected to:

- Reduce length of time spent in hospital whilst supporting the assessment and treatment of patients more effectively.

4. Out of Hours Community In Reach Services

A dedicated community in-reach team, embedded within the emergency department, is being established at the RAH. It will provide a community social work service presence within A&E from 5pm-10pm Monday to Friday and during weekends. This team will enhance the Rehab and Enablement Service (RES) staffing already in place to meet the increasing demand for both rehabilitation and enablement.

The team's role will be to prevent unnecessary admission to hospital following A&E treatment by ensuring that patients, particularly older patients and those with disabilities receive the right community health and social care they need at home as soon as they leave hospital. It will also create an information bank for A&E staff as well as to coordinate on site and discharge supports, including food and transport.

Crucially the team will also work 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 A&E attendance.

This service is expected to:

- Provide a range of support to allow alternative to admission or safe discharge earlier from hospital for patients.
- Support the key points of transition in hours and out of hours to support the whole system to shift the balance of care.
- Support enhancement of 7 days service provision.
- Underpin the developments above in relation to Frailty unit and front door geriatrician/ MDT approach.
- Support and facilitate improved relationships and ways of working with other services to facilitate longer term change and management of patients out with hospital.

These programmes are due to be in place by the end of October following recruitment and preparatory work.

The programme team are continuing to evolve the work programme including developing smaller scale redesign projects using LEAN and other methodologies. Other areas currently being progressed include:

- Developing Ambulatory Care models to increase the proportion of patients who can be managed without admission at the front door. This builds on the work outlined within the Emergency Care Model and the work already progressing with the 'On the Move' programme within Glasgow.

- Day of Care Audit – testing the Appropriateness Evaluation Protocol set out in the Emergency Care Model which looks at who needs to be in hospital based on a review of the severity of illness and the service intensity that requires access to acute hospital inpatient facilities.

- Discharge planning, including interface arrangements between services and across organisations to consider how we improve the patient flow and effectiveness of patient pathways through improved discharge planning, building with timely pharmacy input.

- Further pharmacy input to the programme is being considered in the following areas:
    - Pharmacy technician led medication compliance and reconciliation service.
    - Heart failure optimisation service.
    - Pharmacist led pain medication review clinics.
    - High risk medicines medication review building on the existing Chronic Medication Service.
- Work has also commenced to consider the IT systems and how to maximise the systems and information currently held within these systems to improve communications and information sharing. This work will also consider the opportunities the new version of the Portal offers in terms of pathway functionality to support the projects, such as the Access to Comprehensive Geriatric Assessment.
- Working with the PPF to consider patient / public engagement on how the public use services.

3.5 Communications and engagement

A Communications and Engagement Strategy has been put in place with a unified approach to branding is being employed. A stakeholder review underpins the strategy with detailed plans to communicate with, involve, engage and inform staff and key stakeholders. The aim is two-way communication for active participation to achieve a shared understanding and to allow stakeholder views to influence the Programme. A diverse range of communication methods, including events, discussions, meetings, email, web information and publications is being used to engage with different audiences.

3.6 Knowledge Management

The use of knowledge management is being progressed within the Programme. An action plan has been developed that will allow knowledge management approaches to be tested within the RDP as part of the CSR and will build on the work already undertaken as part of the Knowledge into Action Strategy (K2A) to define the interface between the two and deliver a way forward that will see K2A utilised as one of the tools used to implement the CSR priorities. The K2A method for transfer of knowledge is now being tested using topics and questions from the Programme.

3.7 Evaluation

Information sharing and governance arrangements are being progressed and information analyses are being performed to inform and monitor the programme. A baseline profile of current services is almost complete using patient level data which will allow wide ranging analyses to be performed and further comparisons to be made over time. Comprehensive evaluation has commenced of the individual programmes, using a logic modelling methodology, which will be combined with economic evaluation and measurement of user views.

4. Next Steps

The programme team will to continue to develop the programmes of work outlined above and to fully implement the monitoring and evaluation programme to allow review of the projects which are now being established. As new components of the programme are developed, these will be built into the evaluation process. Further reports will be provided to the Board and the Programme progresses.

5. Recommendation

The NHS Board are asked to note the progress report on the Renfrewshire Development Programme.