Clinical Strategy
Right Care

Building on our progress, the Trust Board of Directors have given considerable thought through strategic planning sessions in year, to our future and the next steps in our journey as we strive to meet all the challenges highlighted in the previous sections.

We want our local community to trust us to always provide the Right Care, with our focus on putting patients at the heart of everything we do. We need to enable patients to be in control of their health and care and respond to their needs and wants in a way that best suits them, when it is safe to do so.

As set out in the diagram above, our patient is at the heart of the picture, supported at home in a way that best meets their needs, enabled by technology.

In Future State Right Care, the patient accesses compassionate, safe care that empowers them, helps make them active and which retains their dignity. Care is integrated around the patient needs, not those of the organisations providing the care. In this approach, patients are able to access support 24/7/365, either at or closer to home, utilising technology where appropriate.

We plan to build on our ground breaking work using telemedicine to support patients with long term conditions at home and in nursing, residential care homes and hospices, which is having a significant impact in terms of avoiding hospital admissions and reducing A&E attendances. Health and social care partners, everyone involved in meeting the patients needs, work together and integrate around the needs of the individual.

Our work through our service transformation programme to date, to develop multi-disciplinary integrated community based teams building on the great work of the Airedale and Craven Collaborative Team (ACT) puts us in a great position to achieve this integration ambition for our local community.
In **Right Care**, the patient has help to navigate them through the system which can often appear confusing and fragmented.

Supporting the patient through their self care goals is key to how we will cope with growing population demand – supporting individuals like this patient to achieve their life goals by helping to build independence and confidence.

Central to achieving the **Right Care** vision is the development of one patient, one record, with the various health and social care providers all having access to one patient record. With our recent investment in a new Patient Administration System, we are one of the first hospitals in the country to have a shared record with primary care. This is soon to be followed with social services also being integrated with this system. This will really help avoid duplication, enable front line teams to make quicker decisions and better communicate with other services, which in turn improves safety and enhances patient experience. This also helps to close the gap between primary and secondary care.

Having shared records and self care devices will help us build up a detailed picture of the health status of our local population’s health status. This in turn helps us better understand their needs and helps us respond to population needs in a better way, tailored to the needs of the individual.

**Impact**
Our own results from work in the community and telemedicine are demonstrating the impact **Right Care** can have for an individual patient as well as for the rest of the health and social care economy.

Reductions in A&E attendances, avoidance of hospital admissions, reductions in length of stay and actual bed days make for a much better patient experience and outcome and free up resources for reinvestment which help support sustainability.

Evidence from self care programmes also demonstrates similar results in terms of reductions in hospital use and show increased confidence and sense of well being in individual patients.

Patients, their carers and health care professionals often share their frustration at the duplication and delay due to handoffs between GPs and hospitals. We believe working in the way described with a single shared patient record, multi-disciplinary integrated teams and care closer to home helps reduce the gap between primary and secondary care.

**Sustainability**
By working in this way, we can see a way to enable individual patients improve their health and well being as well as care experience. This in turn reduces demand for care, generating savings for reinvestment and to cope with growing demand in a climate of reducing resources.

This is how we will sustain and secure our future.