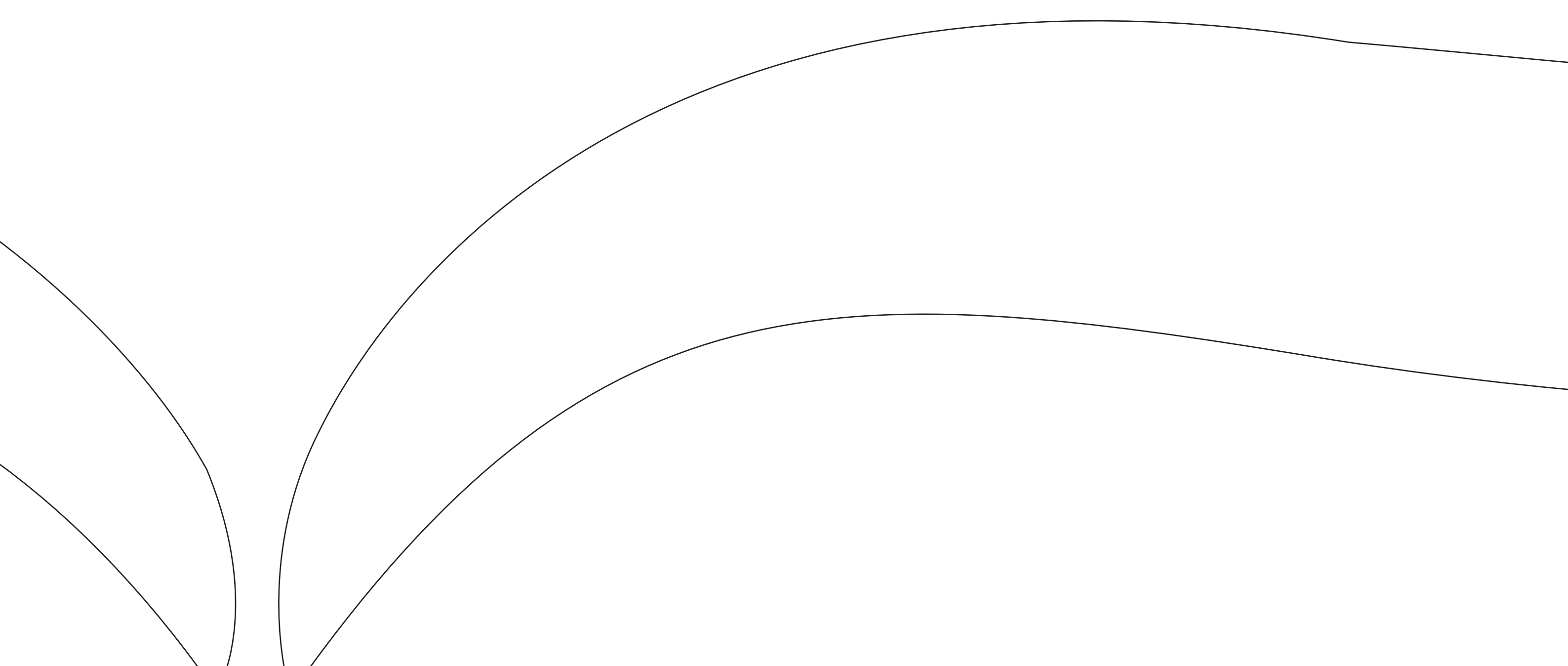
Our Health, Our Future

NHS Lothian Strategic
Clinical Framework
2013 – 2020



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Introduction

We have developed this strategic clinical framework to underpin NHS Lothian's approach to deliver Scotland's vision for achieving sustainable, quality health care services and deliver a healthier future for everyone.

This framework sets out the principles we will embrace in planning and delivering services and care in Lothian, and identifies how, through integrated working with partners and redesigning services around and with people, we will promote good health and deliver safer, more effective and person-centred healthcare.

It affirms our public service ethos based on social justice and valuing our workforce, and our role in public service reform as a socially responsible organisation promoting equality and protection for the most vulnerable in society.

It is clear that future models of delivering health and healthcare will need to be different and we will be engaging staff, patients and stakeholders in this whole system programme of change and redesign.

We want to embed a culture of continuous improvement to ensure our staff can fully contribute to achieving the best possible health and healthcare based on evidence and best practice.

Starting with our most pressing challenges around waiting times and access to optimal care and support for vulnerable groups including the very young and the very elderly, we need to develop integrated care pathways to ensure that services are consistently high quality, efficient and safe.

This approach will drive the development of our workforce and the use of our financial and capital assets to ensure that everything we do delivers value for patients and the public.

The vision for health and healthcare in Scotland

The Cabinet Secretary for Health, Wellbeing and Cities set out a statement of intent for delivery of health and healthcare in September 2011. This recognised the need for health care to be delivered in radically different ways if NHS Scotland is to continue to provide high quality services in the context of significant challenges. These challenges include Scotland's public health record, its changing demography and the economic environment.

The Scottish Government's vision for health care is that by 2020:

- everyone is able to live longer healthier lives at home, or in a homely setting
- we will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management
- when hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- there will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Scotland's vision for health promotion and public health remains focused on:

- developing a fairer society and reducing inequalities in health
- addressing the needs of disadvantaged groups
- promoting health in all policies and prioritising prevention, for example by ensuring children get the best start in life.

The NHS Lothian context – challenges and opportunities

Our framework sets out the principles and themes we will adopt in NHS Lothian to deliver the Cabinet Secretary's vision for achieving sustainable quality healthcare services, which will deliver a healthier future for everyone.

There are specific challenges which we need to address and which mean that we need to change how we operate:

- between 2011 and 2020 the population of Lothian is predicted to increase by 9.3%, from 846,104 to 925,207. The greatest increase with be in the over 75 age group, which will increase by 22.2% over the same period
- the Lothian population aged 0-15 years is also growing, with a projected 14.6% increase in the number of children and young people by 2030
- while the overall health of our population is improving, evidenced by reductions in deaths from coronary heart disease and stroke, there remains a fivefold socioeconomic gradient in the rate of premature death from heart disease. In addition, the risk of multiple morbidity increases with increasing age and lower socioeconomic status. The overall incidence of cancer is expected to rise by 1.4% per annum, and the prevalence of dementia to increase by 70% over the next 20 years. Issues such as obesity, poor diet and limited physical activity, smoking and excessive consumption of alcohol present significant public health challenges and are often closely associated with long term conditions such as cardiovascular disease and diabetes
- despite some good progress, inequalities remain in health outcomes across different social groups in Lothian and people in our poorest communities continue to die younger and live less healthy lives
- the shape of our workforce is changing. There will be fewer doctors overall and where doctors skills are needed in specialist areas of care, these may need to be provided on fewer sites to ensure that services are safe. There are however opportunities to develop and use the skills of many staff groups and professional disciplines more effectively
- The global economic downturn means that real terms growth in health spending is not expected to return to the level of 2009/10 until 2025, so we have to deliver better health and healthcare while making best use of limited public resources.

Key principles of our planning framework are therefore to:

- ensure services are safe, clinically effective and person-centred
- focus on prevention and early intervention to help people keep well and anticipate care needs
- take a whole system approach to planning and managing integrated pathways of care working with partner agencies in local authorities and voluntary sector
- reduce unnecessary variation in the way patients are cared for
- deliver services with the appropriate mix of staff skills, ensuring viable clinical staff rotas
- reduce spend on property and buildings as hospital stays reduce to release money for direct patient services
- consider the continued use of active treatments which have not been shown to extend the length of life or improve quality of life
- identify services that are not sustainable in longer term and proactively plan a new way of delivering care
- make sure we stop procedures and treatments which add no clinical value
- maximise the opportunities for use of new technologies to support health and healthcare.

Our strategic aims

We have identified six strategic aims to ensure we can deliver safe effective and person-centred health and social care to meet the needs of the people of Lothian:

1. prioritise prevention, reduce inequalities and promote longer healthier lives for all
2. put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care
3. ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for patients
4. design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting
5. involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families
6. use the resources we have – skilled people, technology, buildings and equipment – efficiently and effectively.

The specific areas of focus and the actions we will pursue to achieve each of these aims are described in more detail in the following pages.

Aim 1

Prioritise prevention, reduce inequalities and promote longer healthier lives for all

Everyone should have the same opportunities to enjoy good health as a matter of fairness. The NHS provides health care to everyone free at the point of need and has a role to play in:

- providing services designed to prevent future illness
- taking opportunities to provide advice and support to people to help them to take care of their own health
- working with partners to promote the health and well being of communities and the whole population.

On average, people who are better off have better health than those who are less well off. Social inequalities in health are widest between the most well off and the least well off, with people living in poverty more likely to die at a younger age and to have more than one illness than the rest of the population. Health inequalities are an example of social injustice.

Health services play an important role in improving the health of all people as society changes, but more can be done to make sure the NHS improves health outcomes for people at higher risk of ill health, particularly for people living in hard-pressed circumstances. Care needs to be taken to make sure that changes to the health service do not benefit only those who are better off and unintentionally maintain or increase health inequalities.

We have identified five key actions which must be in place to prioritise prevention, to promote longer healthier lives for all, and to ensure that we reduce inequalities in health:

- we must make sure health services deliver high quality care to the whole population. We will measure the way people use health services and the health outcomes for different population groups. This will help us make sure services are working well for everyone
- we will tailor services and health interventions to people who are at highest risk of ill health to prevent illness where possible and reduce socioeconomic differences in health
- we will strengthen the role of clinical services in preventing illness and supporting people who have health problems to access the help and support they need to maintain their well being and social and economic welfare. For example developing the role of the NHS in pathways which support employability and retention of employment and access to welfare rights advice
- our primary care services are central to identifying the majority of people who are at highest risk of ill health while they are still healthy. We will work with GPs and other community health professions to offer evidence based interventions, identify and reduce risk, and make the most of contacts with patients as opportunities for prevention and health promotion
- We will develop the role of primary care through a new primary care strategy and support primary care teams to respond to the needs of people with complex and multiple morbidities
- We will work closely with local authorities and other agencies to address the social determinants of health, to make sure people have the best chance of living a healthy life and that places they live are designed to promote good health.

Aim 2

Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care settings

Working with our partners in local authorities and the voluntary sector, through health and social care partnerships we will integrate care delivery so that services are organised around the needs of the patient/client.

We will jointly plan our new models by looking at the needs of the local population and work with local authorities and other partners to meet health and social care needs and improve health outcomes.

We will provide more and better care at home and in community settings, supporting individuals to stay at home for as long as possible.

Partnerships will deliver 24/7 community responses including integrated elderly care teams to prevent the negative impact of avoidable admissions to hospital.

We will develop our models of care and responses to address the needs of people with complex and multiple morbidities.

Partnerships will work together to ensure families have access to tailored programmes of support, such as the Family Nurse Partnership, to give every child the best start in life.

We will also work in partnership with other key stakeholders, including those in the private sector where appropriate.

Aim 3

Ensure that healthcare is evidence-based, incorporates best practice, and achieves safe, seamless and sustainable care pathways for patients.

Care will be designed on the basis of evidence-based pathways and care bundles, ensuring staff have the appropriate skills needed to deliver these.

We will pro-actively manage the care of those patients with the most complex needs. This will mean putting in place systems to ensure that care plans are delivered and coordinated across settings, including multi-disciplinary case conferences to plan jointly with patients and carers.

We will encourage and support patients and clinical staff to develop anticipatory care plans.

We will develop standardised care protocols which support collaboration among health and care professionals, ensure equitable access to best practice and reduce unnecessary variation in the care patients receive.

Patient information will be shared with relevant professionals in real-time along pathways to support timely clinical decisions.

Improving patient safety in all healthcare settings will continue to be a top priority, through our participation in the Scottish Patient Safety Programme.

Using evidence, we will identify best practice and adopt it as an innovative learning organisation. We will continuously assess and improve our performance at individual, care condition and organisation level through transparent information sharing and learning discussions across care settings.

We will plan with other health boards how care pathways for those using our regional cancer services can be developed to meet increasing patient numbers and changed care needs.

We will continue the development of the palliative care strategy to deliver care at home, in a hospice or in an appropriate hospital setting so that patients and families are fully supported in their final days.

Through our partnerships with further education institutions we will contribute to teaching, training, research and innovation, and maximise the healthcare benefits of collaborative working.

Aim 4

Design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting.

We will work with the local community to enable people to make best use of the services of general practices, community pharmacies, out-of-hours primary care centres and the minor injury service, and reduce unnecessary attendance at emergency departments.

We will increase the focus on prevention, including raising awareness of health risk factors which allow people to anticipate health problems and develop anticipatory care plans to prevent or minimise their impact.

Patients' emergency care needs will be met on an ambulatory basis rather than being admitted to hospital when possible, using agreed care pathways to enable rapid access to assessment, diagnosis, treatment and practical care and support at home.

When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm for most planned hospital care.

For those who do require inpatient care, admission and discharge to their home or community environment will be safe and timely, with no boarding, unnecessary delays or avoidable re-admission.

We will reduce the length of stay in hospital, including in our specialist treatment and rehabilitation facilities for many patients. Hospital teams will work with colleagues in community health and social services to ensure seven-day discharge from hospital.

Aim 5

Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families.

Care will be provided to the highest standards of quality, safety and equity, whatever the setting, with the person at the centre of all decisions.

We will reaffirm our core values, engaging with staff teams and with patients to develop, share and demonstrate our beliefs about what excellent quality care means for patients, carers and staff.

We will ensure stronger public involvement in the design and delivery of health services, and recognise the value that can be added by such participation.

As well as partnership input to designing our pathways of care, we will use patient experience and feedback to check the outcomes and impact.

We will encourage and support individuals to care for their own health through early identification of health issues, providing information and developing self-care plans for those with long term conditions.

We will encourage and support people of all ages to be able to participate positively to health and wellbeing in their local communities.

Aim 6

Use the resources we have – skilled people, technology, buildings and equipment – efficiently and effectively.

People

We will ensure that our management culture, organisational vision and values base support and engage all staff to contribute positively to the implementation of this strategic clinical framework within the ethos of public service.

As an employer we will ensure that our recruitment, retention and workforce development approaches are socially responsible and promote social justice and reduce inequalities.

We will engage fully with staff and their representatives across the care spectrum to maximise their contribution to delivering better services; this will include reviewing the balance of generalist versus specialist teams, facilities and services.

We will ensure service models are based on sustainable service capacity and workforce plans, withdraw from unsafe clinical staff rotas and redesign services to ensure high quality and safe care.

Professionals' skills will be fully utilised with staff skills and roles developed and aligned to maximise effectiveness so that care is delivered by the most appropriate member of the team.

We will continue to work across regions and Scotland to ensure specialist skills and facilities are shared and developed, recognising our role as a regional centre for more specialist services.

Technology

Telehealth and telecare facilities will be coordinated across health and social care to enable remote access to care and monitoring, and support self-management, helping people to live independently at home.

We will always treat information about patients and their care confidentially, but appropriate sharing of information between health and care professionals and with patients themselves should be the norm. Information about patient history and treatment plans will be shared electronically with professionals involved, and the patient/ client, to ensure best possible decisions.

The Clinical Portal being introduced will provide a simple and secure way for clinical professionals to review a patient's medical information from multiple sources in a single, secure on-line location, assisting decision-making about care.

We will also develop a Patient Portal which will allow patients secure electronic access to information on their health and care and to information to support self care and involvement in decisions.

Value for public money

We will focus our funding where it has the biggest impact on people's health and wellbeing and where appropriate disinvest in services of low clinical value.

We will manage our costs to be financially sustainable while maintaining or improving health outcomes through waste reduction, lean processes and enabling staff to work to their full potential.

Care pathways will be designed to reduce wasteful activities for patients and staff: unnecessary duplication of tests, appointments, recording of information; unnecessary waiting for patients; avoidable transfers and travel.

Buildings and Estates

We will look at the physical space and land that we own and make decisions, based on clinical need, on opportunities to safely move off sites, reducing land and property running costs, reducing our environmental impact and releasing funding to be invested in other services.

We will continue a programme of primary care premises development providing accessible community-based healthcare facilities.

Less hospital inpatient care may mean we need fewer hospital beds, with those that we do need provided in appropriate and fit for purpose accommodation.

We will continue to have three acute hospital sites at the Royal Infirmary of Edinburgh, St John's, Livingston and the Western General Hospital, reviewing what services are delivered at each as we redesign care pathways.

We will develop a new Royal Hospital for Sick Children and Department of Clinical Neurosciences on the Royal Infirmary of Edinburgh site at Little France.

We will review the future model for delivery of specialist rehabilitation services in hospital and the community.

We will re-develop the Royal Edinburgh Hospital site as a shared campus for mental health and other related services such as learning disability, brain injury and acquired brain injury and neurological conditions.

We will develop a new model of care for community hospital services in East Lothian.

We will review the future of some of our smaller sites such as the Astley Ainslie Hospital, Corstorphine Hospital and Liberton Hospital, which provide a less than optimal setting for patient care in terms of privacy, dignity and safety, as we modernise the facilities and locations in which the care of older people is provided.

We will ensure that our sites contribute to the development of a healthy built environment that they contribute to delivering Scotland's targets for sustainability and support the local economy.

Addressing our immediate priorities

NHS Lothian is facing particular and immediate challenges to ensure that we are able to provide treatment to patients within an acceptable length of time, and we are taking action to provide additional short term capacity for planned care. Access to responsive and timely unscheduled care particularly for older people is also an area where we know there is a need to do better.

Our initial priorities will therefore be:

- integrated older people's care pathways focusing on care and support for frail/elderly patients with complex needs
- consistency of care for older people with complex needs accessing high volume elective surgical pathways such as urology and orthopaedics
- improved condition-specific pathways associated with long term conditions such as CHD, stroke, respiratory diseases, diabetes.

We are already working closely with our local authority partners to develop new models of care and put in place plans to ensure we can jointly meet the care needs of our population. Our response to the Government's proposals on the integration of health and social care, and local joint commissioning plans for older people and children's service plans, are fully aligned with the aspirations this framework sets out for improved health and healthcare for the people of Lothian.

The process we will adopt

We need to engage staff, patients and other partners to develop new ways of working across integrated pathways for major patient groups and conditions over the next 3-5 years.

Whole system redesign teams will be established with a long term remit and a continuous improvement ethos to plan and implement changes to how care is delivered. Each team will be led by front-line health and social care practitioners with voluntary sector, patient and carer input, supported by health and social care partnerships to:

- systematically review our major clinical care pathways across care settings
- use research evidence, best practice guidance, and staff and patient experience
- design, implement and sustain improved service delivery outcomes
- develop effective primary care, secondary care and social care interfaces
- deliver joined–up care for patients.

Priority areas of focus for teams will be:

- identifying the target (high risk) populations through analysis of patient level data
- setting up enabling processes e.g. access to specialist consultation, protocols and pathways
- allocating resources to deliver care at the right time and in the right location to best meet needs
- using real-time reporting and tracking and shared information to monitor patient progress.

Corporate resources and systems will be aligned to support these service teams, including organisational development, health information analysis, e-health, lean process improvement and quality improvement teams. Teams will have access to a programme of education and support from redesign experts.

Alongside taking steps to improving our services as a priority, we are working with our staff to create the more positive and supportive organisational culture that is essential to achieve our aims. Through affirming our vision and shared values with staff, and developing leadership capability at all levels, we will ensure that staff are able to contribute fully to delivering better health and healthcare.

Appendix

NHS Lothian Clinical Strategy Engagement Events

- Strategic Planning Directorate
- Public Health and Health Policy Directorate
- UHD Senior Management Team
- Clinical Strategy Event – public/ patient (x2)
- Area Clinical Forum
- East Lothian CHP Sub Committee (x2)
- Lothian Partnership Forum (x2)
- Allied Health Profession meeting
- Staff Governance Committee
- Clinical Board
- Informatics Board
- Service Redesign Committee
- Lothian Area Division of Psychiatry
- Directorate Governance Group
- Pharmacy Senior Management Team
- Carers Action Midlothian
- Lothian Cancer & Planning Implementation Group
- Lothian Faith Group
- Primary Care Forward Group
- Lothian Area Pharmaceutical
- Lothian Area Medical Committee
- Nurse Directors Meeting
- West Lothian CHCP sub-committee
- Edinburgh CHP sub-committee
- Carers of West Lothian
- Managed Clinical Network representatives
- West Lothian Community Planning Partnership
- East Lothian Community Planning Partnership
- Health Promotion Department
- The Grand Rounds – RIE
- Lothian Psychology Committee
- Edinburgh Partnership Board
- Midlothian Partnership Board
- Corporate Management Team
- Midlothian CHP sub-committee
- Edinburgh Health & Social Care SMT
- Edinburgh Joint Board of Governance