Our Health, Our Future
NHS Lothian Clinical Strategy
2012 – 2020

‘Safe, effective, person-centred care is at the heart of NHS Lothian’s approach to providing healthcare and promoting positive health for the people of Lothian’
Foreword to the NHS Lothian Clinical Strategy

We have developed our Clinical Strategy to ensure healthcare in Lothian is fit to meet our population’s needs within the wider Scottish health policy and economic context now and over the coming years.

Our strategy sets out the overall service model and principles which will drive service re-design, based on safe, high quality evidence based patient pathways.

We will engage staff, patients and stakeholders to deliver excellent services through a whole system redesign programme to develop integrated pathways for all major patient groups and conditions over the next 3-5 years. We will embed a person centred culture for continuous improvement to ensure our staff can deliver the best possible health and healthcare. This approach will drive our workforce development and the use of our financial and capital assets.

This strategy identifies how we plan to deliver safer, more effective and person-centred health and healthcare for the people of Lothian and beyond.

Dr David Farquharson
Medical Director, NHS Lothian
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1. Executive Summary

Safe, effective, person-centred care is at the heart of NHS Lothian’s approach to providing healthcare and promoting positive health for the people of Lothian.

In order to achieve this in the years ahead we need to review what we do and how we do it, in other words, **how we continue to improve health and deliver high quality healthcare to meet future needs**.

The Clinical Strategy (Our Health, Our Future) sets out our approach to deliver the redesign of our clinical services over the next five to ten years. The key challenges and opportunities the strategy addresses are:

- redressing the balance in capacity and demand for our emergency and elective acute care services
- Supporting longer healthier lives for the population as a whole
- Reducing health inequalities
- Improving the health of the increasing numbers of older people in Lothian
- Using our changing workforce more effectively

Over the past 9 months we have engaged with a wide range of staff groups as well as patients, public, voluntary organisations, local authority colleagues and other partners (see appendix 1). Their involvement has helped confirm the priorities and the principles which will underpin future services. Our initial areas of focus will be:

- Emergency Care high volume pathways
- Elective (planned) surgical pathways
- Older people’s care pathways focusing on care and support for frail/elderly patients with complex needs
- Enabled by improved primary care/secondary/social care interfaces to support the pathways above

In taking forward the Clinical Strategy through an extensive programme of clinical-led service redesign, we expect to deliver the following for patients and the public:

- Safe effective person centred care - every person, every time
- More focus on maintaining existing health
- More support to anticipate health problems and prevent or minimise these
- More and better care at home and in community settings
- Day case and out-patient treatment as the norm for most planned hospital care
- Safe, timely admission and discharge for those who do require inpatient care
- No avoidable re-admission to hospital
- More focus on use of telehealthcare to help people to manage their own health conditions at home
- Information about you and your care to be confidential, but available to you and appropriate health and care professionals when needed
2. Our area - Edinburgh and the Lothians

NHS Lothian provides a comprehensive range of primary, community-based and acute hospital services for the second largest residential population in Scotland. It is our responsibility to monitor, protect and improve the health of the people who live in Edinburgh and the Lothians. The map below sets out the geographic area we cover.

Edinburgh and the Lothians

NHS Lothian is a major teaching health board providing healthcare to a population in excess of 840,000 people. It also has healthcare responsibilities on a regional and national level. We provide a wide range of specialist services for people from across Scotland, including liver and kidney transplantation, neo-natal intensive care, cancer services and complex surgery.

The health board employs nearly 28,000 staff, including 14,000 nurses and midwives (registered and unregistered) and around 2,700 medical staff. We invest around £1.4 billion a year in health care services, provided in people’s homes, in community facilities and in hospitals.

- 3 adult acute hospitals and 1 children’s hospital
- 19 other hospitals with inpatient facilities
- 3,760 Hospital Beds
- 126 GP Practices
- 174 Dental Practices
- 114 Ophthalmic Practices
- 185 Community Pharmacies.
At NHS Lothian we know that working together across all areas of the health service is the best way to provide care for patients. We also know that health care services cannot be provided in isolation. NHS Lothian is committed to forging closer links with our local authority partners in care - City of Edinburgh, East Lothian, Midlothian and West Lothian councils - to support and inform their work to improve health through better housing, social work and environmental health services. We also recognise the importance of working with carers, the voluntary sector and the role of patients in looking after themselves.

The graphic below provides a snapshot of the key areas of healthcare spend and activity in NHS Lothian.
3. What has changed since 2005

In 2004 we consulted with the public on our last major programme of strategic service change called “Improving Care Investing in Change”. At that time we set out plans to modernise our health services, with a particular focus on acute services, services for older people and mental health and wellbeing.

Since approval of our Improving Care Investing in Change strategy in 2005 our staff and our partners have worked together to deliver important service changes. These have resulted in improved care for patients, more services in the community to help people remain at home when it is appropriate to do so and improved facilities for delivery of care in hospitals, community and primary care settings.

Over the past seven years services have been modernised in the following ways:

- Safer and more appropriately staffed acute care for adults provided on three acute sites at the Royal Infirmary of Edinburgh, St John’s Hospital, and Western General Hospital.
- Centre for Head and Neck services developed and university teaching status conferred on St John’s Hospital.
- Development of a state of the art short stay elective surgical centre at St John’s Hospital.
- Redesign of cardiology and critical care services across Lothian, supporting improved access to specialist care
- Improved emergency care for stroke supported by telemedicine to ensure rapid access to urgent specialist assessment
- Re-design of long term condition management through daily telehealth home monitoring to avoid unnecessary emergency admission to hospital
- Services for older people redesigned in partnership with Local Authorities to provide more rehabilitation and care support at home
- Redesign of orthopaedic emergency care involving faster treatment for older patients and improved rehabilitation in hospital and community settings
- The Royal Victoria Building providing state of the art medicine of the elderly facilities due to open on the Western General Hospital site in June 2012
- A new Midlothian Community Hospital opened in September 2010
- The new Chalmers Centre, which provides integrated services for Sexual and Reproductive Health, opened in June 2011
- Implementation of the innovative 5x5x5 programme, which tasked staff with researching and learning from best practice around the world
- Partnership working with Harvard Business School and Napier University to create a Leadership Development Programme for the organisation
- Implementation of Leading Better Care and Leadership in Compassionate Care across NHS Lothian in partnership with Napier University
A major redesign of mental health and wellbeing services has taken place across all local authority areas with a significant shift to community based care, avoiding unnecessary admission to hospital including:

- Enhanced Community Mental Health Teams in each locality
- Access to urgent assessment and intensive treatment services
- 24/7 crisis support for mental health patients
- Specialist Regional Eating Disorders service opened at St John’s Hospital in January 2012.

In primary and community care improved premises have been provided at a number of locations across the region, the most recent being Musselburgh Primary Care Centre, which opened to the public in May 2012. Alongside this general medical practitioners and their staff have delivered substantial improvements in primary care services, including:

- improved management of long-term conditions,
- extended opening hours in 68% of GP Practices,
- forty-eight hour access to appropriate primary care advice, based on clinical need
- an increasing number of contacts for patients – over 5 million in 2009/10 - GP practices in Lothian have contact with 10% of the registered population each week

We have also seen wider improvements in the overall health of the population in this period with improved outcome and recovery for those suffering from coronary heart disease, stroke and cancer. While health inequalities across the Lothian population remain a challenge, there is good news here too with the gap in morbidity and mortality in Lothian less than that in many other parts of the country.

Much has changed since 2005, and there are new and significant challenges in relation to improving health and reducing inequalities, and greater economic and workforce pressures which we need to address. These are set out in detail in section 7 below.

NHS Lothian now needs a new strategic approach to achieving its goals.
4. Our Vision for Healthcare

In working with key stakeholders, we have identified seven key themes as a starting point for developing new models of care over the next 3-5 years. This will ensure we can deliver even better health and care in the context of the drivers identified above.

These are:

- **Population needs-based services**
  We will plan our new models by looking at the needs of the local population and work with councils and other partners to meet both health and social care needs.

- **Effective, seamless and safe care**
  We will develop new models of care that bring care in hospital, in primary care and in the community closer together. We will provide more joined up care pathways for patients through effective working by staff with patients and with each other.

- **Efficient services, outcomes focused**
  Using evidence, we will focus our funding where it has the biggest impact on people’s health and wellbeing.

- **Innovative learning organisation**
  To support our new models of care, we will identify best practice, locally and from further afield, and adopt it across the organisation. We will also use technology to improve care and share information appropriately.

- **Partnership working**
  We will engage with all our partners, especially patients, carers and the public, to ensure we adapt and design services to meet future needs.

- **Health improving**
  We shall continue to prioritise preventative measures, and raise awareness of risk factors. We will identify those at risk and pro-actively offer care to maintain health.

- **Addressing health inequalities**
  We will continue to ensure that the right services are provided to all groups and provide additional support when needed.

5. What Will be Different by 2020
To ensure our strategy for redesigning services is effective in meeting the themes and drivers identified above we have developed a set of principles for system design which will provide the framework for service delivery in future.

These principles have been developed based on evidence from other health systems, refined through discussion with stakeholders and provide a checklist to ensure that future service models are in line with our vision.

They are:

- **Maximise opportunities for prevention and early intervention**
  - Shift care interventions to earlier in the patient pathway
  - Targeted interventions to further reduce health inequalities

- **Care delivered in the location best suited**
  - Shift what is appropriate from inpatient to outpatient/community/ primary care/self management
  - Fewer hospital sites, more fit for purpose accommodation
  - Greater co-ordination and integration of care across care settings

- **Care delivered by the professional best suited**
  - Professionals skills fully utilised with skills and roles fully aligned to maximise effectiveness
  - Care is reliably delivered by the most appropriate member of the team

- **Care standardised and specified**
  - Care is designed on the basis of evidence based pathways and care bundles, and there is equitable access to best practice with no inappropriate variation in care

- **Unit costs relentlessly reduced through waste reduction and lean processes (whilst maintaining health outcomes)**
  - Care pathways designed to reduce wasteful activities for patients and staff: unnecessary duplication- of tests, appointments, recording of information etc; unnecessary waiting for patients; avoidable transfers and travel;

- **Care enabled by technology**
  - Technology enables remote access to care and monitoring, and supports self-management
  - Information about patient history and treatment plans is shared electronically and accessible to professionals involved, and the patient/client, to ensure best possible decisions
  - Telehealth and telecare provision is coordinated across health and social care

- **Separate elective (planned) and emergency care**
Focus on delivering both in a planned and reliable way to meet patient needs
Sustainable service models based on sustainable service capacity and workforce plans
Focus on safety and quality of care as primary drivers for clinical and operational decisions

- Service models co-designed with patients and sense-checked against patient experience.
  - Partnerships with patients and carers fully enabled
  - Pro-active care plans co-developed with patients

“Need to build on best practice and guidelines (SIGN)…tele-health should be encouraged…support people with long-term conditions to self-manage, but recognise we know a lot about our condition so there must be partnership”

What this will mean for patients and the public:
- Safe effective person centred care- every person, every time
- Safe, timely admission and discharge for those who do require inpatient care
- More focus on maintaining existing health,
- More actions to anticipate health problems and prevent or minimise these
- More care at home and in community settings
- Day case and out-patient treatment as the norm for most planned hospital care
- No avoidable re-admission to hospital
- More focus on use of telehealthcare to support people at home for longer and help people to manage their own health conditions at home
- Information about you and your care to be confidential, but available to you and appropriate health and care professionals when needed

What this will mean for staff
- Patient safety and service quality will remain your top priority
- Working as part of an integrated team will be the norm for most
- Where, when and how you work will increasing be designed around the needs of patients
- You will be enabled to participate in improving your service, for and along with patients and carers
- Your constructive ideas for improving how we work will be encouraged, welcomed and considered
- You will be expected to treat patients and carers with respect and compassion at all times
- You will be treated with respect, and supported to develop your skills and ability to deliver excellent services

Our metrics for success:

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1 From workshop with patients, carers and voluntary organisations August 2011
We are clear that safe, effective, person-centred care must be at the heart of our approach to providing healthcare and promoting positive health for the people of Lothian. A range of measures are in already in place to allow us to measure our success in this some of these are set out below.

**Person centred**
- Improve patient experience
- Deliver HEAT health improvement targets
- Deliver HEAT access targets
- Increase anticipatory care plans
- Increase end of life care at home
- Increase patient capacity to self manage care
- Reduce discharge direct from hospital to residential & nursing care
- Increased staff engagement

**Safe**
- Reduce length of stay in hospital
- Reduce delayed discharge
- Reduce emergency admissions
- Reduce healthcare associated infection
- Reduce adverse events
- Reduce hospital standardised mortality ratio
- Zero acquired pressure ulcers
- Reduce falls in hospital and community
- No “boarding” of in-patients
- No overnight discharges

**Effective**
- Deliver HEAT efficiency targets
- Deliver HEAT treatment targets
- Reduce emergency bed days
- Maintain financial balance within limited resources
- Improve use of hospital and community facilities
- Achieve specific clinically effective measures e.g. CHD, stroke, cancer
- Reduce clinic & day case did not attends
- Reduce cancelled procedures
6. How we will realise our vision by 2020

To deliver our vision we need to review how we work, with a focus first and foremost on the quality of care we deliver, ensuring people get access to the right service, right time, right place, every time.

We know what some of the major disease challenges are (as described in section 7.1 below), and we know we need to provide the best possible care in ways which deliver best value for taxpayer's money.

Pursuing Safer Care

The Scottish Patient Safety Programme (SPSP) is a national programme which started in 2007 and aims to reduce adverse events and mortality in hospitals by systematically improving safety and reliability in hospital care. Frontline teams across all acute hospitals are applying evidence based tools and techniques to address the following improvement goals:

- Improve organizational and leadership safety
- Improve critical care conditions
- Reduce healthcare associated infections
- Reduce adverse drug events
- Reduce adverse surgical incidents

Work is underway to develop this programme within maternity mental health and for congestive heart failure, and further safety improvement goals will continue to be developed and progressed across our hospital services.

The *Delivering Quality in Primary Care: National Action Plan* sets out the Scottish Government’s plan for implementing the Quality Strategy in primary and community care, including within the family health services (general practice, optometry, dentistry and pharmacy).

The focus of the Patient Safety Programme in Primary Care is on four main themes:

- High risk medications and medicines reconciliation in the community
- Improving communication between secondary and primary care
- Align with the work of the Long Term Conditions Collaborative
- Healthcare Acquired Infection in the community

Pursuing Integration for Efficient and Effective Care

*Integrating Health and Social Care*

The Scottish Government has identified in the vision for 2020 that integration of health and social care is one of the most important changes we need to pursue to deliver effective seamless and safe care which is truly responsive to the needs of individuals.

We have a great opportunity to improve integration both across the healthcare system between GPs, community services and hospitals, and also with our council and third sector partners.
We recognise there is much work to be done, but there are also great benefits to be gained from designing care from the perspective of the patient, and making care delivery as seamless as possible.

“Transition from hospital to care home/ home is not seamless: while there are plans, the assumption is that these will be delivered and that is not always the case”\(^2\).

We have already embarked upon a number of significant service strategies jointly with our partners, to redesign our services to meet the needs of patients, and we will continue to drive these forward. Through these we will continue to see key developments take place for some of the most deprived and excluded groups. This includes services for people with learning disabilities, mental health problems, sexual health and HIV services, underage pregnancy, alcohol and substance misuse problems, physical disabilities and complex care needs.

Work is underway with our four local authority partners on reshaping care for older people through new service models commissioned through the Change Fund which will invest £11.15m in 2012/13, with £41.794m over the years 2011/12 to 2014/15 in additional community support and rehabilitation services.

Through these joint plans to remodel services around the needs of patients and clients we will continue to shift the balance of care from care in hospitals and care homes to providing services that support individuals at home for as long as possible.

Integration between health and social care will build on the Community Health (and Care) Partnerships (CH(C)Ps) we already have in place in each of the four Lothian local authority areas. Although at different levels of integration currently the CH(C)Ps are already actively involved in considering the changes needed so they can become fully integrated. These discussions will involve our hospital clinicians and managers, particularly in the short term those involved in services for older people with complex needs. We must grasp this real opportunity to join up our care pathways and overcome organisational and cultural barriers between health and social care.

**Integrating Healthcare Pathways**

Equally important is integration between GPs and other community services and hospital services, all with the goal of improving quality for patients and value for money for the public. An important discussion in all pathways will be what clinical activities can and should shift from hospital to be provided in the community. We need to engage fully with primary care and in particular with GP’s, dentists, community pharmacists and optometrists to maximise their contribution to delivering appropriate change.

We will also, as a key tertiary healthcare centre, explore new ways of working regionally and nationally, including how we jointly plan for developments to address the growth in obesity and the demand for bariatric surgery; the development of standards for delivery of care for neonates; vascular services; trauma and burns.

\(^2\) From workshop with patients, carers and voluntary organisations August 2011
The need to deliver more cancer care and treatment is one of the major healthcare challenges facing health services as cancer incidence increases and advances in treatment increase survival rates so that for many cancer sufferers their longer term care needs are most appropriately met in the community. As the regional cancer centre for South East Scotland we are already considering how services need to develop to meet these changed care needs.

Our palliative care strategy has already seen a significant shift towards delivery of care at home or in a hospice rather than a hospital bed. This trend is expected to continue, offering patients the opportunity to choose where they spend their final days, and we are working closely with the local hospices as they remodel their services to meet changing demands.

To do this we will work with our many partners - patients, carers and the public, staff in primary care and hospitals, local authority colleagues and voluntary sector organisations - to systematically review our major clinical care pathways across care settings. We will start with those which impact on large numbers of people, particularly those mainly elderly people with complex needs or more than one long term condition.

Implementing the vision which drives our clinical strategy will require more than just a few technical fixes to specific service issues. To undertake review and redesign of patient care pathways across primary and community, hospital and social care will require strong clinical and managerial leadership at both strategic and operational levels across internal and external organisational boundaries and a significant programme of intensive work. Engagement of health and social care professionals to lead and champion better more effective care will be paramount.

*Our Integration Checklist*

Opportunities to better support multi-disciplinary care delivery based on national and international evidence we intend to pursue are:

- Better sharing of information about patients across care boundaries, and with patients themselves
- Proactive identification of patients at higher risk and designing early interventions to optimise their health outcomes
- Commitment to using evidence based protocols and ensuring staff have the appropriate skills needed to deliver these
- Developing and implementing integrated anticipatory care plans jointly with patients
- Systems to ensure that care plans is then delivered and co-ordinated across settings
- Multi-disciplinary case conferences for the care of the small number of patients with most complex needs
- Continuously assessing and improving our performance at individual, care condition and organisation level through transparent information sharing and learning discussions across care settings
Pursuing Person Centred Care
We know that involving patients, their families and carers as well as our staff is essential if we are to deliver more integrated services. Delivering safe and effective care is paramount and everything that we do must deliver as high if not a higher quality of care in the future. It will be important that we continue to listen to patients and staff and use their experience and knowledge in taking forward service changes.

We need to make sure that our organisational values, behaviours and communication styles are fully aligned with the vision we have set out, and that staff across the NHS are clear what is expected of them in terms of their contribution to delivering person-centred healthcare which is respectful and treats patients as individuals. We will be starting on work to reaffirm our core values in 2012, engaging with staff teams and with patients to develop and share our beliefs about what excellent quality care means for patients, staff and carers.

We want to ensure that as well as having excellent clinical and technical skills our staff have the ability to engage and communicate effectively with patients, families and each other. Our goal is to provide as positive an experience as possible for all patients, regardless of age, disability, ethnic origin, gender, religious belief, sexual orientation or transgender status. We also want to ensure that patients and carers have the information and support they need to be truly involved in their own care.

“Communication within the organisation and without: assumptions are made by staff about what will happen next to the patient without checking with their colleagues and other agencies.”

Pursuing Better Patient Pathways through Redesign

The successful implementation of the clinical strategy will require whole-system transformation by 2020, and we will undertake a systematic programme of redesign for our services, within the framework of the whole system design principles described at section 5 above.

Section 7 below identifies the drivers, challenges and opportunities we have now. It is important that we focus first on our most challenging patient pathways where we know that we could do better, and on the issues which are risks to best quality of care for individuals. Improving “flow” in our services, which will ensure the right facility and services are available at the right time to meet patients needs is the most important priority at this time.

These include avoiding delays in:
- access to treatment within 4 hours for urgent and emergency care
- admission to the appropriate hospital specialist facility, e.g. for stroke care
- timely access to elective (planned) care – in line with the commitment to the maximum 18 week referral to treatment pathway
- access to specialist comprehensive geriatric assessment for elderly patients with complex needs.

[3 From workshop with patients, carers and voluntary organisations August 2011]
To do this we will:

- review the balance of generalist versus specialist teams, facilities and services,
- design and implement more efficient care processes – assessment, diagnostics, treatment and rehabilitation - to ensure safe, timely and effective care
- develop standardised care protocols to reduce unnecessary variation in the care patients receive.
- Increase the availability of ambulatory (not admitted) care for unscheduled care patients through greater use of agreed protocols which allow patients to attend on a daily basis for tests and treatment.

Recent work\(^4\) which benchmarks our performance against comparable health systems has already identified the need to increase the capacity for immediate assessment in our acute hospitals, and the potential to remodel our assessment areas which could reduce the length of stay in hospital for some patients through more effective and timely assessment, diagnosis and treatment. This would free up capacity in our specialist treatment and rehabilitation facilities for those who need these services. Work by an internal team charged with identifying alternative assessment models has also identified greater scope for avoiding some emergency admissions through rapid access to diagnosis and treatment in our hospital assessment units.

We are therefore prioritising the following services and pathways for initial focus in 2012/13:

- **Emergency Care:** e.g. chest pain, abdominal pain pathways across primary and secondary care
- **Elective (planned) surgical pathways:** e.g. urology and plastic surgery pathways across primary and secondary care
- **Older people’s care pathways** focusing on care and support for frail/elderly patients with complex needs
- **Enabled by improved primary care/secondary/social care interfaces to support the pathways above**

We will use robust “improvement science” redesign processes that staff are already familiar with: from our Lean in Lothian programme, our mental health, 18 weeks referral to treatment and long term conditions redesign collaboratives and the important work on patient safety. These approaches involve staff in reviewing, testing change ideas and redesigning their services, using the expertise of front-line staff, the latest evidence on excellent care (from clinical guidelines and research), benchmarking of processes and performance against best practice and an understanding of what is important to patients to ensure we plan optimum services for the future. Appendix 3 sets out an example of the future pathway for unscheduled care we need to deliver.

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\(^4\) Capita Bed Modelling Report 2012
Effective whole pathway redesign teams will be established, and will have social care, acute health care, primary care, voluntary sector, patient and carer input. All service redesign programmes will be subject to thorough equality impact assessment to ensure that positive impacts on patients, staff and communities are maximised.

This process will need full ownership by clinical and support staff and engagement with patients will be essential. Strong clinical and managerial leadership at both strategic and operational level is also important. This strategy builds on our work to date for communication and engagement with staff, patients, carers, partners and the public on our vision. The plans for full and effective communication with all are being developed, to ensure we have a shared understanding of our aims and goals, and the changes required to achieve these.

“Tell people what is going on. The people affected need to be involved when options are being developed”\textsuperscript{5}

We can have confidence that NHS Lothian staff have the skills, ability, expertise and commitment to redesign care using these principles, because we already have evidence of this from successful service ad pathway redesign which has already taken place. Appendix 4 shows some examples which illustrate these principles in practice. The following box highlights the areas of inefficiency or waste which “lean” improvement approaches seek to reduce or eliminate in how we work.

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\textbf{Eight wastes in health care:}

\textbf{Transportation}  
Material, patients or information that is moved unnecessarily or repeatedly, e.g. unnecessary movement of samples.

\textbf{Inventories}  
Anything waiting to be worked on, e.g. excess levels of stock in cupboards and store rooms, specimens waiting to move to next step in process, or people waiting for tests and results.

\textbf{Movement}  
Unnecessary walking, moving, bending or stretching e.g. looking for equipment placed in wrong location, looking for information/people.

\textbf{Waiting}  
Waiting for samples, equipment, staff, appointments or results e.g. patients waiting for test and results, staff waiting for other staff, equipment or information.

\textbf{Overproduction}  
Producing something before it is required, or more than is required e.g. unnecessary/ inappropriate tests, batching samples or tests, multiple forms with same information.

\textbf{Over-processing}  
Duplication of data or repeat testing due to defects e.g. dual data entry, additional steps and checks, clarifying orders.

\textbf{Defects}  
Errors, omissions, anything not right first time e.g. poorly labeled specimens and requests, insufficient or illegible information.

\textbf{Skills utilisation}  
Unused employee skills e.g. highly qualified staff performing inappropriate tasks.

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\textsuperscript{5} From workshop with patients, carers and voluntary organisations August 2011
Delivering Efficiency and Productivity

NHS Scotland has developed its overall Efficiency and Productivity Framework 2010 -2014 with the aim of supporting all health organisations to balance the quality and cost equation as captured in the graphic below. Our goal is to identify improvement opportunities which can improve quality of services which reducing costs whenever possible.

As part of our current efficiency and productivity actions, we are working hard to ensure we can meet patient service requirements within available resources. We have already agreed a number of internal programmes of work for 2012/13 as shown below. Some of these - e.g. efficient procurement and shared services - are part of regional work underway with other health boards and public sector organizations.
Improving and Reviewing our Asset Base

With regard to the physical environment in which care is delivered there are some givens which reaffirm previous commitments:

- We are committed to sustaining three acute general hospital sites at the Royal Infirmary of Edinburgh, St John’s, Livingston and the Western General Hospital. But in so doing we will review what is delivered on each site and optimise how we use these sites to help us deliver better hospital care when people need to come into an acute hospital.

- We will re-develop the Royal Edinburgh Hospital site and in so doing look at opportunities to develop as a shared campus for mental health and other related specialisms such as learning disability, brain injury and acquired brain injury, neurological conditions and substance misuse.

- We will develop the new Royal Hospital for Sick Children and the Department of Neurosciences on the Royal Infirmary of Edinburgh site at Little France as well as the new East Lothian Community Hospital.

- We will continue a programme of primary care premises development with new facilities at Wester Hailes and Gullane in construction and further developments being planned in Edinburgh, West Lothian and East Lothian.

But in pursuing these capital investments and developing new services in the community we will also look at the physical space and land that we own. This will allow us to make decisions based on clinical need and evidence that we can safely move off sites, reduce costs tied up in land and property maintenance and running costs and invest in new services to ensure delivery of the healthcare vision.

We therefore plan to review the future model for delivery of the specialist rehabilitation services at the Astley Ainslie Hospital. Redesign of older people’s services is already identifying a reduced need for services for those with complex needs at this site, and at Corstorphine Hospital. The future use of Liberton Hospital will also be reviewed in the medium term, recognising we need to plan to modernise the facilities in which the care of older people is provided as our resources allow.

**Efficient Use of our Capital Assets**

In 2010 a major programme to rationalise our non-clinical estate was undertaken, which resulted in the transfer of back-office and headquarter functions from a total of 13 locations, including high value clinical space, into two fit for purpose office locations. This resulted in release of funds to be re-invested in healthcare equipment and facilities, and contributed to carbon reduction due to more green travel and reduced energy use. We are now working towards a further programme of non-clinical accommodation release to be delivered in 2012/13 and beyond.
Supporting Strategies – E-health and technology

The use of electronic information and technology already is and will increasingly be a vital ingredient in our future healthcare delivery.

Sharing patient information across different parts of their healthcare journey is important to delivering the seamless and safe care we all want. Much has already been done to join up hospital services through our Trak information system, in use in all our hospitals and being introduced to community services, but much more is needed.

A key development already underway is the Clinical Portal which is being taken forward by a consortium of health boards led by NHS Lothian. The Clinical Portal will provide a simple and secure way for clinicians to review a patient’s medical information from multiple sources in a single on-line location, accessed using a web browser. This development will be taken forward over the coming years to become the way health staff access patient information to ensure clinical decisions are made on the basis of the most complete picture of the patient’s history.

One of NHS Scotland’s objectives for eHealth is to provide patients with secure access to their medical records and information. NHS Lothian is now committed to developing a Patient Portal which will allow patients to access information on their health and maintain their own electronic information.

The likely benefits of a patient portal will be improving health outcomes through giving patients more information about their own health, promoting self-management and improving patient experience. An early pilot involving 50-100 patients is expected to start in April 2012 within Renal, Cardiology and Diabetes services at St John’s Hospital.

Latest evidence suggests that telehealth services can significantly reduce risk of hospital admission for patients with a range of long term conditions. Provision of telehealth is currently limited to fewer than 300 patients across Lothian, whereas telecare services are provided to nearly 20,000 Lothian residents. Rollout of telehealth and telecare is planned in three phases and a Telehealth and Telecare Strategy will be published later in the year. Both telehealth and telecare are key enablers for shifting the balance of care, supporting self management and integration of health and social care.

Supporting Strategies – Using Information for Improvement

The adoption of the TRAK Patient Management System in Lothian has not only benefitted patients directly but also indirectly through the massive amount of service information that can now be analysed and used to improve patient safety, to improve patient pathways through the healthcare system and to benchmark our local healthcare delivery against national and international standards.

e-Health systems are increasingly being used in innovative ways to help services address patients’ additional support needs, such as the need for an interpreter, hoist or large format letters. NHS Lothian is the global lead for a major new programme to
build these support needs into the Trak system so that where a need is identified, the system will ensure that the appropriate action is taken by staff in a consistent and timely way. The impacts on patient experience and service efficiency are likely to be significant, as patients will receive care appropriate to their needs with minimal risk of key information being missed by services.

The developments will also provide detailed information about the additional needs of Lothian’s population for the first time, and enable better service planning.

National developments within ISD Scotland have led to the development of a national comparative database – allowing Health Boards for the first time to use hospital activity databases across Scotland for comparative purposes. NHS Lothian’s membership of the international **Leading Systems Network** provides further access to global service benchmarking and population based health care indicators. Lothian also benefits from international service improvement projects such as the 2011 Cardiac Improvement Network where work was jointly undertaken with Singapore, Hong Kong, the states of Queensland and Victoria in Australia, Pais Vasco in Spain and NHS South West Strategic Health Authority here in the UK.

The key to making high quality information available to those who need it is the availability of a real-time dynamic delivery system. Lothian has acquired a licence for a professional **Performance Dashboards** system capable of querying and reporting direct from the TRAK system in real time – and displaying key performance indicators at optimum frequencies of refresh. This system is also capable of generating alerts in the form of emails direct to staff who will be interested in certain changes in activity and can investigate the issue in real time.
7. Our Challenges – The need for a new Strategy

There are four main drivers that will have a direct impact on the delivery of healthcare within Lothian both now and in the future. These drivers are changing demography, the challenging financial context, ongoing workforce pressures and addressing health inequalities. The graph at appendix 2 summarises the strategic context and the range of settings, life stages, challenges and opportunities within which NHS Lothian operates.

Over and above these drivers, there is also a need to recognise the current environment in which NHS Lothian is operating, with pressures in relation to achieving waiting times, unscheduled care and delayed discharge standards as well as wider performance targets to ensure patients receive timely access to healthcare.

The following section sets out these drivers more detail.

7.1 Changing Demography:
The population of Scotland is projected to increase over coming years, however the projected changes are more significant within Lothian, with the overall population expected to exceed 900,000 by 2017 and reach 925,000 over the life of the Clinical Strategy in 2020. The population increases across Edinburgh and the Lothians are set out in the table below.

Table 2: Projected population by Council and NHS Board area (2010-based)

<table>
<thead>
<tr>
<th>Area</th>
<th>2011</th>
<th>2014</th>
<th>2017</th>
<th>2020</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Lothian</td>
<td>98,673</td>
<td>102,177</td>
<td>105,634</td>
<td>109,263</td>
<td>+10.7%</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>492,233</td>
<td>511,565</td>
<td>528,115</td>
<td>543,785</td>
<td>+10.4%</td>
</tr>
<tr>
<td>Midlothian</td>
<td>81,644</td>
<td>82,994</td>
<td>84,258</td>
<td>85,553</td>
<td>+4.8%</td>
</tr>
<tr>
<td>West Lothian</td>
<td>173,683</td>
<td>178,442</td>
<td>182,684</td>
<td>186,735</td>
<td>+7.5%</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>846,104</td>
<td>875,049</td>
<td>900,562</td>
<td>925,207</td>
<td>+9.3%</td>
</tr>
</tbody>
</table>

Whilst all areas within Lothian are projected to have an overall population increase, within these, there are significant changes in the age profiles. For example, there is a projected 30% increase in the 65-74 years population within Edinburgh, whilst those aged 75+ years is projected to rise by 50% in West Lothian, 32% in East Lothian and 27% in Midlothian.

Whilst there is evidence to suggest that people are living longer, healthier lives, the patterns of disability and disease across Lothian will change as the population changes:

- The majority of over 65 year olds have 2 or more chronic conditions and the majority of over 75 year olds have 3 or more conditions.
- The growth in the older population is expected to result in an increased prevalence of long term conditions equating to an additional 13,000 patients with at least one condition in the first five years of the strategy.

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6 General Registers of Scotland 2012
7 Ibid
8 Multimorbidity in Scotland, Stewart Mercer 2012
9 Measuring Long Term Conditions in Scotland ISD 2008
- Overall incidence of cancer is expected to increase by 1.4% per annum, equivalent to 1,000 additional new cases in a year\textsuperscript{10}.
- The prevalence of dementia in the population is expected to increase by up to 70% in the next 20 years\textsuperscript{11}.
- Approximately 25% of the adult population is obese and 64% are overweight. Obesity has a significant causal relationship with health problems such as type 2 diabetes, hypertension and coronary heart disease. Similar proportions of children and young adults under the age of 19 years are thought to be obese\textsuperscript{12}.

### BURDEN OF DISEASE

#### ESTIMATED NUMBER OF PEOPLE WITH DIABETES

![Diabetes Graph]

Source: NHS Lothian Public Health Annual Report 2009-11

The number of people with diabetes has steadily increased in Lothian in line with increases seen in other areas. The Scottish Diabetes Survey reported that in 2010, there were 32,717 people with diabetes in Lothian, in 2011 this increased to 34,024.\textsuperscript{13} This means that diabetes has a crude prevalence of 4.0% of the population and very close to the Scottish average.

One of the key drivers to the increasing number of people with diabetes is demographic change. Diabetes is more common among older people so as more of us survive to older age it is expected increasing numbers will be diagnosed with diabetes. Another reason for the steady rise is because more people are becoming overweight or obese.

This is a key risk factor for the development of type 2 diabetes. The increases currently seen are also believed to reflect an improvement in care of people with diabetes across the life course. More people are surviving with diabetes, we now know that controlling blood glucose, cholesterol and blood pressure can make a real difference to long term survival.

\textsuperscript{10} Cancer in Scotland Sustaining Change, Scottish Executive 2004

\textsuperscript{11} Scottish Public Health Observatory 2011

\textsuperscript{12} Impact of health behaviours and health interventions on demand & cost of NHS Services. Burns, H

\textsuperscript{13} Scottish Diabetes Survey 2010. Scottish Diabetes Survey Monitoring Group. NHS Scotland
7.2 Economic and Financial Context:

Health funding has increased in recent years. NHS Lothian’s baseline allocations has increased by £151m since April 2007, from £902m to £1,053m. However pay, prices and medicine costs have increased by a slightly larger amount - £157m. We have also invested £150m in additional local, regional and national services over that period.

The graph below shows how we have used our allocation for health services in the last 3 years:

As a result of the global economic downturn and UK government spending restrictions real reductions in the Scottish Government spending totalling circa £42bn have been projected between 2009/10 and 2015/16, with levels of public sector funding taking account of general inflation not expected to return to those of 2009/10 until 2025/26.

In this context the Scottish Government are protecting spending on health services relative to many other areas, but nevertheless the NHS continues to face pressures, including the higher levels of cost associated with increasingly expensive technology and medicines.

NHS Lothian like all public sector bodies is required to live within its budget resources, and to do this we had to deliver efficiency savings of £50m in 2011/12, with similar levels of efficiencies needed in future years. These internally generated savings are reinvested into meeting the unavoidable cost increases we have to meet. The graph below illustrates the level of these in 2012/13.
Unavoidable Costs 2012/13

- Infrastructure: 7%
- National Policy: 9%
- Pay: 7%
- Pay Modernisation: 19%
- Supplies: 27%
- Drugs & Prescribing: 31%
- Total: £33.8m

Spending Review 2012-2015 - NHS Lothian Budget

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base budget</td>
<td>1,053.3</td>
<td>1,092.7</td>
<td>1,122.8</td>
</tr>
<tr>
<td>Uplift to Base</td>
<td>27.1</td>
<td>17.9</td>
<td>16.4</td>
</tr>
<tr>
<td>NRAC funding</td>
<td>12.3</td>
<td>12.3</td>
<td>12.3</td>
</tr>
<tr>
<td>Total Budget</td>
<td>1,092.7</td>
<td>1,122.8</td>
<td>1,151.5</td>
</tr>
<tr>
<td>Increase on previous year</td>
<td>3.70%</td>
<td>2.80%</td>
<td>2.60%</td>
</tr>
</tbody>
</table>

There are additional financial pressures as a result of plans for major new build projects, which due to capital budget restrictions will have to be funded through revenue projects – via the Scottish Futures Trust sponsored Non-Profit Distributing agreements with private sector funders or Hub projects.

Lothian also faces financial challenges as the health board with the biggest population growth since our share of overall NHS funding in Scotland lags behind our expected share under the NHS Scotland Resource Allocation Committee formula.

The level of savings required to meet these challenges is not achievable by marginal savings alone. We need to find ways of delivering services in more cost effective ways to balance our budget.
7.3 Our Workforce Challenge:

The National Reshaping the Medical Workforce initiative seeks to reduce the number of higher specialty trainee doctors to a level that will meet the anticipated vacancies and retirement within the trained medical workforce. This follows a decade where there has been unprecedented growth in all areas of the medical workforce, enabling NHS Scotland to achieve European Working Time Regulations compliance. Specialty training numbers are now being reduced over the next four years in key specialties. These reductions mean that it will not be possible to maintain all existing training grade rotas within the South East Scotland region. A mixture of medical and non-medical roles is required to provide sustainable alternative workforce models, with a lead-in time for the development of these roles which means we will have to reconsider the way services are delivered. Close working with our regional partners and with the Postgraduate Dean who determines where and how training is delivered is essential given the regional nature of training programmes.

The demographic change in the population as a whole are also reflected within the NHS Lothian workforce. In the last 6 years the proportion of registered nurses aged more than 50 years old has increased from 19% to 27%.

![Registered nursing demographic change - headcount](image)

Whilst the age distribution of staff varies by site and service the ageing workforce is an issue in most areas. There are particular hotspots - such as community nursing and in small specialised areas within Healthcare Sciences - where we need to develop new strategies for both the recruitment and the retention of staff. Changes to the pension scheme are also likely to have a significant impact on historical retirement trends and need to be factored into planning.

As a large employer locally, and in knowledge of the impact of poverty on the health and well-being of the population, we have an obligation to act as a socially responsible employer. The NHS Lothian Human Resources Strategy sets out our commitment to create training opportunities and employment for unemployed 16 to 24 year olds. It also sets out the development of a sustainable job structure, which provides entry level staff realistic promotion opportunities to advance their careers based on ability and ambition.
We need to balance the positive aim to provide family friendly working conditions for staff with the need to extend the working hours of our services. Extended days and 7 day working already apply in many areas, but extending the availability of other important staff groups who support diagnosis, treatment, rehabilitation and care at home will be required to ensure we can provide services when needed and make best use of our resources.

It is also essential that we seek ways of improving workforce efficiency and productivity whilst improving quality. The development of new and innovative roles are required, to enable services to be provided to a growing population at a lower unit cost and to a higher standard.

We are reducing the size of our workforce too, after a period of significant growth in recent years. We have been reducing staff numbers by 2000 since 2010, while protecting front-line services posts wherever possible. We are also expected to reduce our senior manager posts by 25% between 2011 and 2014.

7.4 Health Inequalities:

Whilst good progress has been made within Lothian in addressing health inequalities, there is still further work to be done if we are to realise our ambition of enabling all people to live longer, healthier lives.

Research shows that people who are disadvantaged in income have poorer health than those who are more advantaged. This can be seen in differences between geographical areas that are more or less deprived, or between individuals who are more or less disadvantaged. People in some minority ethnic groups, for example gypsy travelers, are often disadvantaged and have poorer health. In Lothian, people who live in our poorest communities die younger and live less healthy lives.

The graph below highlights the disparity in emergency admission rates across areas of deprivation within Lothian.
Avoidable or amenable mortality refers to ‘deaths that should not occur in the presence of effective or timely health care’\textsuperscript{14}. In Lothian there are still a disproportionately high number of early deaths in our poorest communities.

\begin{center}
\textbf{AMENABLE MORTALITY RATE BY DEPRIVATION} \\
\textit{AGE-STANDARDISED RATES PER 100,000 POPULATION: 2002 - 2009}
\end{center}

Tackling these health inequalities means that we must ensure that our efforts to prevent poor health are effective for all of Lothian’s population and that healthcare is equitable for all who require it. In practice, this means recognising that policies and plans have differential impacts across our populations and that we need to take action to ensure that disadvantage is not accentuated as a result. Pivotal to this is recognising the importance of addressing the underlying determinants of health.

Put simply, the higher one’s social position, the better one’s health is likely to be. …serious health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, ‘bad’, unhealthy behaviour, or difficulties in access to medical care, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society.\textsuperscript{15}

Therefore NHS Lothian will continue to adopt a ‘whole systems approach’ to addressing health inequalities. This has the following elements:
\begin{itemize}
\item Ensure mainstream services are accessible, appropriate and high quality for all e.g. Equity Audits, Rapid Impact Assessments
\item Provide targeted initiatives where needed to enable vulnerable groups to access care e.g. Keep Well, The Access Practice, ‘Healthy Happy Bairns’
\item Work with partners to address underlying determinants of health and social inequalities e.g. community planning partnership, health improvement projects and programmes
\item Using technology (web-based information, telehealthcare, community pods and digital television) to improve patients’ and relatives’ access to health information and services.
\end{itemize}

7.5 Our current environment

NHS Lothian, like other health boards across Scotland, is tasked with delivering on key targets through their Local Delivery Plan around the areas of health improvement, efficiency, access and treatment (HEAT targets).

Whilst NHS Lothian continues to make good progress against a range of these measures, we still face particular challenges in reducing delayed discharges, delivering waiting times, and meeting the emergency access standard.

Delayed discharge
NHS Lothian and the four Local Authority Partners work closely to ensure that services and systems are in place to support individuals leaving hospital and returning to a community setting be it home or supported accommodation. However of the circa 150,000 in-patients annually across Lothian, around 2% are unable to be discharged, after becoming clinical ready to do so. Primarily this is due to the services they will need in the community still being arranged.

The Lothian Partnership currently has a local target of no more than 66 delays overall and a national target of no delays over 6 weeks, which will reduce to 4 weeks by 2013 and 2 weeks by 2015. The 6 weeks target is not currently being met on a consistent and sustainable basis across the Lothian area. The impact of unnecessary delay in hospital on patients includes loss of confidence and increased risk of infection. It is also harmful to other patients as it reduces access to beds, exacerbates the boarding of patients which is itself an impediment to good care, and contributes to delayed access to emergency care and postponed operations. There is also an impact on the wider hospital system, resulting in reduced patient flow and pressures across sites, particularly within accident and emergency.

The work to tackle delayed discharge requires a whole system approach, working in partnership with local authorities and primary care. There has been progress made in previous years in reducing the number of patients who are delayed however there is still much work required to reduce this further.

![Lothian Delayed Discharges 2011/12](source: EDISON Database, NHS Lothian 2012)
**Waiting Times**

The Scottish Government has made a commitment to reduce the length of time patients need to wait from initial referral through to treatment, set out in the waiting times guarantee, for a range of specialties. The consistent achievement of these targets across all specialties has proven challenging for NHS Lothian, as set out in the performance table below.

**Inpatient Waiting List Trend (April 2011 onwards)**

![Graph showing Inpatient Waiting List Trend (April 2011 onwards)]

In terms of specific areas in which there are most pressures, these are currently Urology, Plastic Surgery, General Surgery and Orthopaedic Surgery. There is a need to examine the patient pathways and capacity associated with these areas through the key workstreams within the clinical strategy.

**4hour emergency care standard**

There is strong evidence to support improved patient outcomes through prompt access to emergency care, with the need for safe, effective and timely assessment, followed by treatment and discharge or admission to an appropriate inpatient bed. This is reasoning behind the 98% 4 hour access standard set by Scottish Government. This is a whole system target and needs to be approached on the basis that a well performing system will deliver this standard reliably. The graph below set out performance against the 4 hour standard.
The current challenges facing NHS Lothian represent particular issues in relation to matching capacity with demand, which impacts across the whole health and social care system. There are explicit interdependencies between emergency care, elective procedures and delayed discharge, each in turn exacerbating the pressures on the hospital system and ultimately impacting on the delivery of safe patient care.

NHS Lothian, with our partners, need to achieve equilibrium within the system, balancing our elective (planned) and emergency care, whilst ensuring supportive, timely and safe discharge of patients to the most appropriate environment. This means rebalancing care between hospital and community, with greater capacity in and responsive 24/7 community based services which are able to prevent unnecessary admission, maintain independence at home and ensure those who do come into hospital can go home when ready with appropriate support.

Our Asset Base
In line with other public sector bodies, NHS Lothian needs to address issues relating to our estate and assets, i.e. our hospital sites and other buildings and whether they remain fit for purpose to support the delivery of high quality healthcare. There is also a need to consider the future of our hospitals in light of the policy agenda to shift the balance of care from institutional to community-based settings. This means we should be planning for fewer hospitals and beds and using released money to invest in more community services.
8. **Our engagement and communication plan**

NHS Lothian is required to inform, engage and consult people and communities affected by service developments and change\(^{16}\). It sets out guidance for engagement in service change. It describes the different levels in the process: informing and engaging and consulting. This plan recognises that the overall strategy describes the key issues and the broad themes that need to be considered. It recognises that the strategy provides a direction for the next five to ten years, but not the detail which will affect patients and carers. The detailed development of options for service change for particular services will need to be taken forward by each of those services. It is the respective services which will need to engage staff and patients, carers and partners in the development of options.

A Strategic Programme Board has been formed which includes membership from patients, voluntary organisations, NHS staff and local authorities. The remit includes:

- Oversee the process for the development of “How we treat people” – a strategic approach 2011-2021
- Prioritise and co-ordinate work streams and services and investments in line with the Strategy and Financial Plan
- Develop policy in relation to investment priorities
- Monitor the implementation of the Clinical Strategy by means of a suite of high level indicators and targets reflecting all work streams
- Ensure strategic linkage with other Planning functions
- Ensure strategic linkage with other internal committees such as the Productivity and Efficiency Group, Improving Care Investing in Change Executive Group and Service Redesign Committee of NHS Lothian.

### 8.1 Informing

The informing stage began in 2011 with some discussion on the challenges faced by the NHS and the broad themes that need to influence the model of care. This took place at a workshop with patients, public representative and voluntary organisations in August 2011 and at meetings with staff, forums and committees. The informing stage will continue to ensure wider understanding by the public and communities of the challenges being faced.

This will take place through a variety of communication methods such as:

- Engagement with the media
- Use of the NHS Lothian Website
- Use of the NHS Lothian Social Media sites (Facebook, Twitter)
- Use of the Health Link external newspaper
- Liaison with local and nationally elected members
- Use of TV Screens within some clinical settings

The opportunity to attend community groups and patient and public forums through 2012 will also be sought to continue to inform people of the challenges and broad direction being taken.

\(^{16}\) Informing Engaging and Consulting People in Developing Health and Community Care Services – CEL (4) 2010)
8.2 Engaging
In order to meet the challenges outlined earlier in the strategy document, different service models will need to be explored, re-assessing the locations for health and care delivery with a key focus on integration around patient pathways, partnerships, and greater emphasis on the development of primary care and community services.

The key focus for the strategy will therefore be on particular services and their need to engage. Each of these will need to follow the guidance CEL (4 2010) to involve people, including staff in the development of options. Whether there will need to be wider consultation and whether it would be considered major service change is not known at this stage. It will be dependent on the outcome of the engagement stage and the outcome of assessment against the guidance checklist for major service change developed by the Scottish Health Council.

8.3 Next steps
Following identification of work streams / services each will develop a communication and engagement plan to ensure the involvement of affected patients, carers, voluntary organisations and staff in the development of the options. The respective services will also take note of any previous engagement and patient experience evidence, together with any clinical, financial and government policy. Realistic timescales will need to be set out at the start to ensure appropriate, proportionate and manageable engagement.

Following the development of options, the next step will be to determine the affect on other work streams / services and therefore the breadth of any consultation required. At that stage consultation plan/s for individual or collective service proposals will be set out in accordance with the CEL 4 (2010).
9. Our policy context – The Next 10 Years

In September 2011, the Cabinet Secretary for Health, Wellbeing and Cities set out the strategic narrative and vision for achieving sustainable quality in the delivery of healthcare services across Scotland. The vision 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.

The commitment towards creating a mutual NHS, which places patients at the centre of their own care, has allowed for greater partnership working between clinicians, patients, carers and their families. This concept also includes the emphasis on stronger public involvement in the design and delivery of health services and the value that can be added by such participation\(^\text{17}\). This has been further supported through the **National Patient Experience Programme (Better Together)**, which obtains patients feedback on their experience and seeks to ensure NHS Boards learn lessons and improve that experience. The **Patient Rights (Scotland) Act 2011**, reaffirms this partnership and the healthcare principles to be followed e.g. that patients’ needs, circumstances, opinions and abilities must be taken into account when they receive healthcare and that healthcare should be based on current clinical guidelines and standards.

NHS Scotland aims to deliver the highest quality of healthcare services to people in Scotland and, through this, to be recognised as amongst the best in the world. The **NHS Scotland Quality Strategy** emphasizes that quality is at the core of the purpose and ethos of the NHS. It establishes the commitment to ensuring that the way in which people receive healthcare is as important as how quickly they receive it.

Through the implementation of the strategy, people will be encouraged to be partners in their own care and can expect to experience improvements reflecting the things they have said they want and need from their health services:

- Caring and compassionate staff and services;
- Clear communication and explanation about conditions and treatment;
- Effective collaboration between clinicians, patients and others;
- A clean and safe care environment;
- Continuity of care; and
- Clinical excellence.

\(^{17}\) Better Health, Better Care:2007
The strategy identifies the internationally recognised dimensions of healthcare quality for particular focus:
- Safe
- Person Centred
- Efficient and effective
  (timely and equitable are already priorities);

The report from the Christie Commission on the future delivery of public services set out the message that our public services ‘are in need of urgent and sustained reform to meet unprecedented challenges’\(^{18}\). It goes on to note radical changes are required in the design and delivery of public services in order to tackle the deep-rooted social problems within our communities. A key finding in the report was an acknowledgement that there is a lack of emphasis on preventative measures. The report estimates up to ‘40% of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach’.

The focus on prevention applies to all health needs and care groups - prevention of those indicators of health risk now – smoking, obesity, lack of exercise, alcohol and drug misuse – which are linked to early and unnecessary morbidity and mortality in the population, and particularly associated with those groups who are less likely to access help for health issues at an early stage.

The recent Statement of Ambition\(^{19}\) from Scottish Government and CoSLA sets out the need for effective community planning arrangements to be at the core of public service reform. It notes the need for Community Planning Partners to drive the pace of service integration, increase the focus on prevention and secure continuous improvement in public service delivery, in order to achieve better outcomes for communities. Community Planning and Single Outcome Agreements (SOAs) will be the basis for partnership working for wider reform initiatives, such as integration of health and adult social care and the establishment of single police and fire services.

Getting it right for every child (GIRFEC) is a national programme to improve outcomes for all children and young people in Scotland. It threads through all existing policy, practice, strategy and legislation affecting children, young people and families, with the aim of improved outcomes for children and young people and ensuring resources are used more effectively and efficiently. Getting it right for every child requires a positive shift in culture, systems and practice across the managers and practitioners who work in frontline services for children, young people and families.

Scottish Government also has set out key policy goals of the Reshaping Care for Older People approach;
- Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting.
- To optimise the independence and wellbeing of older people at home or in a homely setting. This will involve a substantial shift in focus of care from institutional settings to care at home – because it is what people want and provides better value for money.

\(^{18}\) Commission on the Future Delivery of Public Services 2011
\(^{19}\) Statement of Ambition – Scottish Government & CoSLA, March 2011
In December 2011, the Scottish Government announced their intention on the Health and Social Integration, which will see Community Health Partnerships replaced by Health and Social Care Partnerships. The Partnerships will be the joint responsibility of the NHS and local authority, and will work in partnership with the third and independent sectors. A single, jointly appointed, senior accountable officer in each Partnership will ensure that partners' joint objectives are delivered.

The Partnerships will initially focus on improving older people's care and are set to include measures such as reducing delayed discharges, reducing unplanned admissions to hospital and increasing the number of older people who live in their own home rather than a care home or hospital. To support this, NHS Boards and local authorities will be required to produce integrated budgets for older people's services. Alongside this, the role of clinicians and social care professionals in the planning of services for older people will be strengthened.

In summary, the key messages to emerge from the overall national policy context are the need to ensure patients and the public remain at the heart of services; there requires to be greater focus on prevention and early intervention; the shift in balance of care is towards community settings for all age groups; there is still work to be done on tackling inequalities; and all of this needs to be taken forward through integrated partnership working. NHS Lothian, through CH(C)Ps and partners are well placed to respond to this policy agenda.
Appendix 1

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
- Lothian Partnership Forum
- 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
- 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

Planned events
- Edinburgh Health & Social Care SMT
- Lothian Partnership Forum
- Edinburgh Partnership Board
Strategic context, drivers & enablers:

Outcomes:
- Person Centred
- Safe
- Effective

Lifestages:
- Early Years
- School Age
- Working Age
- Older People

Programmes/ Factors:
- Obesity
- Cancer
- Disabilities
- Long-term Conditions
- Substance Misuse
- Alcohol
- Mental Health
- Sexual Health
- Medicine
- Surgery

Pressures:
- Waiting Times
- Accident & Emergency
- Delayed Discharge
- Workforce
- LRP
- In-patient flow
- Prescribing costs

Settings:
- Home/ Community
- Primary Care
- Acute Hospitals
- Inpatient Complex Care
- Community & Specialist Hospitals

External:
- Inequalities
- Demographics
- Finance
- Integration
- Prevention
- Mutuality
- Patients Rights

Enablers:
- Staff
- Patients
- Public
- Partners
- Technology
- Pathways
- Redesign
- LEAN
- Resources
- Comms
Future State Emergency Care Model:

HOME:
- Self-care
- Primary care
- Social care
  (prevention, telehealth and telecare, early intervention, health improvement)

Accident & Emergency
Minor Injuries

LUCS
NHS24
SAS

Acute Hospital
In-patient care/specialties
(LOS >=75th percentile)

CAA
PAA
ARAU
MAU

Community Hospital
Rehabilitation
(LOS >=75th percentile)

Intermediate Care/Step Down Facility

<4 hours
12 - 48 hours
24hrs - 5 days
>5 days

Residential Care / Long-term care
(LOS <2 years)

HOME:
- Self-care
- Primary care
- Social care
  (reablement, crisis care, health improvement, telehealth and telecare)

Community Hospital Rehabilitation

Intermediate Care/Step Down Facility

<4 hours
12 - 48 hours
24hrs - 5 days
>5 days

Residential Care / Long-term care
(LOS <2 years)
KEEPS WELL – TARGETED INTERVENTIONS
The overall aim of Keep Well was to reduce premature mortality and morbidity from cardiovascular disease in areas of deprivation. Locally, Keep Well delivered 25,532 cardiovascular health checks to patients aged 45-64, in areas of deprivation, by the end of September 2011.

Keep Well in Lothian recruited 129 participants to investigate self-reported behaviour change twelve months after receiving a check. The survey found 87% of patients reported they were overweight, 94% made changes to their diet following a Keep Well check and 75% reported that this was as a direct result of attending Keep Well. Looking at physical activity levels, 67% reported that they were now meeting physical activity guidelines; of these, 54% made changes to their activity levels following a Keep Well check.

From April 2012, we will deliver five yearly review checks to everyone resident in the 15% most deprived datazones in addition to new checks. The team will also complete review checks for those at high risk of cardiovascular disease. Two small review pilots have been carried out locally for individuals at high risk. Feedback from patients was positive and most had made at least some lifestyle changes.

DERMATOLOGY SERVICE REDESIGN PROGRAMME 2009/10
Additional capacity was released from the existing service resources to see more patients after the team’s lean improvement work starting in 2009:

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>1215</strong></td>
<td>Additional outpatient appointments</td>
</tr>
<tr>
<td><strong>176</strong></td>
<td>Nurse-led biopsy slots</td>
</tr>
<tr>
<td><strong>420</strong></td>
<td>Nurse-led cryotherapy slots</td>
</tr>
<tr>
<td><strong>500</strong></td>
<td>30-minute dressing slots</td>
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</tbody>
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- Service is now meeting all access targets without additional funding.
- Resulted in **£258,000** cost avoidance due to team “working smarter”.

Improved patient experience and appointment choice introduced, by expanding Patient Focused Booking (PFB) to all sub specialties:

- Popular with patients, who often say that they would like to be able to do the same in other specialties.
- A reduction in number of calls from patients needing to check if referrals have been received, and trying to rearrange appointments.
- The service is able to get accurate contact information (e.g. mobile phone numbers) and periods of patient unavailability direct from patient.
- New patient did not attend rate has reduced from average 8.9% to 5.8% (target is 8%).