

Achieving Excellence

A plan for person-centred, innovative healthcare to help Lanarkshire flourish

MARCH 2017



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Foreword

It is five years since NHS Lanarkshire published “A Healthier Future – A Framework for Strategic Health Planning” which set out a route map to improve the quality of the services we provide, while also setting out our plans for meeting the future health needs of the Lanarkshire population.

In that time, we have seen important changes in the way in which health and social care is planned and delivered. The needs of the population, and the way in which clinical services are provided, have also moved on. So, in 2016 NHS Lanarkshire revised and refreshed the Healthcare Strategy, looking to the future healthcare needs of the population. Our vision is to ensure these services are safe, effective, person-centred and sustainable.

Our aim in Lanarkshire is to develop a healthcare system that supports the development of an integrated health and social care system which has a focus on prevention, anticipation and supported self-management. With the appropriate use of health and care services, we can ensure that patients are able to stay healthy at home, or in a community setting, as long as possible, with hospital admission only occurring where appropriate.

During 2015 and 2016, Lanarkshire NHS Board collaborated with patients, carers, staff and its partners to refresh the vision as to how services should and could change over the next ten years. We recognise and acknowledge the valuable role played by carers and this is reflected in our ambitions for the future.

We carried out a three-month consultation on the content of the draft Healthcare Strategy. There were some strong themes which came from the consultation, for example with respect to supporting carers and improving transport links, and these led to changes to the strategy. A summary of that consultation and its conclusions is described in section 9, and is reflected in significant revisions to the strategy document itself.

“Achieving Excellence” summarises our future plans, which will play an important role in improving health and social care alongside - and integrated with - the two Strategic Commissioning Plans for Health and Social Care North Lanarkshire and South Lanarkshire Health and Social Care Partnership. Other key influences on this work are both The National Clinical Strategy for Scotland, and the Health and Social Care Delivery Plan, both published by the Scottish Government in 2016. The key stages to implementing these plans are described in section 7.

Our foremost ambition is to ensure we are successful in turning this strategy into positive changes for the communities of Lanarkshire.

Finally we would like to thank those who have helped shape the strategy, the people who responded to the consultation, and the many staff involved in developing the workstreams.

Mrs Neena Mahal, *Chair of Lanarkshire NHS Board*

Councillor Harry McGuigan, *Chair of North Lanarkshire Joint Integration Board*

Councillor Jackie Burns, *Chair of South Lanarkshire Integration Joint Board*

The Case for Change



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1 THE CASE FOR CHANGE

Introduction

In Scotland, just as in the rest of the developed world, health and social care services are facing a rising tide of demand which is driven by demographic changes, advancing medical science and new technologies, at a time of constrained resources. As people live longer, healthy life expectancy is not advancing at the same pace. This means that we will have more people, many of whom are older, living with multiple long-term conditions and often complex needs, who will be reliant on support and intervention from health and social care services. If we do not change our approach by shifting the balance of care away from acute hospital-focused care to one where there is a greater emphasis on prevention and community-based intervention, then NHS Lanarkshire would need an additional 500 acute hospital beds by 2025 – equivalent to a fourth district general hospital in the county. This is not achievable, affordable or desirable given that the people of Lanarkshire have clearly stated that¹, where it is safe to do so, they would like to receive their care at home.

These circumstances mean that all public sector services need to adapt and innovate in order to ensure that the highest standards of treatment and care continue to be delivered. Scottish Government has commissioned a number of strategic reviews, including the Christie Commission²; the Healthcare Quality Strategy for Scotland³; Everyone Matters: 2020 Workforce Vision⁴, the National Clinical Strategy for Scotland (2016)⁵; the Health and Social Care Delivery Plan⁶ and the Carers (Scotland) Act to provide a road map to support future public service reforms that ensure safe, effective, person-centred and sustainable services are delivered through a workforce that has the right skills and competencies and is able to achieve the best possible outcomes for our patients.

Aim

Our aim in Lanarkshire is to develop a healthcare strategy that supports the development of an integrated health and social care system which has a focus on **prevention, anticipation and supported self-management. With the appropriate use of health and care services we can ensure that patients are able to stay healthy at home, or in a community setting, as long as possible, with hospital admission only occurring where appropriate.**

This healthcare strategy is one part of a trilogy of plans, with essential co-dependencies between this and the Joint Strategic Commissioning Plans produced by the North and South Lanarkshire Health and Social Care Partnerships (HSCPs). The Chief Officers of the HSCPs and NHS Lanarkshire are co-authors of this strategy (see section 3 for more information).

The plans are based on the assessed needs of our communities and are designed to ensure that the right mix and volume of services are delivered to best meet the changing needs of our population. At the same time as focusing on local priorities, the Lanarkshire healthcare strategy will take full account of the National Clinical Strategy and the Health and Social Care Delivery plan which set out the principles that will underpin clinical service changes across Scotland. Future services, locally and nationally, will have:

- system-wide drive for improvement across disease prevention, early professional intervention, supported self-care and improved rehabilitation
- primary care with a more prominent role, treating more people without the need to refer to hospital
- secondary care organised in ‘centres of excellence’ and networks of hospitals providing specific clinical services (as opposed to all clinical services as at present) thus making best use of skilled staff and specialised facilities and equipment to produce excellent outcomes
- a new clinical paradigm which will ensure that patient value is enhanced by proceeding with minimally disruptive, realistic medicine.

Lanarkshire Quality Approach

NHS Lanarkshire is committed to delivering world-leading, high-quality, innovative health and social care that is person-centred. Our ambition is to be a quality-driven organisation that cares about people (patients, their relatives and carers, and our staff) and is focused on achieving a healthier life for all. Through our commitment to a culture of quality we aim to deliver the highest quality health and care services for the people of Lanarkshire.

Our focus on quality is not new, but sometimes it has meant different things to different people. We have therefore developed a Strategic Framework called the Lanarkshire Quality Approach. It will underpin all of the work that the organisation does. It will ensure that the decisions the organisation takes, the services we provide and the way in which we do so, align with the values at its core. This means that when we plan and redesign our services, the organisation’s key principles will inform any changes we make. It provides the structure and values to drive healthcare improvements such as those described in this Strategy.

People at the Heart of our Approach

The Lanarkshire Quality Approach sets out core values and principles and will ensure these reflect our aim to provide assurance to the public, the Board and Ministers that as a quality organisation we demonstrate:

- A caring and person-centred ethos that embeds high quality, safe and effective care
- That we continually strive to do the best individually and collectively
- That we accept individual accountability for delivering a service to the best of our ability
- That we are responsive to changing culture, expectations and needs

Quality Driven Aims

We have identified four strategic aims to achieve our vision, which have as pre-requisite criteria the NHS Scotland Quality Strategy ambitions of being person-centred, safe and effective along with the requirement to improve efficiency and to achieve financial sustainability by doing the right thing, on time and within budget. These strategic aims are:

- to reduce health inequalities and improve health and healthy life expectancy
- to support people to live independently at home through integrated health and social care working

- for hospital day case treatment to be the norm, avoiding admissions where possible
- to improve palliative care and support end of life services

Our underpinning quality ambitions are to deliver person-centred, safe and effective care. For us this means:

- person-centred – mutually beneficial partnerships between patients, their families, carers and those delivering health care services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision making;
- safe – there will be no avoidable injury or harm to people from the health care they receive and an appropriate clean and safe environment will be provided for the delivery of health care services at all times;
- effective – the most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit and wasteful or harmful variations will be eradicated

We believe that our shared pursuit of these three quality ambitions will make significant and positive impacts on efficiency and productivity and through this we will secure both improved outcomes for the people we serve and financial sustainability for the organisation.

Our Values

It is not only what we do that is important; the way we do things also matters enormously. The NHS Lanarkshire values of Fairness, Respect, Working Together and Quality underpin our purpose, providing local focus and context for the improvement of our services and guiding our individual and team behaviours.

For us this means:

- **Fairness:** Ensuring clear and considerate decision making at all levels
- **Respect:** Valuing every individual and their contribution
- **Quality:** Setting and maintaining standards in everything we do
- **Working Together:** Thinking, growing, delivering as a team

How will we get there?

We are committed to establishing a connected infrastructure that supports the organisation to deliver on its ambition of putting quality at the heart of the organisation. The components of this infrastructure include:

- **Leadership and Behaviours** – To bring the culture to life the quality ambitions must be demonstrated in day to day behaviours “from board room to the patient”. We will ensure that leaders at all levels in the organisation are empowered to work in this way
- **Improvement and innovation** – We will use a consistent approach to improvement throughout the organisation that reflect all stages of the improvement journey and apply to continuous daily improvement as well as large-scale transformational change
- **Communications and Engagement** – To support our approach we will implement a comprehensive communication and engagement plan in order to promote our organisational purpose and quality ambitions and develop even further our partnership with patients, the public, staff, professional

advisory committees, local authorities, general practitioners, general dental practitioners, third and independent sector, carer organisations and elected representatives

- **Information** – We collect a range of data on the services we provide. This information can support us to measure how the Strategic Framework is being applied to give the Board confidence that the organisation is planning and delivering within the aspirations of the Framework
- **Knowledge and skills** – We want our staff to be the most caring, knowledgeable and skilled workforce in Scotland. We are committed to ensuring staff are provided with the appropriate knowledge, skills and confidence to deliver high quality services on a day to day basis and at the same time continuously improve those services.

These themes are intended to illustrate areas of action that will enable us to achieve the cultural changes needed to sustain the organisation with quality at its heart.

In summary, the Lanarkshire Quality Approach provides a clear outline of the vision, mission, values and objectives of our organisation. It is important that we are clear with ourselves and others about our vision and the key values and objectives we believe will enable us to deliver good quality, person-centred care. In order to provide this clarity we have developed a visualisation of the Lanarkshire Quality Approach as shown below.

The Lanarkshire Strategic Framework



References

- 1 NHS Lanarkshire Online survey, 2016
- 2 Commission on the Future Delivery of Public Services. Edinburgh: Scottish Government, 2011.
- 3 The Healthcare Quality Strategy for Scotland. Edinburgh: Scottish Government, 2010.
- 4 Everyone Matters: 2020 Workforce Vision. Edinburgh: Scottish Government, 2013.
- 5 A National Clinical Strategy for Scotland. Edinburgh: Scottish Government, 2016
- 6 Health and Social Care Delivery Plan. Edinburgh: Scottish Government , 2016

The Changing Health & Social Care Needs of the People of Lanarkshire



2

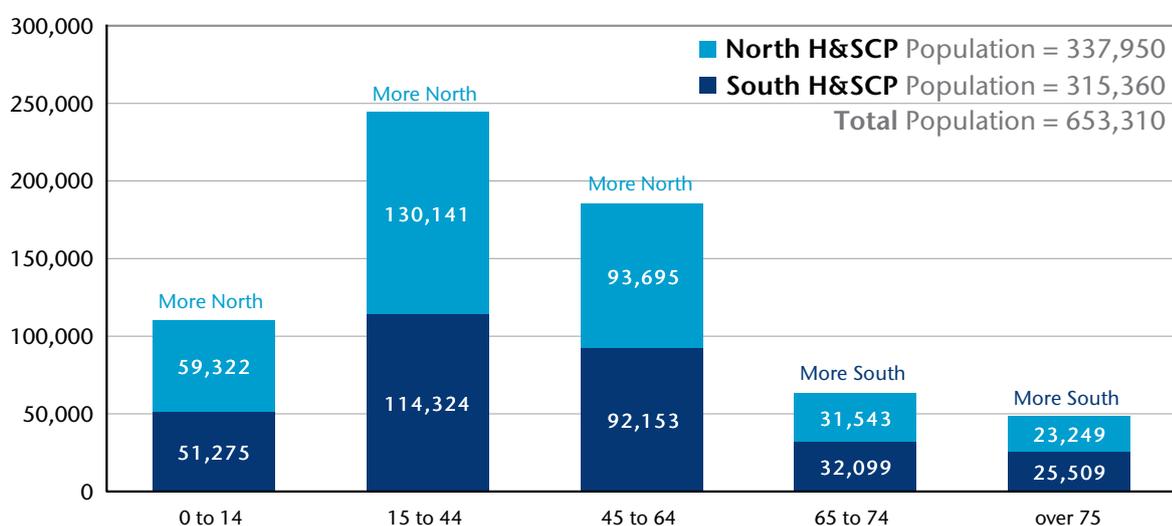
2 THE CHANGING HEALTH & SOCIAL CARE NEEDS OF THE PEOPLE OF LANARKSHIRE

2.1 Population Profile

The population of Lanarkshire is 654,490 with 338,260 people living in North Lanarkshire and 316,230 in South Lanarkshire.

Figure 1 outlines the population by age group and by health & social care partnership area. There are more people aged less than 65 years living in North Lanarkshire when compared to South Lanarkshire, whereas more people aged 65 years and over live in South Lanarkshire when compared to North Lanarkshire.

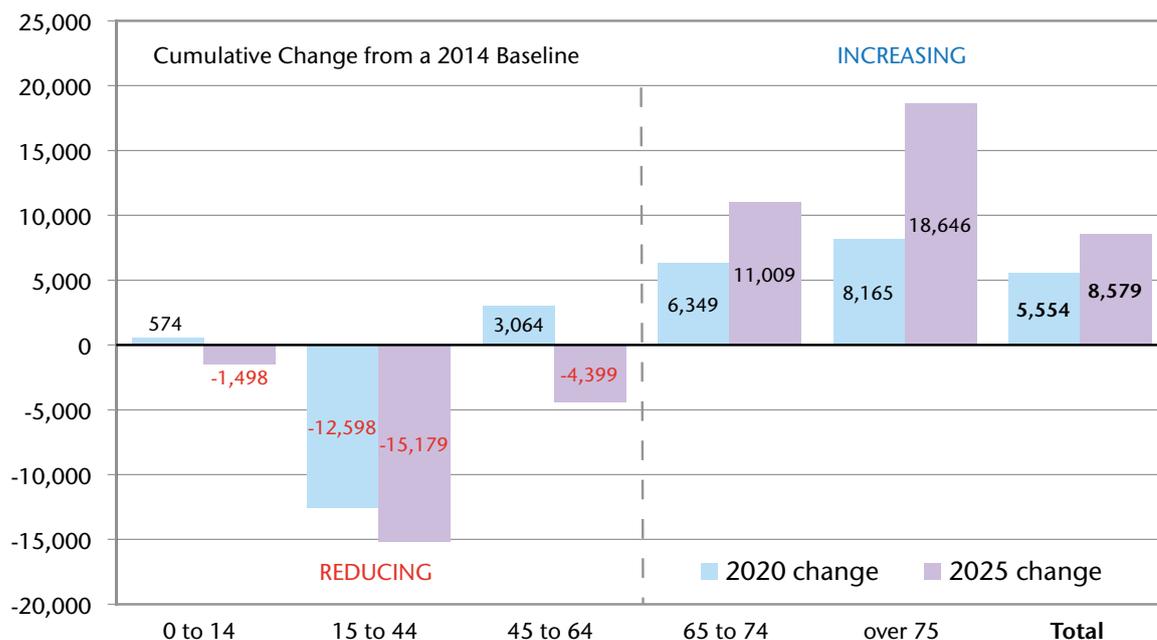
Figure 1: Population of NHSL by age group and health and social care partnership areas



The total population is expected to increase by only 1% by 2025.

Using 2014 data as a baseline, figure 2 overleaf illustrates that there will be falling numbers of people aged under 65 years and more people aged 65 and over in future years.

Figure 2: Predicted cumulative population change from 2014 to 2020 and 2025 by age group



2.2 Birth and Death Rates and Life Expectancy in Lanarkshire

Births

There were 6,901 babies born in Lanarkshire in 2015. This number will fall over the coming decade. The overall birth rate in Lanarkshire was 56.5 births per 1,000 women compared to the Scottish birth rate of 53.9.

Deaths

There were 7,121 deaths recorded in NHS Lanarkshire residents in 2015. There is considerable variation in death rates across the different localities in Lanarkshire, which largely reflects differences in deprivation levels.

Deaths rates from the so-called ‘big killer’ diseases of cancer, coronary heart disease (CHD) and stroke continue to fall but still caused almost half of all deaths in 2015.

Individually, cancer, CHD and stroke were responsible for 29%, 12% and 7% respectively of all deaths in Lanarkshire. Respiratory disease was also a significant cause of death in 2015, being responsible for 14% of all deaths.

While there is some evidence of improvement in death rates for cancer, CHD and stroke, the death rates for respiratory disease in Lanarkshire remains significantly higher than that for Scotland. It is estimated that there will be an increase in the incidence of all cancers by 33.5% by 2027, mainly as a result of the population growing older.

Life expectancy

As is the case across Scotland, life expectancy continues to increase in Lanarkshire. A male infant born in Lanarkshire in 2012 could expect to live to 75.8 years of age, while a female infant could reasonably be expected to live to be 80.0 years old. This represents an increase across a 10-year period of 2.9 years for males and 2.1 years for females in Lanarkshire. However, life expectancy is still below national levels; both males and females in Lanarkshire live on average a year less than others in Scotland.

There are significant inequalities in life expectancy for those living in some of our most deprived areas when compared to our least deprived areas. For example, life expectancy for a man living in one of our most deprived communities is 68.2 years compared with a life expectancy of 81.1 years for men living in one of our most affluent communities.

KEY POINTS

- The NHS Lanarkshire total population is expected to increase by only 1% by 2025
- There will be fewer children in the future population
- There will be fewer people of working age in the future
- The elderly population will be growing at the fastest rate in the future – while greatly welcomed, this population will proportionately need most healthcare resources
- The over 75s population is expected to grow by 11% by 2020 and 29% by 2025
- The growth rate for the elderly population is higher in Lanarkshire when compared to Scotland as a whole
- Life expectancy is increasing in Lanarkshire
- The life expectancy gap between Lanarkshire and Scotland is not closing
- There are stark differences in the life expectancy of those living in our most deprived areas compared with the least deprived

2.3 Inequalities and Social Issues

The Lanarkshire population profile is poorer than the national average for many indicators. For example, NHS Lanarkshire is significantly worse than the average for:

- smoking attributable deaths
- deaths from alcohol conditions
- children living in poverty

There are exceptions, however, such as the number of people with high levels of need being cared for at home, child dental health in primary school and immunisation uptake for '5 in 1' vaccination at 24 months in which NHS Lanarkshire is better than the national average.

The link between inequalities and poverty to poor health has been firmly established. Inequalities lead to poorer health and increased demands upon clinical services.

Lanarkshire has many challenges to face. For example, 20% of people in Lanarkshire live in one of Scotland's most deprived datazones; there are 1,440 looked-after children in Lanarkshire.

Inequalities go beyond socio-economic deprivation issues. There are, for example, particular groups in our communities such as homeless and travelling people who experience poorer health outcomes.

The work of the Health and Social Care Partnerships (HSCPs), the Community Planning Partnerships and of people in their communities is vital in addressing inequalities and is inextricably linked to the success of this strategy. Detailed analysis of this work can be found in both North and South Lanarkshire HSCPs' respective Strategic Commissioning Plans.

KEY POINTS

- The health consequences of poverty are well documented and NHS Lanarkshire faces major challenges to deliver healthcare due to levels of poverty and inequalities within its communities
- NHS Lanarkshire and its partners will strive to deliver services that are responsive to needs and that contribute to the reduction in inequalities in health.

2.4 The Ageing Population

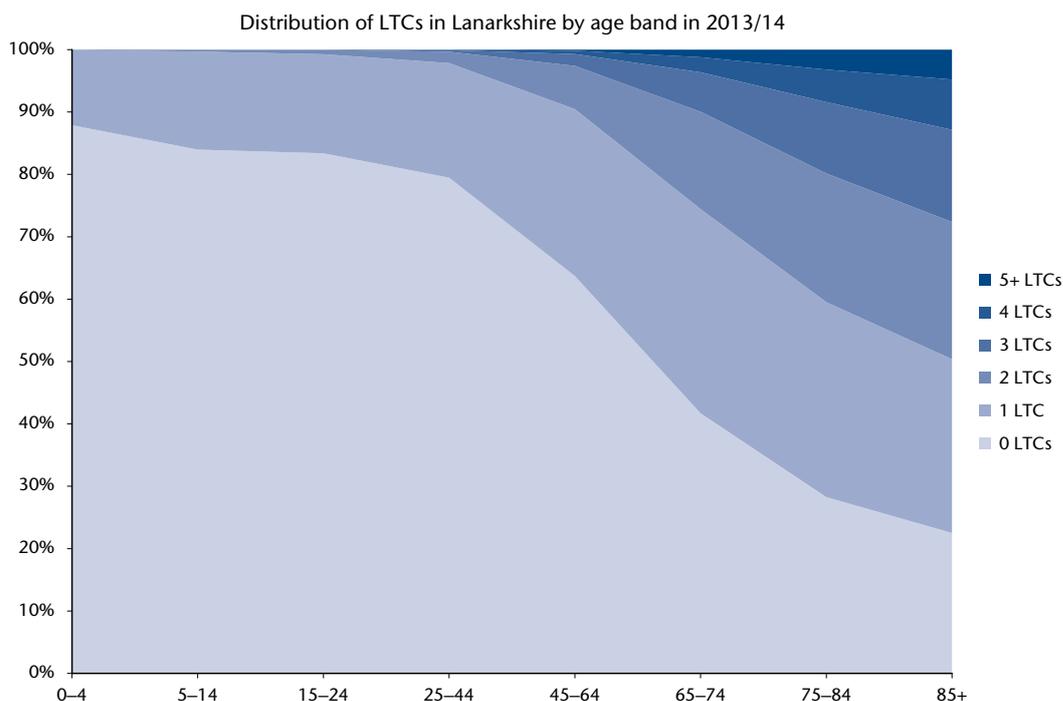
As described, we will see more people surviving into old age, often continuing to contribute to our communities as carers. It will be the role of our health and social care services to support people as they grow older to help people to maintain an active and enjoyable old age. However, this will mean we will have to adapt these services. Diseases such as dementia, hip fractures, Parkinson's, stroke and frailty generally have a strong age correlation. In addition, multi-morbidities (the possession of more than one chronic disease) are increasingly common amongst older adults leading to increased vulnerability to acute illness as well as a risk of dependence or disability.

For the care sector, impaired health resulting in disability can lead to increased demands on care at home or admissions to long term care.

Sustaining services to promote healthy ageing, active social involvement, management of acute illness, rehabilitation and ultimately palliation must be done with the patient and carer at the centre and with the aim of maximising a healthy, engaged and independent old age.

Figure 3 provides an indication of the distribution of those adults living with long term conditions (LTC) by age group.

Figure 3: Relationship between a person’s age and number of long-term conditions



KEY POINTS

- The people of Lanarkshire will live longer, but the burden of disease in later life will increase the proportion of people with long-term health conditions.
- The ageing of the population presents potentially the single biggest challenge to the health and care sector in the first half of the 21st Century.

2.5 Significant Risk Factors and Issues

The risk to individuals of developing the major life-threatening illnesses (cancer, coronary heart disease and respiratory illness) can be reduced by not smoking; being a healthy weight; being physically active; drinking within recommended levels of alcohol; and maintaining a healthy diet and good mental health.

Tobacco

Tobacco smoking remains the most significant preventable cause of ill health in Lanarkshire, accountable for approximately one quarter of all deaths.

Smoking prevalence in Lanarkshire is 21.3% compared to the national average of 20.2% with males and all age groups not significantly different from their respective Scottish averages.

Obesity

Approximately 65% of adults in Lanarkshire are overweight (including obese). The proportion of adults who will be overweight (including obese) will be 87.5% by 2050.

The percentage of total NHS spending on obesity related conditions such as Type 2 diabetes, heart disease and stroke was 9% in 2015 and is expected to rise to 12% by 2050.

Significant efforts are required to create environments that support good health by promoting healthier eating and increasing levels of physical activity to reduce numbers of overweight and obese people.

Alcohol and Substance Misuse

Levels of alcohol consumption in Lanarkshire, as in the rest of Scotland, are falling. Fewer people are exceeding weekly drinking guidelines and the average number of mean units consumed is falling, both for men and women. While this is a welcome trend, it does mask a greater tendency in Lanarkshire than in the rest of Scotland to exceed daily drinking guidelines.

The rate of deaths directly attributable to alcohol-related causes such as liver disease continues to be higher in Lanarkshire than in Scotland overall, and is of particular concern in North Lanarkshire. The outcomes for health issues related to alcohol and drug use are also worse in deprived areas. Similarly, the majority of drug-related deaths occur in areas with the greatest levels of multiple deprivation.

Mental Health and Learning Disabilities

There is no health without mental health: every part of the health and social care system is required to play a more active part in improving the mental health and well-being of the people of Lanarkshire.

One in five adults will have mental health care needs at some point in their life. It is estimated that there are 10,000 people with dementia living in Lanarkshire and that approximately 17,000 people may have a learning disability. The number of people with learning disabilities is likely to grow by 14% by 2021: advances in medical science and care mean that many more people with learning disabilities are living longer, more fulfilled lives than has ever been the case before.

Improvements are being made in Lanarkshire with fewer people self-reporting common mental health problems and more self-reporting improved levels of wellbeing and life satisfaction. The modernisation programme in mental health, which invested across the various tiers of service provision, has resulted in the delivery of more prevention and early intervention programmes, improved access to self-help, social prescribing, group based and telephone support and enhanced access to community based mental health and psychological therapy service.

KEY POINTS

- Smoking is reducing, but remains a major cause of life-threatening illness
- Increasing obesity will impact on both health and social care
- Alcohol and substance misuse presents major challenges for the delivery of healthcare
- Significant effort is required to promote good mental health and well-being and provide supports to people with mental ill health or a learning disability

What Will Success Look Like?

- Life expectancy for men and women to be similar to that of the Scottish population, with the greatest improvement among those living in our most deprived areas
- Smoking prevalence to continue to reduce and achieve the same level as the rest of Scotland
- To work with Community Planning Partners to reduce the number of children living in poverty to, at least, the Scottish average, with specific focus on those who are most deprived
- To achieve the Scottish average for the prescription of drugs for anxiety, depression and psychosis
- To improve the mean mental wellbeing score as measured by the Scottish Health Survey to that of the national average
- To work with Scottish Government and Community Planning Partners to reduce the predicted rate of increase in the population who are either obese or overweight
- To enable those with long term conditions to manage their conditions in the community and reduce their reliance on acute services.

The Role of Health and Social Care Partnerships



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3 THE ROLE OF HEALTH AND SOCIAL CARE PARTNERSHIPS

The Scottish Government Vision for Health and Social Care Integration:

‘Ensuring better care and support for people where users of health and social care services can expect to be listened to, to be involved in deciding upon the care they receive and to be an active participant in how it is delivered. This will result in better outcomes for people, enabling them to enjoy better health and wellbeing within their homes and communities.’

Integration of health and social care is the Scottish Government’s programme of reform to improve services for people who use adult health and social care services. The Public Bodies (Joint Working) (Scotland) Act was granted royal assent on 1 April 2014. That means changes to the law which require health boards and local authorities to integrate these services. The Act is a landmark adult health and social care reform for Scotland and is the most substantial reform to the country’s national health services and social care services in a generation.

One of the main aspects of the Public Bodies (Joint Working) (Scotland) Act is to create statutory Integrated Joint Boards in each local authority area replacing Community Health Partnerships (CHPs). 1 April 2015 marked the conclusion of a highly successful era in the delivery of community health services in Lanarkshire. As the integration of health and social care came into effect, the respective North and South Lanarkshire Integrated Joint Boards superseded Lanarkshire’s North and South Community Health Partnerships (CHPs).

There are nine national outcomes that provide a framework for measuring the impact of integrated health and social care on the health and wellbeing of individuals:

- 1 People are able to look after and improve their own health and wellbeing and live in good health for longer
- 2 People, including those with disabilities or long term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- 3 People who use health and social care services have positive experiences of those services, and have their dignity respected
- 4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- 5 Health and social care services contribute to reducing health inequalities
- 6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- 7 People who use health and social care services are safe from harm

- 8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- 9 Resources are used effectively and efficiently in the provision of health and social care services

The Integrated Joint Boards are the bodies that are responsible for planning and have operational oversight of integrated care. They will decide which integrated services will be provided, how they will be funded and what they should look like and will direct the NHS Board and local authority to deliver those services. They will report annually against progress towards the nine national outcomes.

The table below describes which Lanarkshire services will be delivered or commissioned by the HSCPs.

Figure 4: Responsibilities of the two HSCPs in Lanarkshire

Community based health services	Hospital based health services	Community based social work services
<ul style="list-style-type: none"> • Allied Health Professionals (in an outpatient department, clinic or outwith a hospital) • Care Home Liaison service • Community Addiction services • Community based Geriatric Medicine • Community based Paediatrics • Community based Palliative care • Community Children’s Health services • Community Learning Disability services • Continence service • Diabetes service • Dietetics • District Nursing • GP out of hours • Health and Homelessness • Health Visiting • Mental Health and Learning Disability • Ophthalmic services • Pharmaceutical services • Primary Care Administration • Primary Care out of hours • Primary Medical services • Prisoner Healthcare • Psychology • Public Health – Health Improvement • Public, General and Community Dental services • Sexual & Reproductive Health and Blood Borne Viruses • Traumatic Brain Injury 	<ul style="list-style-type: none"> • Accident & Emergency (A&E) • General Medicine • GP Inpatient services • Hospital based Addiction / Dependence services • Hospital based Geriatric Medicine • Hospital based Mental Health services (including low secure forensics) • Hospital based Paediatrics • Hospital based Palliative Care • Occupational Health • Physiotherapy • Podiatry • Psychiatry of Learning Disability • Rehabilitation Medicine • Respiratory Medicine • Speech and Language Therapy 	<ul style="list-style-type: none"> • Addiction services • Adult Protection • Adults with Disability and Long Term Conditions • Care Home • Carers Service • Community Care Assessment and Planning • Contracted Support services • Day opportunities and day services • Equipments and Adaptations, Technology, Equipment and Telecare • Health and Wellbeing improvement • Homecare services • Housing support (some aspects) • Intermediate Care service • Mental Health services • Occupational Therapy

Core to the ethos of integration is a move towards locality-based planning, providing localities with the autonomy to identify priorities and shift resources within a coherent strategic context and with due regard to clinical and professional governance. Locality profiles have been developed as part of the Joint Strategic Needs Assessment, providing an assessment of activity, demand and resource within each of the ten recognised localities, six in North (Airdrie, Bellshill, Coatbridge, Motherwell, North - Cumbernauld, Kilsyth and the Northern Corridor - and Wishaw), four in South (Clydesdale, Hamilton East, Kilbride and Cambuslang/Rutherglen), supporting the identification of key actions to enable the delivery of better outcomes for the people of Lanarkshire.

The vision in Lanarkshire is to develop an integrated model that will put the person at the centre of decisions about their treatment and care, with greater understanding and confidence to manage their own condition, taking control of their life and having their voice heard. This will be supported by education and group programmes, harnessing the range of third sector and community assets, anticipatory care planning and greater use of technology, preventing or delaying the need to use more intensive services. We will promote the use of anticipatory care plans which enable individuals to develop a record of what they would like care providers to do following a clinical deterioration in their condition or a crisis in their care or support. This proactive approach aims to prevent the need for formal services arising, building resilience in both individuals and communities.

Where formal services are required, these will be integrated in localities, removing hand-offs and service barriers. The integrated model will support people to maintain their health and wellbeing in the community or their own home, with hospital services only required for real accidents and emergencies and some elements of specialist care. Components of acute care will also be delivered in the community, co-designed and embedded within the integrated community infrastructure.

The objectives and priorities set out in this Healthcare Strategy are one part of the overall programme to improve the health and social care for the people of Lanarkshire. The Strategic Commissioning Plans (SCP) developed by the Health and Social Care partnerships (working with the wider community planning partners) form the two other key components of this work and describe the actions that the Partnerships will undertake within the near future to improve health and tackle health inequalities to form the Strategic Commissioning Plans.

The South Lanarkshire Integration Joint Board, has agreed a vision which commits the partnership to **“working together to improve health and wellbeing in the community – with the community”**.

Through the strategic direction of the Integration Joint Board (IJB) there will be a conscious move towards commissioning based upon the achievement of better patient and client outcomes.

Ten emerging priorities are reflected in the South Lanarkshire SCP:

- 1 Statutory and core work
- 2 Early intervention, prevention and health improvement
- 3 Carers support
- 4 Models of self-care and self-management including telehealth and telecare
- 5 Seven day services
- 6 Intermediate care to reduce reliance on hospital and residential care
- 7 Suitable and sustainable housing
- 8 Single points of contact
- 9 Mental health and well-being
- 10 Enablers to support better integrated working

The implementation plan will ensure all commissioning intentions are linked to the 9 national outcomes and the 10 HSCP priorities.

Health and Social Care North Lanarkshire has identified the core aim of enabling “**safer, healthier, independent lives**” through locality-based engagement a series of commissioning priorities which will form the basis of the North Lanarkshire Strategy:

- 1 Development of integrated locality teams;
- 2 Strengthening rehabilitation within the community;
- 3 Reconfiguring Support at Home;
- 4 Bed Modeling;
- 5 Self Directed Support;
- 6 Universal Health Visiting Pathway;
- 7 Family Nurse Partnership;
- 8 Campaigns and messaging for the public;
- 9 Organisational development for staff;
- 10 Technical solutions and data sharing mechanisms to improve care delivery;
- 11 Implementation of the Carers (Scotland) Act 2016.
- 12 Community transport;
- 13 Telehealth and telecare services and solutions for people requiring support;
- 14 Community capacity building and carer support;
- 15 Supporting the redevelopment of Monklands.

You can find out more about these plans for North Lanarkshire at <https://mars.northlanarkshire.gov.uk/egenda/images/att85465.pdf>

What Will Success Look Like?

- Prevent avoidable admissions to hospital
- Improve timely discharge from hospital
- Support more people to remain at home
- Shift resources from a hospital to a community setting

Workstream Summaries



4

4 WORKSTREAM SUMMARIES

4.1 Introduction

During 2015 and 2016, Lanarkshire NHS Board asked service leaders to engage with their patients, carers, staff and partners to set out a refreshed vision of how their services should and could change over the next ten years.

This section of the Healthcare Strategy summarises that work. There is particular emphasis on what our priorities for improvement are to ensure we improve healthcare outcomes for the people of Lanarkshire. This programme for improvement has been developed alongside the plans set out in the Strategic Commissioning Plans for North and South Lanarkshire Health & Social Care Partnerships (HSCPs).

4.2 Primary Care: A Transformation Programme

Vision

The future model of primary care in Lanarkshire will help all clinicians to spend more time with their patients, less time on unwarranted bureaucracy and have each professional individually and collectively working to their full potential. It will promote the aims at the core of Scotland's Quality Strategy. Safe, effective and person-centred care will be delivered within a more collaborative health and social care system, and increasingly shaped at a community level.

Stronger primary care services are essential to: managing future demand; ensuring the success of community-based integrated working; and reducing the healthcare system's reliance on hospital beds. Multidisciplinary teams in health and social care will work together to meet the assessed needs of patients and it is this multidisciplinary team work which will deliver improved care for the future.

However, the future vision will only meet the needs of the population and the service if continuing investment is made in community based services and the entire health and care system is better coordinated. We also want to prevent ill health and reduce the burden of existing ill health. This requires a major change in the size and skills of our workforce, as well as major changes in the way that people access primary care services.

The implementation of this vision will be strengthened by the commitment of Scottish Government to spend an additional £500m on primary care services by 2021³.

Current Services

Primary health care provides the first point of contact in the health care system. This may be with a general practice doctor (GP), nurse, community pharmacist, optometrist, general dental practitioner, podiatrist, health visitor or other allied

health professional. As such, primary care is the largest part of the healthcare system.

The aim is to provide an easily accessible route to care, whatever the patient's needs. Primary health care is based on caring for people rather than specific diseases. This means that many professionals working in primary care are generalists, dealing with a broad range of physical, psychological and social problems, rather than specialists in any particular disease area. However, there are many specific services provided in primary care such as optometry or continence services. The GP is often seen as the ultimately responsible professional.

An important role of the GP is acting as the patient's advocate and co-ordinating the care of the many people who have multiple health problems. Since primary care practitioners often care for people over extended periods of time, the relationship between patient and practitioner is particularly important. Primary health care involves providing treatment for common illnesses, the management of long term illnesses such as diabetes and heart disease and the prevention of future ill-health through advice, immunisation and screening programmes. Through the variety of disciplines, it also provides input to rare illnesses and complex interventions to patients, carers or other health professionals.

Primary care also acts as a conduit to the opportunities for care provided by specialist hospital-based services, and it is these interconnections which are fundamental to the effectiveness of the entire health system. The GP is often seen as the route to more specialised care.

The Need for Change

Demands on general practice and primary care have never been greater with primary care professionals seeing more patients than ever with complex health issues. Rising patient expectations and persistent health inequalities illustrate the challenges facing primary care. Descriptions of the challenges at a population level have been provided in the early sections of the strategy, and without change these challenges cannot be addressed. There is currently a significant and increasing difficulty with workforce and resource capacity within the primary care sector and without change the current arrangements will not deliver on the requirements of the population or the system. This is happening now and is evidenced by shortages of clinicians in a number of areas and a deteriorating performance on access to primary care.

At present, general practice and in particular the GP is expected to provide services to all those who are or believe themselves to be unwell. This is unsustainable.

The challenges described within 'Realistic Medicine'¹ need to be addressed. This report resonates with the National Clinical Strategy which calls for a new clinical paradigm that adopts the least invasive or disruptive processes as a first step. This is both a change of mind-set and a change of service provision. This will often more appropriately include lifestyle interventions before drugs and operations

as well as a better understanding of the limitations of any intervention. We want patients to remain in control of their own illnesses.

We need to avoid unwarranted variation in standards of care and avoid wasteful investigations and treatments that do not add value for patients. Quality improvement is one of the keys to unlock the productivity of primary care.

The Scottish Government has set out an ambitious vision for health and social care to enable everyone to live longer, healthier lives at home or in a homely setting by 2020. Primary care is at the heart of this vision and is most people's experience of the NHS most of the time. To meet this ambition at a time of increasing demand, we need to change the way that primary care operates by creating teams of health and care professionals working in partnership.

Whilst life expectancy is rising, healthy life expectancy is not rising so rapidly and so the need for ill health care increases. Sustainability for the system can only be delivered when the healthy life expectancy increases and when the population are empowered to take a much more active part in their own care when they do become unwell. This requires resource much earlier in the health / ill health continuum.



What Will Change

The presumption that the GP alone is responsible for all healthcare outside hospital will change. The way this will change is likely to be made clearer in the 2018 and the 2020 GP contract reviews. These changes will be managed by the Health and Social Care Partnerships (HSCPs) in North and South Lanarkshire.

Self-management will increasingly be seen as a sensible option. This is true for long term conditions and shorter duration illness. Self-management should not be considered an inferior option: it is a desirable high quality intervention with an evidence. It does require adequate resourcing, and is a cost-saving option.

Also, the assumption that all complex care has to be delivered in a hospital will continue to change: there will be increased in the clinical skills across a wide variety of healthcare professionals in primary and community care. This idea is mentioned a lot in "Achieving Excellence", but is delivered in primary care. The strategic directions outlined across other parts of this document are

fundamentally dependent on the changes in primary care being effective.

Hospital care remains as an important element of total health care. The change as we move forward is that only those who need to be in hospital will be in hospital. The services provided in hospital will be better able to deliver on these requirements (see section 4.8).

As a result of this, our approach to primary care will support GPs and other health professionals to work together to enable the sustainable delivery of high quality, safe and effective patient care that is integrated where necessary with access to hospital based services when required. This will inevitably include a greater focus on self-care, supported self-management and joined-up care for people with multiple conditions and complex needs. It also requires continued development of IT systems, laboratory and investigation access. As such, we are dependent on national as well as local changes.

As responses to the 2016 consultation emphasised, people want to be at home; they also get on better at home. Therefore, there needs to be a mechanism by which the proportion of health and social care spending on primary and community care is increased in real terms.

Transport is an important consideration. Transportation of patients to routine appointments via the patient transport service has traditionally been only to places designated as hospitals. For more information on how we will do this see section 5.4.

“Achieving Excellence” deals with the health and social care contribution to the lives of our people. It would be wrong to ignore the vast contribution made by unpaid carers, the voluntary sector and the paid carers to healthcare. Further development to allow these services to contribute to an ever increasing extent and in a person centred way is essential to make sense of the rest of primary care.

Prescribing in primary care will be developed to ensure maximum benefits for patient outcomes, while avoiding wastage. Wastage includes unused, unwanted, ineffective and unnecessary medications (see more in section 5.1).

Locality teams, including GPs, will be configured to co-ordinate and manage complex clinical conditions; this will speed up access and improve outcomes.

Three additional themes will form part of our changes: health improvement models will be implemented to deliver the nine national health and wellbeing outcomes; there will be greater use of digital technologies to improve safety, efficiency and effectiveness of clinical decision making; we will support leadership for change, quality and efficiency.

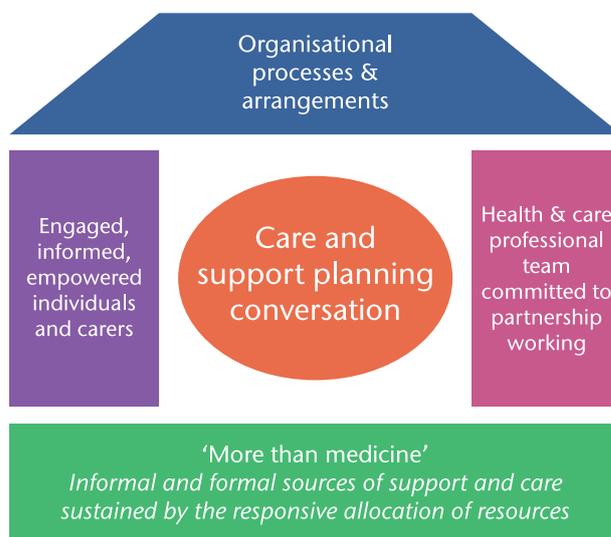
Recent improvements in the quality of urgent out-of-hours primary care will be sustained, with clear linkages between these services and other emergency care services (hospital emergency departments, NHS 24, Scottish Ambulance Service). The HSCPs will commission Urgent Care Services (out-of-hours) that deliver safe, effective and sustainable services in accordance with the Independent

Review of Urgent Primary Care Services². The new model will be developed and implemented to significantly improve access to a range of in-hours services and to provide improved collaborative working to provide urgent care in the community that requires a response before the next routine care service is available.

There are multiple initiatives being employed to implement some of these changes, many of which are collected together as the Primary Care and Mental Health Transformation Programme. Some of these are described below.

House of Care (HoC)

The House of Care Programme (HoC) describes a framework to enhance the quality of life for people with long-term conditions (LTCs), no matter what their conditions. It is being introduced currently within Lanarkshire across a number of practices and teams. By listening to the experiences and feedback from people coping with LTCs, it is evident that the individual needs to be at the centre of how care is designed and implemented. (See section 4.3).



Personalised care which understands and supports the individual is vital. There is no magic bullet which will support the delivery of personalised care but there is evidence that thinking systematically about the essential components does.

The approach provides the building blocks that need to be in place to enable care and support planning to take place as the new normal care for everyone with one or more LTCs. The HoC provides the planning tool for both a community-wide steering group and for a practice based team to use as they redesign their services and is already beginning to transform thinking across the whole health system. Strategically, House of Care is one example of an important transformative way of working and can be seen as a model of change across many parts of the system. It coordinates delivery of care, concentrates on what is important to the patient, encourages self-care and makes links to the wider networks of support. It may become a strategic leader in our system. All of this is

consistent with the other parts of “Achieving Excellence” and with the Health and Social Care Delivery Plan³, which committed an additional £23m to support these new models of care across Scotland.

Pharmacists in Practices

Pharmacists are experts in medication and introducing pharmacists into practice settings should assist in quality improvement and release time for other professionals to deliver on their specialist areas. Pharmacists began to be introduced and their impact assessed in 2016. The learning from the early phases will be used to extend this in 2017 and beyond.

Mental Health Transformation

Scottish Government has funded our mental health transformation plan which will link up and support the care delivery in many ways close to practices and at an early stage in the patient journey. We will meet the mental health needs of people with other ill-health problems. From a patient’s point of view, this will improve both the delivery of complex mental health interventions and the ability to reduce the duration of impact of problems within a mental health field.

WebGP/eConsult

This initiative uses innovative processes already used in England, and is being tried in Lanarkshire to encourage patients accessing their practice to access services of all kinds via a digital route. This will include email based consultations. This has the potential to bring parts of primary care into the heart of the digital age. It will be implemented from 2016-2018 where appropriate for individual patients and their medical condition.

There are also initiatives in leadership, use of IT hardware and software, recruitment and retention of GPs, and new delivery of psychology services each of which are of significant impact, but when applied together have the potential to create significant change.

Taken together, these changes are required to provide better access to appropriate clinicians and others and enable many more people to self-manage (with good support). The whole system impact of this approach will reduce the pressure on hospitals whilst expanding the range of care available in community and primary care.

When Will It Change?

As described, some strategic changes are already happening as part of the transformation programme. Additionally, this section within the Healthcare Strategy represents a summary of work started in 2015 and continued into 2016. We will continue to use this larger body of work from many stakeholders to drive our improvements over the coming years. The programme for improvement timescale is supported by changes in 2018 to the contractual arrangements for general practice being led by the Scottish Government and key stakeholders, and on the work to be set out in the Strategic Commissioning Plans of the HSCPs.

The likely milestones will be:

Phase 1: 2016–2018

Tests of change in preparation for 2017 contract: Embedding the structures and opportunities from integration of Health and Social Care Partnerships. Development of new roles for health and care professionals to enable them to deliver a wider range of treatments and interventions.

Phase 2: 2018–2020/2021

Implementation of substantial changes required by new GP contract. This work will lead to widespread use of new roles with more integrated working. We will implement workforce plans to provide staff who have the right skills and competences to meet changing patient and carer needs.

Phase 3: 2020–2025

Consolidation and completion of spread of successes of 2018 contract and new service models using the evidence from the test-of-change to demonstrate improved access, better outcomes and enhanced patient and carer experience.

The strategic changes will continue to be led by the strategic commissioning plans of the HSCPs, their implementation plans and the outputs from the transformation programme.

The timetable described here is in relation to changes driven on a Scotland-wide basis. There is also a need to deliver before 2018 substantial change to primary care. The contractual changes cannot limit the immediately required changes across the whole sector which are already developing at pace.

What Will Success Look Like?

- Better clinical outcomes for patients
- Speedier access to a care professional with the right skills to meet the patient need
- Design of care built around needs and aspirations of patients and carers
- Patients going to hospital only when that is the best place to meet their needs as more care will be delivered at (or closer to) home with better patient and carer experience of our services
- Improved linkages to streamline the patient journey across care boundaries, including progress on a single electronic patient record to support clinical decision making wherever the patient receives their treatment
- A sustainable long term future for general practice built around the new GP contract, with a smaller GP workforce working as part of larger multidisciplinary teams
- A sustainable long-term future for community based services built around a variety of professionals working in the multidisciplinary teams with wider skills
- Greater self-management based on better information for patients and their carers enabling more choice and options for care
- Safer and more cost-effective prescribing and use of newer technologies to support all of these success measures.
- Reduced need to access health care but when needed access in all its forms including transport support is improved

References

- 1 Chief Medical Officer's Annual Report 2014–15; Scottish Government, 2016.
- 2 Pulling together: transforming urgent care for the people of Scotland; Scottish Government, 2015
- 3 Health and Social Care Delivery Plan; Scottish Government, 2016

4.3 Long Term Conditions

Vision

We will provide integrated care – care that brings general practice and community services closer and crosses the boundaries between primary and community, hospital and social care. We will provide a full range of services for people with long-term conditions (LTCs) in the form of high quality, comprehensive community health care and, when necessary, hospital care. Active and early interventions to prevent the onset of worsening conditions, coupled with more effective management of people living with LTCs, will be pivotal to improving health and wellbeing outcomes for the population.

Current Services

Services for people with long-term conditions tend to focus on a single condition management approach and do not always consider the person's multiple conditions or the person as a whole. Existing services are provided across acute and primary care services and do not always meet the needs of people to allow them to live as independent a life as they would wish.

The Need for Change

Services in the future will need to change because of:

- An increase in the number of people living with LTCs (some of which can be delayed or prevented)
- advances in health techniques and treatments mean that people are living longer lives with long term conditions
- increases in the number of people living with complex care needs (more than 3 or 4 LTCs)
- the health needs of the Lanarkshire population is greater than the national average for many indicators of health inequalities
- patients having a greater expectation of health care
- challenges in available workforce creating planning, retention and recruitment challenges

What Will Change?

The proposed approach has been designed as a model of care which takes account of the importance of maintaining people's wellbeing and providing care, support and treatment to prevent any deterioration or exacerbation of their condition. This integrated model of care will be supported by the development of pathways of care which contain clear thresholds to assist in strengthening a whole-person approach to the management of the complex care needs of people with several chronic and long-term conditions.

- People will have access to a range of high quality services to meet physical and psychological health needs, as well as welfare services to provide a well informed and supportive advice, support, care and treatment service with sign-posting to alternative organisations to ensure support is available.

- The future model will demonstrate that we have listened to patients who universally say that they wish to be treated as a whole person and for the NHS and social care to act as one team, supporting people to remain in their communities with the appropriate infrastructure of support.
- Future care models will further improve services for those people who have more than one condition, particularly adults and older people, who may have previously faced an increasingly fragmented response.
- The needs of people with long-term conditions go beyond the organisational boundaries of social care, GPs, primary care and hospital care. The future model of care will replace the current system which feels disjointed for individual patients, is lacking continuity and that evidence suggests often leads to poorer outcomes and increased hospital admission.

KEY POINT

A model for community practitioners has been developed to meet the needs of the future community health services model. This will require the current nurses and allied health professionals to work in new ways and develop a range of skills to meet the changing needs of their patients, creating an enhanced range of accessible service options for people to improve the opportunities to deliver care within communities. The future model will be facilitated by robust information systems to support these new models of care delivery.

We will provide support at a range of points:

- 1 A solid foundation of population-wide prevention, health promotion and targeted health improvement activity, through action to prevent disease, raise awareness of risks to health and support healthy lifestyle choices. This will involve education across the age spectrum to both prevent and reduce the impact of long term conditions on the people of Lanarkshire. This is essential given the high prevalence of long term conditions which are preventable, and the health inequalities associated with living with long-term conditions;
- 2 Self-care and supported management, where people with long term conditions are given the information and other practical support they require to manage their own conditions in a way that helps them use this information to their own benefit with confidence in their knowledge of their condition and what support is available;
- 3 Condition management in which a greater level of professional support is required to help manage their condition(s) and avoid complications or slow the progression of disease; and
- 4 For those with particularly complex care needs who require more frequent and an intensive level of care, often referred to as care management, a proactive and co-ordinated approach to improve their health circumstances, help prevent deterioration where possible and manage exacerbations and complications of their condition(s).

Through providing this support, the health and social care system will place an explicit expectation on users of our services to increase self-management and

in time make this the norm. Primary, community and secondary care services will be provided when necessary, that is where other alternatives and self-management of long term conditions have proved insufficient. This will support health services being more accessible to all when necessary.

Next Steps

- General practice, community health and social care services will work together to design and develop the range of community based services to support the population to live healthier and happier lives.
- As we move to implement change we will modernise our workforce to meet future requirements with the capacity and capability to meet the needs of the population.
- We will build on areas of good practice in integrated community teams and address the service pressures to deliver the current demand in outpatients as well as the number of patients who currently attend and are admitted to acute services.

What Will Success Look Like?

- People with long term conditions (LTC) will be supported to live as independent lives as possible
- Care across community services will be integrated to meet the needs of the local populations
- Worsening of a LTC will be identified early, through self monitoring or enhanced community monitoring and treated appropriately
- Community based staff will be skilled and equipped to support more complex illness in caring for people with LTC therefore promoting self care and better management of health conditions
- Transitions of care across the system will be seamless, supported by robust information systems around episodes of care, creating care continuums
- Tailored care pathways will be developed for people with LTCs to support changes in care needs and the ability to return to a home or to a community setting as quickly as possible
- People will be involved in developing their care considering all of their care needs and not designed with a single disease process approach
- People with LTCs will not require hospital admission unless in the most acute circumstances
- As a result of a more integrated community health service people will live longer in an independent environment

4.4 Older People's Services

Vision

We will promote independent, active and engaged citizenship; ensure clear recognition of crises through shared information between agencies; support active early specialist management of acute illness; facilitate rapid recovery and independence at home or close to home and provide patient-centred, dignified, supportive care to those who require support at the end of life.

Current Services

As we described in section 2, people in Lanarkshire are living longer, more active lives and this trend will continue into the foreseeable future. The partner organisations in Lanarkshire have developed a strong track record of developing new and innovative service models which can adapt to the changing health and social care needs of patients, their carers and their families.

This has included:

- testing of different models to prevent people being admitted to hospital and providing more support at home after discharge;
- linking housing services to social care packages;
- listening to what clients' and carers' needs are;
- moving toward 24 hour/7 day per week care in the community and reducing the need to admit people to older people's hospital beds.

People as they age are likely to have one or more chronic diseases. In addition, the prevalence of impairment and disability is also directly linked with age. The priority of treatment is to prevent dependence, decline and physical or cognitive impairment with a move to earlier intervention, self-management and enhanced recovery.

What will change?

Our aim is to reduce dependence on acute hospital or residential care by building additional capacity and capability within local communities. One key element of this enhanced provision is the Integrated Locality Teams which bring together district nurses, Allied Health Professionals, social workers, mental health clinicians, home support workers and general practitioners to ensure that there is a unified focus on prevention, self-management and support and, where service is required, to provide a seamless approach to delivery.

We need to change the way in which hospital beds are used for the care of older people, with more focus on rehabilitation followed by support at home: more hospital beds will be used as 'intermediate care' which is defined by Healthcare Improvement Scotland' as:

'Intermediate care services provide a package of focused, intensive, time-limited interventions commonly provided in the home or a community setting.'

Intermediate care hospital beds can be used both to avoid admission to acute hospital services and also as part of the discharge and rehabilitation pathway following a spell in an acute hospital.

By building this capacity and capability in the community – including early access to services traditionally only available via secondary care, we will lessen dependence on residential care homes and hospital-based care. This will enable an ongoing review of how these resources are deployed in ways which better meet the needs of patients, carers and families.

To reduce the length of stay in hospital, we will identify patients' acute, rehabilitation and homecare needs earlier in the recovery phase. This will include the identification and allocation of community support and interventions, i.e. more intensive earlier care, then initiation of comprehensive assessment. This will reduce the need for hospital admissions and time spent in hospital for those people who do need to be admitted.



Providing safe alternatives to admitting frail people to a hospital will be the main objective and will lead to care packages delivered by a joint health and social care team, leading to ongoing recovery and rehabilitation in the community. Joint working also results in better discharge planning and earlier return to home or community care.

The model of service, which is clearly articulated in the National Clinical Strategy², will recognise that the acute hospital is a small part of the support that people need to maintain their health and wellbeing; the majority of advice, support and care (including some urgent and non-urgent acute care) can be provided in the person's home or the place of ordinary residence such as residential or nursing home.

All locality staff and primary care professionals will work as an integrated team and have access to diagnostics and support from acute clinical decision makers allowing them to provide support to people across the spectrum from primary prevention through to acute care at home. The locality team will include all health and social care staff including consultants, GPs, the third and independent sectors and will be able to harness a range of third sector and community assets to support its work.

Supporting independence, giving choice and control through signposting and giving non service based options will be a key focus of planning within localities as will the following:

What Will Success Look Like?

- Carers and family will be supported and enabled to provide care through appropriate advice and support
- Community capacity will be developed and commissioned on locality need
- Personal outcomes are at the heart of decision making
- Services are provided from a fully integrated health and care service.
- Older people will spend less time in hospital beds
- Delayed discharges will be effectively tackled by all care providers
- Greater level of treatment and care will be provided at home
- People will be enabled to live longer at home or in a homely environment

References

- 1 Healthcare Improvement Scotland. Care of Older People in Hospital Standards, Standard 12.
- 2 A National Clinical Strategy for Scotland; pp65; Scottish Government, 2016

4.5 Mental Health and Learning Disability

Vision

The Mental Health and Learning Disability (MH&LD) element of the strategy proposes further expansion of our focus on prevention; supporting people to look after their own mental health wherever possible; building stronger, more resilient, better informed communities; and providing consistent advice, information, support and care so that fewer people require specialist mental health services. Those who require mental health or learning disability services will receive the majority of these in their local area. We aim to provide person-centred, clinically effective, safe mental health and learning disability care, where required, which is of the highest quality.

Of paramount importance is the principle that there is no health without good mental health. Every part of the health and social care system is therefore required to play a more active part in improving the mental health and well-being of people with whom they work and by doing so contribute to the well-being of the population through collective action.

The implementation of this vision will be greatly assisted by the Scottish Government to invest £150m in improving mental health services¹.

Current Services

The MH&LD service is a Lanarkshire-wide service hosted within Health and Social Care North Lanarkshire. The MH&LD Service provides inpatient and community services for people living in Lanarkshire aged 16 to end of life. There are approximately 1,200 MH&LD health staff based across the service.

Inpatient Provision

The MH&LD service currently provides inpatient care for acute admission, rehabilitation and recovery, forensic low secure, intensive psychiatric care, learning disability assessment and treatment and continuing care. This is provided within 17 wards based over eight sites across Lanarkshire. In addition, urgent assessment and liaison services are available 24/7 at the three district general hospitals both in emergency departments providing advice, assessment and support and throughout the general acute hospital wards. There is a commitment to sustaining access to specialist assessment and initial treatment at all three hospital sites.

Hospital care remains a vital aspect of the model of care but is increasingly being used for the shortest time required for safety and clinical effectiveness.

Community Provision

The community provision is centred on multi-disciplinary community mental health teams for adults, older people, and community-based psychological services within each of the 10 localities. These community services provide

a range of interventions from low level inputs through to high intensity support for people with complex needs. Locality services are multi-agency and include colleagues from North and South Lanarkshire Councils, the third and independent sectors and service user and carer organisations. Additionally there are Lanarkshire-wide specialist community services which include learning disability. These community services are an essential part of the range of services that need to be available for people with learning disabilities. They have important roles to play in training, facilitating access to mainstream services, health promotion, health screening and the provision of specialist assessment, interventions and monitoring.

Need for Change

By shifting the balance of care from hospital to community locality-based care and increasingly delivering care through a tiered model, Lanarkshire MH&LD Service has seen a significant improvement in safe, efficient, person-centred care while at the same time improving capacity to meet increasing service demand. This significant service change has seen a reduction in beds with an increase in occupancy while at the same time a reduction in length of stay and readmissions. The implementation of the tiered model has seen an increase in community capacity which has supported improved access to lower tier interventions and use of technology enabled care and a decrease in waiting times.

Lanarkshire MH&LD service has consistently performed well against national targets and standards, being one of the best performing Boards in Scotland. However, there are still some areas where matching capacity to meet demand remain a challenge. These include:

- post diagnostic support for dementia
- clinical health psychology including neuropsychology
- developing a sustainable senior and trainee medical staffing model
- inpatient nursing staff across mental health and learning disability wards
- services for adults with autism
- providing fit-for purpose clinical accommodation
- reviewing the balance between levels of secure forensic care

The need to meet these demands can be supported by continuing the modernisation process that has delivered a transformation in quality of services over the last decade. Further modernisation will include progress towards the goal of bringing specialist admission beds for mental health on to two district general hospital sites (within North and South Lanarkshire, respectively). The provision of beds on two sites will be supported by further development of assessment and initial treatment capacity on all three sites. Further detailed stakeholder involvement will take place as part of the process of moving towards this goal.

In 2016 we saw the integration of functional assessment beds for older people, in Coathill Hospital and Airbles Road Centre, into more fit-for-purpose accommodation in Wishaw General Hospital. Further consideration will also be now given to 'best fit' of adult and older people's wards across the estate and to potential solutions for older adults' inpatient services in South Lanarkshire that

will in due course move to Hairmyres Hospital. These moves will help ensure that mental health inpatient facilities best meet the highest specifications with patient safety, dignity and comfort as principle aims.

What Will Change?

Community

- A further shift towards a person-centred approach that encourages self management and family, carer and peer support. Prevention, early identification and intervention for mental health problems in primary care settings will be supported through increased multiagency working as part of the primary care transformation process.
- Integrate community mental health services with wider health and social care functions at locality level in both North and South Lanarkshire, using local assets and resources to support improved mental health for all.
- Improve the physical health of people with mental health problems and/or a learning disability and improve the mental health of people with co-morbid physical illness. To include the development of a clinical health psychology service across Lanarkshire focusing on co-morbid physical health and mental health conditions, and medically unexplained symptoms.
- Further improve care pathways which support access to and integration of services which include primary care, acute care, independent sector and voluntary organisations.
- Address specific health inequalities of people with a learning disability through health improvement/health promotion initiatives.
- An improved response to crisis and/or distress will be provided by a multi-agency approach offering improved access to brief interventions.

Hospital

- Pursue strategic intent for adult and older people's mental health acute admissions to move to a two site model on district general hospital sites.
- Complete older people's mental health inpatient modernisation plan for acute admissions/hospital based complex care.
- Review of Lanarkshire service model for forensic inpatient and community services and inform work of the National Forensic Network to assess future needs for high/medium/low secure provision
- All wards will have a Quality Improvement Group to allow local focus on safe and clinically effective care
- Review of Lanarkshire service model for rehabilitation and recovery inpatient and community services
- Increase capacity of mental health liaison service in all three DGHs to ensure good mental health service provision at each site

We will also:

- Strengthen partnership working between health, the councils, the third sector and other key partners, building on existing joint and integrated working
- Develop an information system which works across sectors, providing both quantitative and qualitative information, and which provides a basis for information sharing across services involved in support and care.
- Ensure the MH&LD inpatient and community estate is fit for purpose to support the delivery of safe and effective care in the right setting to match an individual's level of need at any point.
- Resolve medical staffing issues at senior and trainee levels
- Provide a good fit for fluctuating demand for the three levels of secure care.

What Will Success Look Like?

- Increased focus on prevention and early intervention
- More people able to look after their own mental health
- Better informed, more resilient communities
- More people able to live with mental ill health or a learning disability unaffected by stigma
- Provision of easily available and consistent accessible information; advice; support; high quality, safe, locally based care when required
- Fewer people requiring specialist community or hospital based services with ease of access and flow through for those that do
- Narrowing of the inequalities gap
- Provision of services that recognise the diverse/complex health needs of people with learning disabilities

References

- 1 Health and Social Care Delivery Plan; Scottish Government, 2016

4.6 Alcohol and Drugs

Vision

We will continue to develop a recovery orientated system of care which has at its heart the needs of individuals, their children and other family members affected by alcohol and drug problems.

The national alcohol strategy, *Changing Scotland's Relationship with Alcohol: A Framework for Action*¹ 2009, and the national drug strategy, *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*² 2008, will continue to provide the framework for delivering alcohol and drug prevention, treatment and support services in Lanarkshire. The Lanarkshire Alcohol and Drug Partnership (ADP) is responsible for implementing these national alcohol and drug strategies within each of our local authority areas.

Current Services

All of our alcohol and drug services recognise that recovery is not simply about tackling the symptoms and causes of dependence, but about enabling people to successfully reintegrate back into their family and local communities. It is also about ensuring that they have somewhere to live, something to do and the ability to form positive relationships with others. This includes ensuring that there is a full range of services within every locality in Lanarkshire. These services include: identifiable community rehabilitation services which have people with lived experience within their staffing complements; access to detoxification and residential rehabilitation; access to a full range of psychological and psychiatric services and proactive engagement with employability and accommodation providers.

Go to www.lanarkshiredp.org for further details of the services available across Lanarkshire. Our Delivery Plan also provides this information.

The Need for Change

The life course perspective refers to an approach which recognises the structural, social, and cultural contexts in which we live and work. In doing so, it reflects the importance of our early years and how this impacts on a range of other health and social indices. Additionally therefore, we will strive to promote health and well-being within our wider communities by tackling the underlying root causes of alcohol and drug problems including trauma, socio-economic deprivation, family breakdown, poverty, mental ill-health and crime.

Moreover, the issues associated with social exclusion and health inequalities for patients on long term opiate replacement therapy (ORT) are deepening. The demographic characteristics of those using substances that might benefit from ORT have changed in recent years. The average age of the group has markedly increased suggesting that the degree of both physiological and psychological difficulty, already high, is likely to increase further. Equally, as health inequalities continue to increase so the effects on this already deprived and marginalised group will become more extreme. These factors further compounded by the

effects of stigma, will produce a picture of increasingly complex social and medical difficulty which will require a more coordinated approach from all providers of social and medical care than is currently the case.

In developing the *Lanarkshire Alcohol and Drug Partnership Strategy*³, we have therefore included the views of service users, their family members, carers, staff working within our treatment and care services, members of our third sector and community groups as well as other key community planning partners (housing, mental health, criminal justice, education, social work and police). We have also reviewed a number of local plans and national strategies to ensure that we are reflecting the key priorities of our community planning partners.

Continuing investment by the Scottish Government also provides an opportunity for our ADP to make considerable progress towards achieving the national outcomes and ministerial priorities as set out in the national strategies

What Will Change?

The community plans and single outcome agreements for both North and South Lanarkshire Councils outline the priorities for Lanarkshire's citizens and communities in the future. These are the overarching strategy documents which link to the priority outcomes we hope to achieve. We have reflected these priorities within our strategy and will work with our community planning partners over the next three years to report on our progress. Further information on how this will be achieved is included in our delivery plans for North and South Lanarkshire (2015–2018).

There is also a suite of national recovery indicators which form part of the national Drug and Alcohol Information System (DAISy) database which will be used from 2016. We will therefore work in partnership with our local statutory and third sector providers to ensure that these are included within our service level and partnership agreements in order that we can measure the recovery outcomes for all clients within our treatment and care services.

What Will Success Look Like?

- Recovery orientated system of care are developed within our communities
- Adults, including parents and older people with alcohol and/or drug related problems are supported to receive the right kind of service, in the right place at the right time
- The interests of children, young people and young carers affected by substance misuse are safeguarded and promoted
- Speedy access to wider health care services (such as primary care, sexual and reproductive health)

References

- 1 Changing Scotland's Relationship with Alcohol: A Framework for Action. Edinburgh: Scottish Government, 2009
- 2 The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem. Edinburgh: Scottish Government, 2008
- 3 Lanarkshire Alcohol and Drug Partnership Strategy:
www.nhslanarkshire.org.uk/boards/2015-board-papers/Documents/August/15-ADP-Strategy-2015-18--August-2015-Board.pdf

4.7 Maternity (Including Neonatal), Early Years, Children and Young People

Vision

All children and young people will have the best possible start in life and reach their full potential – regardless of their starting point. We will improve health and wellbeing outcomes by delivering targeted early intervention and prevention from services which are designed and delivered to reduce inequalities and best meet the changing needs of women, children and their families achieving generational changes by 2025.

Current Services

Universal and Additional Service Provision: NHS Lanarkshire together with their partners in North & South Lanarkshire are in the process of adopting the Universal Pathway for children and young people set out in Getting It Right For Every Child (GIRFEC)¹ national guidance which spans the early antenatal period until the child's 18th birthday. In addition there are national and targeted initiatives such as Family Nurse Partnership, Early Years Collaborative² and First Steps which provide a focus of intensive support for particular cohorts of the population from the antenatal period into the postnatal period and beyond.

Maternity and Neonatal Services within NHS Lanarkshire are delivered from a wide range of community settings including the woman's own home and Wishaw General Hospital. The Neonatal Intensive Care Unit is capable of caring for the smallest and sickest of new-born babies delivered both within Wishaw General Hospital and those transferred in from other Maternity Units across Scotland.

Community and Primary Care: Most of the activity related to children is carried out in the community. General practice activity is largely concerned with children presenting with acute illness. In addition to this however some chronic conditions which were previously managed in an acute setting are now almost entirely managed in a GP setting, e.g. asthma, teenage acne and childhood eczema. Nurses and Allied Health Professionals support GP practices to offer both specialised clinics and one-to-one consultations.

Hospital Care: for children is concentrated on a single site at Wishaw General Hospital. GPs refer children to Wishaw Hospital for emergency treatment or can access specialist paediatric advice from the Paediatric Unit. Outpatient consultant clinics are held on all three acute hospital sites and also in health centres across Lanarkshire. Clinics which are more specialist are generally focused on the three acute sites. Those children who cannot be treated locally are referred to the Royal Hospital for Children in Glasgow.

There are in total approximately 30,000 attendances per annum at the three Emergency Departments (EDs) within Lanarkshire for patients aged under 16, of which around 80% are classed as minor injury and illness.

The Need for Change

It is essential that the services we provide to children, young people and their families are timely, of high quality, efficient and continually improving. We need to demonstrate through the services we provide that we understand the health needs of Lanarkshire's children and young people and that we are responsive to them.

- Most of the activity related to children is carried out in the community, not in hospitals, and so developing community teams must be our priority.
- Maternal obesity levels are expected to rise from the current level of 20% to a conservatively estimated 30% by 2030. This will increase the caesarean section rates, which are currently a third of all deliveries. Therefore, hospital maternity services will need to adapt.
- There is an issue of cot spacing within the neonatal unit which will need to be resolved.
- We can expect the population of children in Lanarkshire to fall, and so our paediatric models of care will have to adapt.
- There are approximately 30,000 attendances per annum at Emergency Departments (EDs) for patients aged under 16, of which around 80% are classed as minor injury and illness. Data analysis suggests that a large proportion of these children could be managed better in primary care, with speedier access and better outcomes.
- Generally, health and life outcomes for those children born into poverty are poorer when compared to children who are born into more affluent life circumstances. Likewise the health and life outcomes for Looked After Children are generally much poorer than those who are not.
- The Children and Young People (Scotland) Act 2014 requires us to strengthen the focus on the rights and wellbeing of individual children to enable them to achieve their full potential.

What Will Change

- Improved health and wellbeing outcomes for this particular population will only be achieved through delivering targeted early intervention and prevention from services which are designed and delivered to reduce inequalities and best meet the changing needs of the women and children to achieve generational change. In line with the Children and Young People (Scotland) Act 2014 children and families will benefit from enhanced support from universal (midwifery and health visiting) and AHP services enabling earlier identification of need and subsequent appropriate intervention. All children and young people in Lanarkshire will have a Named Person who will be responsible for promoting, supporting and safeguarding their wellbeing.
- Support will be given to the Community Planning efforts to address the wider issue of obesity. Specific focus will be placed on intensive support to women before, during and after pregnancy. Length of stay for obese pregnant women requiring planned caesarean section will reduce as a result of an enhanced recovery service
- We will implement the recommendations of the recently published report "The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland"³

- Neonatal services will be redesigned to ensure appropriate capacity and improved cot spacing.
- As opposed to attending A & E unnecessarily, pathways will be redesigned to ensure that children and young people are treated in the community when clinically appropriate.
- We will redesign our services to support our most vulnerable children and young people such as Children with Learning Disabilities, those with Complex Care Needs and Looked-After Children to improve their health, wellbeing and life chances as they transition into adult services.
- Data systems will be reviewed to ensure identification of need and risks in vulnerable populations.

What Will Success Look Like?

- Overall, we will focus on the delivery of the key outcomes set out in the Children and Young People's Health Plan to ensure:**
 - The health and wellbeing of children and young people is improved and the stretch aims of the Early Years Collaborative are achieved and exceeded
- Delivery of targeted early interventions**
 - Reducing the rate of increase in maternal obesity levels
 - Reducing foetal alcohol spectrum disorder levels
 - Enhancing support for perinatal mental health
 - Enhancing the multi professional/agency interface
- Delivery of increasingly person centred maternity and neonatal services**
 - Enhancing early pregnancy assessment
 - Enhancing the model of parenthood education
 - Reducing inappropriate interventions
 - Reducing need to transfer beyond Lanarkshire
- Delivery of the Stretch Aims of the Early Years Collaborative**
 - Women experience positive pregnancies and the rates of stillbirth decrease by 15%
 - 85% of all children reach all their expected developmental outcomes at the time of their 27–30 month child health review
 - 90% reach their expected developmental outcomes at the time the child starts primary school
 - 90% of children achieve their developmental and learning outcomes by the end of primary 4
- Delivery of increasingly person centred paediatric, child and adolescent mental health services (CAMHS)**
 - Enhancing out of hours services for children
 - Enhancing access to CAMHS up to 18 yrs
 - Reducing minor ED Attendances
 - Reducing no-show rates at community and hospital clinics
 - Children and young people experience smooth and efficient transitions

Delivery of more with less

- Building community capacity to reduce inequalities
- E-enabling the workforce
- Remodelling clinic provision
- Strengthening outcome focused approach to inform continuous improvement

References

- 1 Getting it right for every child (GIRFEC); Scottish Government, 2004
- 2 www.gov.scot/Topics/People/Young-People/early-years/early-years-collaborative
- 3 The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland; Scottish Government, 2017

4.8 Planned and Unscheduled Acute Care

Vision

Our Health and Social Care Partnerships (HSCPs) will commission services that support people in the community and avoid hospital admission. Both Partnerships will aim to ensure that social work and community health support and services for people who are admitted to hospital are better aligned so that our discharge processes from hospital are as smooth as possible.

Acute hospital teams will work with our partner agencies and clinical teams in community and primary care settings to ensure the demand for planned and unscheduled services is delivered by the most appropriate healthcare professional, in the most appropriate location, through the development of clinical and service models designed to meet the assessed needs of the population.

Current Services

Each of our three acute hospitals Wishaw, Hairmyres and Monklands has the following core services:

- an emergency department (ED),
- acute medical and surgical services
- diagnostics and imaging
- operating theatres and critical care
- outpatient services

Clinical services on each hospital site are relevant to each hospital's bed configurations and service models are arranged around our 'Centres of Excellence'² in Lanarkshire where individual specialty services deliver care for the whole of the Lanarkshire population with consistently high levels of clinical quality and patient satisfaction. These are arranged as follows:

Monklands DGH	Hairmyres Hospital	Wishaw General Hospital
<ul style="list-style-type: none">• ENT surgery• Haematology (cancer)• Histopathology• Infectious disease medicine• Lanarkshire Beatson (radiotherapy)• Renal medicine• Urology surgery	<ul style="list-style-type: none">• Interventional radiology• Ophthalmology surgery• Optimal cardiac reperfusion• Vascular surgery	<ul style="list-style-type: none">• Bariatric surgery• Intensive Psychiatric Care• Maternity & neonatal• Paediatric services• Specialist Lab services

These services are underpinned by clear patient pathways supported by the Scottish Ambulance Service, NHS24 and Primary Care Out of Hours Services.

The Need for Change

KEY POINTS

- In 2016 Lanarkshire residents used the equivalent of 1,750 acute hospital beds; mostly in Lanarkshire, but also in the Glasgow and Lothian acute hospitals
- If we do not change our models of care, the population needs assessment shows that this will rise to over 2,200 by 2025: nearly a 30% increase which would require over 500 more hospital beds, the equivalent to another District General Hospital
- To stand still, admissions and/or hospital lengths of stay must reduce by 25% in the next 10 years.
- The service redesign work both in hospitals and in the community over the last 10 years has already delivered a 29% reduction in lengths of stay in hospital.

Changes to Specific Clinical Specialties

a Gastroenterology and Upper Gastrointestinal (GI) Care

During the last 15 years there has been a significant change in the number of gastroenterology and upper GI treatments which can now be delivered by keyhole surgery or using endoscopes, which means that many patients have a shorter length of stay in hospital. There is currently a different model of care in place on each site. An improved clinical model, a single Centre of Excellence within Lanarkshire, could be created to deal with patients with severe gastric bleeding. For patients, this would ensure better clinical outcomes and a better patient experience, based on a multi-disciplinary approach for management between endoscopic techniques, interventional radiology and surgery. We will explore this idea further in 2017 and beyond.

b Trauma

Healthcare services must constantly adapt to the evolving needs of the population. The Academy of Medical Royal Colleges and Faculties in Scotland evidenced the need to reconfigure orthopaedic services to provide the consolidated clinical teams who work together to improve the quality of our services, the clinical outcomes and experience of our patients and optimise the use of our resources.

The NHS Lanarkshire Board has accepted that the first change that NHS Lanarkshire must make to acute services is in the provision of orthopaedic surgery. In keeping with the National Report on Trauma Services, and the National Clinical Strategy², the most effective and efficient way to meet the needs of people with severe traumatic injuries must be provided. The Academy of Medical Royal Colleges and Faculties has specifically asked NHS Lanarkshire to consider creating a trauma service with inpatient

services based at a single hospital site. This will be a major change in the configuration of several key acute specialties (including critical care, general surgery, orthopaedics and rehabilitation). This work will require time to plan and implement. In the interim step towards this in November 2016 we reconfigured orthopaedic inpatient services to be shared between Hairmyres and Wishaw (see also section 4.9).

Wishaw General Hospital will be a trauma unit as part of the West of Scotland Trauma Network centred at the Queen Elizabeth University Hospital's new Major Trauma Centre in Glasgow. This will see the development of improved patient pathways for those who suffer major traumatic injury, and the augmentation of the healthcare workforce to deliver 24/7 integrated care across a range of clinical specialties particularly emergency medicine, critical care, general and emergency surgery, orthopaedics, paediatrics and imaging. Should it prove possible to resource a single trauma site in future without substantial disruption to other key services, this would be located at Wishaw General Hospital.

c Impact of Glasgow changes in hospital services

The changes to Glasgow's hospital services in 2015 saw a step-change increase in the unscheduled care activity at Hairmyres Hospital and a corresponding increase in the capacity of the hospital's emergency care teams. The pattern of patient flows across East Renfrewshire, South Glasgow, Rutherglen and Cambuslang will continue to be closely monitored but increased regional working is likely to be a growing feature of healthcare delivery in the future with less emphasis on which NHS Board people live in. This is expected to have a significant impact on the future development of both general and specialist regional services at Hairmyres Hospital.

d Other areas of possible change

The continued capacity for ophthalmology procedures, e.g. cataracts, to be provided at Hairmyres Hospital will be reviewed in 2017 in conjunction with regional plans for capacity at the Golden Jubilee National Hospital.

The provision of vascular surgery and interventional radiology services will also be reviewed in conjunction with regional plans based on availability of specialist expertise across a number of health boards.

We will seek to get the best clinical outcomes through ensuring specialist surgery (either involving overnight stays or as a daycase) is provided safely and effectively as part of the Centres of Excellence concept.

The Scottish Government will create a series of diagnostic and elective treatment centres which will affect how planned orthopaedic care is delivered (see section 4.9).

What Will Change?

a On all three hospital sites

KEY POINT

Each DGH will continue to have staffing and infrastructure to deliver emergency care that includes:

- An emergency department (ED)
- Acute medical and surgical services
- Diagnostics and imaging
- Operating theatres and critical care
- Outpatient clinics

We plan to continue to provide a comprehensive programme of planned care across the three acute hospital sites, but reduce the proportion of care we deliver which is unscheduled in nature and only use emergency inpatient hospital services as a last resort. This will, in turn, allow us to shift resources and use a greater proportion to deliver more planned care in hospital and in the community. This would reduce the need for inpatient stays in hospital.

In the main, patients would have their clinics, pre-admission assessment and rehabilitation locally at their DGH, but with specialist surgery provided in centres of excellence covering the whole Lanarkshire population (as is the case at present for many types of surgery – see table above). This may involve further concentration of day surgery procedures, and/or shifting some clinical procedures from operating theatres to outpatient clinic treatment rooms.

We plan to deliver Realistic Medicine¹ eliminating procedures with low clinical effectiveness, improving our use of medicines and reducing variation in clinical practice².

These themes were explored further through the consultation process and were broadly supported. Members of the public considered that more emphasis needed to be given to prevention, self-management and realistic medicine approaches including important conversations around medical interventions and likely outcomes.

People also wanted to understand what realistic medicine would mean in practice, for example, in the delivery of cancer care. Our clinical staff gave strong support for realistic medicine, recognising that without this kind of approach the strategy would not work and acknowledging the work already being progressed across the Board to progress guidelines and important areas of work such as anticipatory care plans. Likewise the Royal College of Nursing reiterated their position of supporting treatment which is minimally disruptive and based on realistic outcomes. Where medications were discussed, people were comfortable with a realistic medicine approach, using the cheapest available if quality is assured and maximising the use of cheaper generic drugs wherever possible.

b Monklands

KEY POINT

NHS Lanarkshire is now preparing a business case for a major new development to replace the existing Monklands Hospital, creating a modern infrastructure that will help to support the redesign of service models for both hospital and community care. This was strongly supported during our consultation process.

The planning process will continue into 2018 and subsequent building work will take several years. This will provide a unique opportunity to ensure our specialist acute services and Centres of Excellence can be developed further and fully integrated into community-based services.

In the short-term we plan to enhance our existing front door facilities and emergency department on the Monklands site and create improved facilities for day surgery and a same-day admissions unit.

We will prepare plans to create a single centre of excellence for the gastrointestinal (GI) bleeding service.

We plan to consolidate cancer services in a centre of excellence at Monklands. While cancer care for Lanarkshire residents will continue to be provided at Hairmyres, Wishaw, the Beatson Cancer Centre and elsewhere, the planning assumption will be that where cancer services are developed in the future, any expanded capacity would be co-located with the existing cancer services at Monklands Hospital (see also section 4.10).



Longer-term, planned orthopaedic surgery is proposed to be concentrated on a single site which is likely to be either Hairmyres or Monklands (see section 4.9).

c Hairmyres

Hairmyres Hospital became the second inpatient unit in Lanarkshire, alongside Wishaw General Hospital in an interim reconfiguration of orthopaedic services in 2016. As stated above, longer-term, it is proposed that elective orthopaedics would be concentrated on a single site which is likely to be either Hairmyres or Monklands (see section 4.9). Hairmyres will also see new facilities created for ophthalmology.



d Wishaw

In the short term, we plan to enhance our existing front door facilities and Emergency Department at Wishaw.



In the longer term NHS Lanarkshire propose to create a single trauma site at Wishaw alongside a second elective site. This site would serve as the Board's trauma unit within the West of Scotland regional trauma network.

What Will Success Look Like?

- Seamless care provided through collaborative working across Lanarkshire in partnership with the patient, providing a better patient experience
- Specialist care at home especially for the elderly, minimal hospital stays with follow up in the community
- Reduce the need for admission to hospital and in particular expand the range of preventative and/or acute interventions provided in or close to people's homes
- Emergency services accessed as a last resort ensuring only people who require specialist hospital care are admitted into a general hospital
- More patients treated within planned care (urgent) services through improved access to diagnostics, outpatients and day surgery procedures
- Rapid access to treatment supporting improved clinical outcomes and minimum length of stay in hospital following surgery
- Centres of excellence delivering the highest possible standards of safety and clinical care
- Further improving quality of care and clinical effectiveness by reducing variation in clinical practice
- Enhance our research and development work to support improvements in clinical practice
- Improve the training support and environment for healthcare professionals
- We will enhance our ability to recruit and retain highly skilled specialist clinicians

References

- 1 Realistic Medicine – Annual Report by the Chief Medical Officer; Scottish Government, 2016
- 2 A National Clinical Strategy for Scotland, Scottish Government, February 2016.

4.9 Orthopaedic Services

Vision

Orthopaedic services will be provided to a high standard comparable to any other UK service. Patients will enjoy a seamless treatment pathway from referral through to rehabilitation, and will spend the right amount of time in hospital. The service will be fully integrated with other health and social care providers in primary, community and acute. Our workforce model will be sustainable into the future as the needs of the population change.

Current Service

Orthopaedic services are the second largest surgical specialty, and are currently provided from outpatient clinics in the three District General Hospitals, with surgery being performed at Hairmyres and Wishaw. Over 26,000 people are seen in orthopaedic clinics each year. 10,000 people are admitted to hospital for orthopaedic treatment as either emergencies (generally referred to as “trauma” e.g. a fractured leg) or for planned surgical procedures (“elective” e.g. a hip replacement).

Not all orthopaedic specialist services are provided on each of the three DGHs: the service is split into sub-specialties (e.g. foot and ankle surgery, paediatric surgery) and these services are provided in single specialist units at one location for all of Lanarkshire. Also, nearly 1000 Lanarkshire patients are treated at the Golden Jubilee National Hospital each year for elective surgery (mainly hip and knee replacements).

The Need for Change

A formal review of trauma and orthopaedic service in Lanarkshire began in 2014 following the publication of the “Rapid Review of Safety and Quality of Care for Acute Adults in Lanarkshire” carried out by Healthcare Improvement Scotland¹.

The conclusions from that review, and the case for change, were considered by the NHS Lanarkshire Board in July 2016. Further information is available through the consultation website and the NHS Board papers: www.nhslanarkshire.org.uk/boards/2016-board-papers/Pages/July.aspx.

The NHS Board considered the case for change for orthopaedic services to ensure:

- improved patient outcomes,
- a sustainable medical workforce; and
- future pathways of care that meet the changing needs of the Lanarkshire population.

The view of NHS Lanarkshire, which has been confirmed by the 2016 report from the Academy of Medical Royal Colleges and Faculties in Scotland⁴, is that maintaining the status quo was neither a sustainable option, nor would it address the safety and quality issues raised in the 2013 HIS Rapid Review report. The Academy also noted that there was consensus on this opinion across Emergency Departments, Trauma & Orthopaedics and Care of the Elderly teams across NHS Lanarkshire.

Whilst initial work within NHS Lanarkshire’s orthopaedic review focussed on immediate changes necessary within the service and how they could be delivered, further consultation with clinicians led to wide acceptance that the strategic direction is to move to Trauma and Elective work on separate sites. These conclusions have been reinforced by the recent publication of the National Clinical Strategy for Scotland².

The NHS Lanarkshire review of Orthopaedic services focussed on 4 possible options for reconfiguration of services.

Maintain Trauma and Elective Across Two Sites		Trauma and Elective on Separate Sites	
<ul style="list-style-type: none"> • 50/50 Split between Wishaw and Hairmyres 	<ul style="list-style-type: none"> • 50/50 Split between Wishaw and Monklands 	<ul style="list-style-type: none"> • Wishaw Trauma Only • Hairmyres Elective Only 	<ul style="list-style-type: none"> • Wishaw Trauma Only • Monklands Elective Only

Further information and analysis is available through www.nhslanarkshire.org.uk/INVOLVED/CONSULTATION/ORTHO/Pages/Traumaorthopaedicchanges.aspx.

All options reviewed included Wishaw General due to its proposed designation as a trauma unit within NHS Lanarkshire. With the proposals to create a major trauma network across Scotland, one major trauma centre will be created at the Queen Elizabeth University Hospital in Glasgow. NHS Lanarkshire’s proposal for inclusion in the network is the creation of a designated major trauma unit at Wishaw General Hospital. Wishaw is best placed for this development due to its centre of excellence for paediatric care and geographic location with a catchment covering south/central Scotland.

The scale of change that is required to achieve this within Lanarkshire is challenging and it is impossible that a single trauma unit can be achieved within the current bed complement and Emergency Department footprint at Wishaw without causing significant disruption to other services. The pragmatic approach is therefore to move towards this strategic objective in a phased manner by moving initially to two combined trauma and elective units. The NHS Board agreed to make immediate changes to orthopaedic inpatient services on the grounds of clinical safety and service sustainability in July 2016, and this was implemented in November 2016.

Another factor is the commitment by the Scottish Government (2016 SNP manifesto) to invest in a series of diagnostic and elective treatment centres to provide concentrated elective surgery for a range of procedures, including hip and knee replacements. The service model for these centres is not yet agreed, but whatever their configuration this will change the future service configuration for elective orthopaedic surgery for Lanarkshire.

Sustaining the medical workforce

A key issue noted in the 2013 Healthcare Improvement Scotland (HIS) report was the need for a fundamental review of the distribution of orthopaedic services across NHS Lanarkshire to support the provision of safe, person-centred and effective care. The report noted significant and persistent issues, the solutions for which required models of care built around patients but which take account of the available workforce. Onerous and stretched out of hours and on-call rotas for consultants impacting on recruitment and retention was identified as a challenge of the current clinical model which has elective and trauma services provided across three sites.

Since March 2014, the service has been subject to enhanced monitoring by NHS Education for Scotland (NES) on behalf of the General Medical Council (GMC) to ensure that the necessary quality of training and environment of safe patient care in which training is provided can be assured. Without this continued assurance, which is currently at risk, training recognition will be removed and the service will not be sustainable within NHS Lanarkshire.

The 2016 interim move to two in-patient units has assisted with managing some of the more acute pressures on the service, but it is the commitment to longer term sustainable change as part of the major trauma network that has helped to provide assurance to the regulatory agencies of continued progress to a centre of excellence for both trauma services and elective operating.

The changing needs of the population

Planning the future service provision will require account to be taken of a number of significant changes which will impact upon the demand for the service over the next twenty years. The largest factor is the increase in over 75s, recognising that patients are living longer and the added complexity of each individual's clinical presentation due to a number of age related factors (see also section 2). Orthopaedic activity is expected to increase by 12.9% by 2020 and a further 11.7% by 2025. Activity for 2015 is shown below as a baseline for future development as well as the predicted activity levels for 2020 and 2025.

Patient Category	2016	2020 estimate	2025 estimate
Day Cases	2,147		
Elective In-Patients	1,578		
GJNH Patients	960		
Elective Total	4,685		
Emergency/Trauma Patients	4,631		
Overall Total	9,316	10,760	12,019

The proposed model for change cannot be a single step process. The complexity of change, staffing and resource implications, impact on other services, physical capacity and new models of care all point to the need to manage service redesign within a stepped programme of change.

The agreed development of a case for a new hospital at Monklands presents opportunities and flexibility within the programme in order to ensure appropriate capacity is available to locate services whilst achieving the intended goal of a single site Trauma model. Lanarkshire will set out the case for the development of a trauma unit at Wishaw General Hospital, as part of a Lanarkshire emergency care service based on three Emergency Departments, and a West of Scotland major trauma network. The national case for the major trauma network identifies how this will save lives and reduce significant disabilities.

The move to the final configuration will see all trauma surgery at Wishaw, with all elective surgery on another site. The location of elective surgery will be shaped by:

- The final service model for the 5 National Elective Treatment Centres (SNP manifesto 2016);
- The final service model for the West of Scotland major trauma network
- The capacity for surgery, diagnostics etc. to be provided by the development of Monklands Hospital (earliest 7 years in the future) which would enable changes to beds, theatres and clinic capacity across Lanarkshire. This will also embed sufficient capacity to meet the future needs of the population for surgery
- The views of patients, public and other stakeholders through the consultation process.

New service models will be underpinned by agreed patient pathways and workforce plans to optimise clinical expertise.

Outpatient contacts account for greater than 85% of all orthopaedic appointments and admissions. The service will remain local with the vast majority of patients accessing the service at their local hospital. The interim step was completed in November 2016, with orthopaedic outpatient care and care within emergency departments provided across all 3 sites. Only inpatient and day case surgery currently provided at Monklands was affected.

Where specific inpatient care is required pathways were implemented to ensure patients are transferred directly to the nearest inpatient site and where the services of a Major Trauma centre is required for specialist care appropriate pathways were implemented with Queen Elizabeth University Hospital (QEUH) and the Scottish Ambulance Service (SAS).

This provides a comprehensive package across all of 3 acute sites in NHS Lanarkshire ensuring patients can access the majority of their care as close to home as possible whilst concentrating specialist care to appropriate sites in order to improve outcomes. Even with the eventual consolidation of trauma onto 1 site, orthopaedics will retain a presence across all 3 sites.

There are a number of key principles/issues which were addressed in the planning process:

- An Emergency Department pathway for patients with orthopaedic injury to be implemented at any site without inpatient orthopaedic activity.
- Scottish Ambulance Service (SAS) pathways for patients and pre hospital management of trauma & orthopaedic patients.
- Workforce planning for all clinical, non-clinical and community based staff affected by changes to the current service models.
- A detailed protocol/pathway which sets out how the Care of the Elderly (COE) team now engage orthopaedic patients as part of their workload and to take over the care of appropriate patients at a much earlier point in the process.
- A Joint Clinical Pathway Model for orthopaedic, older people's care and locality services.
- Management of the impact on other priority services which were impacted on by implementation of a service reconfiguration e.g. theatres / anaesthetics, ward staffing, trauma and out-patient clinics, locality based services.
- Full staff engagement with affected staff and other stakeholders on the proposed service models throughout.

It was also recognised that a key driver in this change process is the development and early implementation of a new clinical and social care pathway which delivers improved access to Care of the Elderly (COE) services and community based services. In particular services such as Hospital at Home and community based Care at Home will improve our ability to support patients within the community and will facilitate the 'Home First' approach that will be applied. This focusses on patients being transferred home with appropriate support to manage their ongoing medical and rehabilitation needs and improve their outcomes. Implementation of this approach will ensure that the care of elderly patients is not disrupted and also that those patients that do require a longer stay in hospital are managed in the most appropriate location under the care of the most appropriate clinician.

This improvement will deliver a significant benefit through improved patient outcomes as we move care from hospital to home. The reduced dependency on inpatient beds will facilitate the ability to accommodate orthopaedic beds within the existing bed allocation across the two sites.

Stakeholder Engagement

Throughout the orthopaedic review process NHS Lanarkshire has been committed to ensure that it informs, engages and consults with stakeholders and an orthopaedic planning group was established to take forward this review process. This group included clinical, managerial, patient and staff representation. As part of the NHS Lanarkshire Review process two key stakeholder events were held to consider and understand the challenges of the current configuration of orthopaedic services and to identify and appraise options for a revised service model which would address the review's key objectives. The events were held in December 2014 and in March 2015 with each attended by approximately 60 delegates including patients, patient representatives, carers, clinicians, managers, and staff representatives. Scottish Health Council representatives were also in attendance.

The short list of service reconfiguration options from the December workshop was defined in detail prior to the next stage of formal option appraisal, which took place at the March 2015 workshop. The detailed process included identification and impact assessment of any changes required at individual hospital level to facilitate implementation of any of the options. It also took account of working practices, capacity, demand, bed requirements, theatre availability and demographic changes.

The analysis of final outcomes concluded that outpatient services should continue to be provided across three sites and that surgery should be located at Wishaw General Hospital and one other site.

At their meeting in July 2016 the NHS Board considered all evidence from the review, including the Academy report, further peer review visits and further reports on the safety and sustainability of medical staffing from NES. They concluded that a move to an interim service model (the 50-50 split between elective and trauma) should be put into place immediately, and that Monklands DGH could not provide sufficient capacity (theatres and wards) to provide inpatient services as part of this change.

In July 2016 a third (external) stakeholder event took place in advance of the consultation process which allowed patient, carer and voluntary organisation representatives to understand the continuing work of the orthopaedics review, the decisions made by the NHS Board in July 2016, and the proposals for the longer term configuration of single trauma and elective orthopaedic centres.

What Will Change?

Interim Changes to Inpatient Services

The National Clinical Strategy² and the National Trauma Network Report³ set out how concentrating trauma and elective surgery on separate sites can deliver a range of benefits, both in terms of clinical outcomes and the effective use of highly skilled staff.

In terms of delivering service improvement a key change will be through recognising that a large element of the care for the 65+ age group, the largest patient group receiving orthopaedic care, does not necessarily need to be delivered in an orthopaedic setting, and will be more effectively delivered in rehabilitation/shared care environment.

The new model of care sets out significant changes:

- improved patient pathway for the elderly patients, leading to
- improved clinical outcome, and
- reduction in length of inpatient stay.



The younger and the elderly patient groups have different needs which are best met by developing patient pathways specific to each group.

The scale of change that is required to achieve this within Lanarkshire is very challenging: a single trauma unit cannot be achieved at Wishaw General Hospital within the current bed complement at that site without causing significant disruption to other hospital and community services. The NHS Lanarkshire Board agreed on 14th July 2016 to move towards this strategic objective in a phased manner by first moving to two combined trauma and elective units, which was achieved without major disruption to other hospital services. This will enable the development and implementation of a clinical model which improves services for patients, results in improvements to the length of stay in hospital (LOS) and improves the sustainability of the highly skilled workforce.

This had no impact on outpatient clinics, fracture clinics and fractures treated in the three local Emergency Departments.

Longer Term Changes

The trauma work of the orthopaedic service will become part of the West of Scotland major trauma network, focussed at Wishaw for Lanarkshire patients. This was supported by those who responded to the consultation. The timescale for this is dependent on the conclusion of national and regional planning for the new major trauma networks, and the planning of new/refurbished Monklands Hospital (which would allow changes to acute services to be made beyond the limitations of the current buildings).

Similarly, the future configuration of elective surgery may be affected by the Scottish Government's plans for diagnostic and elective treatment centres. However, elective orthopaedic surgery will continue in some form in Lanarkshire and this would be concentrated on one site, either Monklands or Hairmyres.

There was no clear view from the consultation alone as to which hospital this should be, and further appraisal work and stakeholder engagement will take place before a decision on this can be made

Both of these national and regional developments will have a bearing on the future level of services we provide for orthopaedic surgery, which when combined by the increase in the needs of the ageing population - and any opportunities for developing surgical services presented by the replacement/refurbishment of Monklands DGH - mean that the configuration of these surgical services is not yet finalised.

Impact at Monklands DGH

KEY POINT

The NHS Lanarkshire Board has made it clear that Monklands will continue to provide full A&E services throughout the current and future changes to orthopaedic services described above (see also section 4.8).

The Monklands emergency department team will continue to treat the majority of fractures (almost 3,000 each year), and refer those patients to the local fracture clinic – as at present. The Scottish Ambulance Service now takes the small number of emergency cases with major fractures to the nearest appropriate hospital (Wishaw, Hairmyres, or into Glasgow – as at present). Patients who self-refer at Monklands (i.e. not sent by a GP or by the ambulance service) and who require immediate surgery are stabilised, transferred and admitted to either Hairmyres or Wishaw.

In total this has seen a change to the current pathway for emergency treatment for three or four patients each day.

The total reduction in activity at Monklands ED will be around three per cent, and so will not affect the sustainability of the department.

This is now the same process which allows patients who present at a Lanarkshire hospital site with the need for other types of specialist surgery to be safely managed – as at present. For example, specialist vascular surgery cases are

only operated on at Hairmyres, urology and ENT surgery only at Monklands, paediatrics at Wishaw, serious burns at the Royal Infirmary, and serious head and spinal injuries at the Queen Elizabeth University Hospital. This 'Centres of Excellence' model has shown to provide much better clinical outcomes and faster recovery than providing all procedures in every DGH².

What Will Success Look Like?

- Improved quality of care and outcomes for patients
- Shorter hospital stays for patients with enhanced rehabilitation and home support
- Introduction of consistent practice within orthopaedic services
- Improved sustainability of the highly-skilled workforce
- Shorter waiting times for patients prior to surgery
- Building capacity to meet the future population needs for orthopaedic surgery

References

- 1 Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire; Healthcare Improvement Scotland, 2013
- 2 A National Clinical Strategy for Scotland; pp67; Scottish Government, 2016
- 3 Sustainability and Seven Day Services Taskforce Interim Report: www.gov.scot/Publications/2015/03/7764/8
- 4 Trauma and Orthopaedic Services in Lanarkshire; Academy of Medical Royal Colleges and Faculties in Scotland, 2016

4.10 Cancer Services

Vision

To ensure high-quality diagnosis, treatment and care for patients, the work of clinical teams should ensure that care is provided consistently i.e. with less variation. This will take account of the patients' views, preferences and circumstances when considering the clinical team's advice on the care that is most appropriate for the patients' conditions. There should also be clear communication pathways to include patient, GP and wider community teams, with documented evidence to reflect the discussions and outcome.

Current Services

The number of people diagnosed with cancer is rising, reflecting the increase in Scotland's ageing population as well as improvements in diagnostics. As treatments improve, more people will live with cancer for longer (see section 2).

The ambitions of the National Cancer Strategy¹ are:

- To make early detection of cancer the norm
- To have swift diagnosis and results for clinicians and individuals
- To enhance the role of primary care in beating cancer

Larger multi-disciplinary clinical teams working across the West of Scotland will be further enhanced which will improve access to, and outcomes for, cancer treatment.

NHS Lanarkshire has a Cancer Strategy² and this is supplemented by service development plans which cover all 9 main tumour groups :

- Cancer Prevention and Screening
- Genetic and Molecular Testing
- Referral and Diagnosis
- Treatment
- Living with and Beyond Cancer

The Cancer Strategy Implementation Steering Group has broad representation from across Lanarkshire and its partner organisations. It has taken forward a wide range of initiatives to embed primary and secondary cancer prevention messages in the clinical community as well as within the wider community and has actively supported the national Detecting Cancer Early campaign work.

One of the most pressing key clinical drivers for change across the West of Scotland has been the significant increase in Systemic Anti Cancer Therapy (SACT). SACT is commonly referred to as chemotherapy. In 2015 NHS Lanarkshire saw a 24 per cent increase and the SACT Regional Executive Committee project an increase of at least eight per cent per annum to continue.

Currently NHS Lanarkshire provides almost 1,000 SACT patient treatment episodes per month. The service is delivered in over 60 treatment spaces

distributed between Wishaw, Hairmyres and Monklands Hospitals, with each space providing two or three patient treatment slots per day.

The changes in the current delivery of SACT, in relation to the frequency of chemotherapy episodes and complexity of regimens have resulted in an increased chair time from three hours to five hours for some treatments. In addition, patients are also being treated longer, for example, the intensity and duration of treatments has significantly increased therefore the impact on available capacity has been very difficult to manage.

On a weekly basis there is a need to schedule and reschedule patients to ensure all patients can have their chemotherapy safely as per national guidance which involves daily careful co-ordination, including patients requiring supportive care (for example blood transfusion).

Detailed analysis shows that currently capacity across the three sites for SACT is adequate but it is not used efficiently. Patients can receive their treatments from more than one hospital. Patients find this confusing and less than acceptable when feeling unwell.

Need for Change

NHS Lanarkshire has a strong track record over several years of delivering care in accordance with the national cancer diagnosis and treatment waiting time standards. We are amongst the very best in the UK. This has contributed to more people surviving after cancer. However, the growing level of demand as people live longer means we need to continuously look for the means to provide effective and safe care.

One third of SACT treatments are haematology cancers, one third breast cancer, and the remaining third from other cancers. The greatest increase by 42 per cent was seen in colorectal cancer, with an increase in activity across all specialties as illustrated in Figure 10.

Figure 10: Patient Treatment Episodes per Month

Year	Average monthly treatment episodes	Increase from previous year
2012/2013	674	N/A
2013/2014	745	10.5%
2014/2015	925	24.2%

What Will Change?

The future service model for SACT treatment will need to meet the clinical needs of the people of Lanarkshire. The standards of clinical care will be world-class to ensure that we continue to reduce the mortality rates for cancer within the population.

There are indicators which suggest that a clinical model with clinics and day-unit SACT treatment types concentrated on one site in a centre of excellence would lead to better clinical outcomes and greatly improve patient and carer

experience. This option would require only one site as a focus for oncology assessment and treatment delivery. Monklands Hospital would be the specialist site to sit alongside clinical haematology, the new Lanarkshire Beatson radiotherapy unit, Lanarkshire Maggie's Centre and the potential new pharmacy aseptic facility (below).

Patient outcomes will be improved from this change to current services through:

- SACT chair spaces and some bed spaces used more efficiently and are sufficient to meet all future demand
- Dedicated outpatient and diagnostic facilities to ensure timely and effective diagnosis
- Multi-disciplinary team working improved through full use of existing (teleconference) and any new technology
- Effective and timely aseptic pharmacy provision to SACT Units

There will be a phased approach to planning and implementing changes to the current and future service which enables a transition over time towards the single site, but which will ensure continuity of services to patients.

Further engagement with patients, carers and staff will take place to allow future changes to the service to ensure the issues of service quality, patient access and staffing roles are fully explored before any changes are agreed.

Initial planning work began in February 2016 with further capacity modelling leading on from a review of SACT provision across the West of Scotland cancer network. As the major capacity issues are within colorectal oncology, the focus was around this speciality in the first instance. Activity and demand modelling has provided further understanding of the current position and the challenges faced by services and identified areas where improvement and developments are required. Small tests of change are underway with the aim of improving the flow and capacity of patients undergoing colorectal chemotherapy treatments and for those waiting to commence. The output from the learning will be adopted and implemented within other oncology clinics to improve service efficiency and patient experience.

There is also an opportunity to consider a supporting pharmacy facility to this proposal. The national shared-service review of pharmacy aseptic services has recommended that a single Lanarkshire aseptic facility should be built, preferably in the site that minimises lines of distribution. This would provide comprehensive SACT services for patients within the same building complex and serve as a new Centre of Excellence.

This will be used to evidence a direct benefit to patients and clinical care including:

- Consistency of clinical treatment
- Reduction in delays
- Improved patient education
- Improved experience and promptness of chemotherapy delivery
- Improved skills development of staff.

This work will underpin the further redesign of services and enable more detailed modelling work to be undertaken to identify and quantify future resource requirements.

What Will Success Look Like?

- A service co-designed with patients, carers and families to ensure better access to services and treatment
- Sustainable high quality diagnosis, treatment and care for patients diagnosed with cancer
- Improved communication pathways within the wider healthcare professional teams to reflect decision making, care management and follow up requirements
- An improvement in treatment options to include palliative care, when considering the quality care aspects of people diagnosed with cancer and their families
- A radical improvement in the efficiency of flow and chair capacity for chemotherapy delivery
- A single site offering a centre of excellence within NHS Lanarkshire for chemotherapy delivery
- A person-centred approach to chemotherapy delivery through the introduction of outreach models that include treating in the community or within an individual's home
- Improved skills development of staff
- Improved pharmacy aseptic services supporting centre of excellence
- Continue to work in partnership to support and recognise carers' needs to enable them to continue in their caring role
- Utilise voluntary driver services and continue to link with the Travel and Transport work programme and improve transport for cancer services

References

- 1 Beating Cancer: Ambition and Action. Edinburgh: Scottish Government, 2016
- 2 Cancer Strategy – A Framework for Lanarkshire, NHS Lanarkshire, 2013

4.11 Stroke Services

Vision

We will continue to provide excellent stroke care that improves the speed of access to the most appropriate clinical treatment and care resulting in improved outcomes for patients. This includes access to both acute stroke care in a dedicated stroke unit and effective rehabilitation to reduce the risk of longer-term disability. Wherever possible rehabilitation treatment and support will be delivered in a community setting.

Through improvement work, the Stroke Service will continue to deliver world-leading stroke care which is consistently person-centred, evidence-based and safe. We will consult and liaise with other clinical specialties, patient and carer groups and the voluntary sector. Communication with all service partners is key in being able to continue to deliver improvements.

Current Service

When measured against other parts of Scotland, NHS Lanarkshire has a consistent track record of providing very safe and effective care for people who have suffered a stroke. Stroke is the most common cause of severe adult disability and the second most common cause of death in Europe. Stroke incidence has been relatively stable over recent years and this is not expected to change significantly despite the changing demographic profile. NHS Scotland spends five per cent of its budget on stroke care. Lanarkshire has particular challenges, with a younger stroke population than the rest of Scotland, resulting in a greater need for services to be delivered to meet the health and social challenges this presents. NHS Lanarkshire currently has three integrated, comprehensive stroke units, one on each of the three acute hospital sites providing stroke care to the local population. In 2015, 995 inpatients were admitted to the Lanarkshire Stroke Service.

Rapid access to time-critical stroke care is important. The focus of stroke improvement has moved towards measuring the quality of stroke care through defined aspects of care known as the stroke care bundle, i.e. a group of specific interventions/processes of care that significantly improve patient outcomes if done together. Instead of measuring how an individual fares against any one stroke standard, the bundle measures how that individual fares against all relevant Scottish Stroke Care Standards. These clinically evidenced interventions aim to ensure that all patients receive all aspects of high-quality care that are proven to improve the outcome for patients, reducing death and disability.

KEY POINT

“Achieving a care bundle for ischaemic stroke is associated with reduced mortality at 30 days and 6 months and increased likelihood of discharge to usual residence at six months.”¹

NHS Lanarkshire has made continuous improvement year on year in the delivery of the stroke care bundle. Over the past five years, a continuous improvement in performance has resulted in NHS Lanarkshire improving compliance with the stroke bundle from 46 per cent in 2010 to 83 per cent in 2015. Through the cooperative working of stroke clinicians, stroke unit staff and the Stroke Managed Clinical Network, the stroke service model has developed into an effective and efficient service with length of stay at least five days shorter than the Scottish average in all three units. We seek to build on this excellent standard of care in the future.

The Need for Change

With ongoing changes to the evidence base and standards becoming more challenging, a reshape of elements of the stroke services is inevitable in order to respond and continuously improve outcomes for patients.

Alternative models of delivering hospital stroke care were reviewed in 2015, including consideration of the concentration of acute stroke care at one hospital site in Lanarkshire. Evidence supported the current service model (with three stroke units) to be the most effective model of stroke care for NHS Lanarkshire, with other models likely to lead to poorer outcomes for patients including longer inpatient lengths of stay and increased mortality. Therefore, Lanarkshire will continue to provide comprehensive stroke services at each district general hospital.

However we do need to consider our ongoing challenges across the pathway:

- Interventional radiology for clot retrieval
- Neurovascular clinics and outpatient care packages, including same day treatment and use of new drugs treating atrial fibrillation
- Stroke spasticity patients currently treated by Glasgow services
- Stroke education
- Carotid surgery

What Will Change?

By 2020 more advanced 'clot-busting' treatments involving specialist input from neuro-radiology services are likely to develop. The best models to deliver this intervention nationally are not yet clear, and work is ongoing across the UK to explore this. It is possible that some patients will need to be transferred to Glasgow or Edinburgh for these treatments. Alternatively, telemedicine/ technology advancements may make more local treatment feasible.

In neurovascular clinics, an outpatient care package including imaging, secondary prevention, medications and lifestyle advice is planned for 2020. By 2025, patients will be treated on the day of their event to facilitate better patient outcomes and more efficient use of hospital beds. Use of new drugs will allow speedier treatment of outpatients with atrial fibrillation (AF) and reduced stroke risk. It is expected that by 2020, all patients with newly diagnosed AF will have the option of receiving one of these newer agents. Stroke rates will be reduced.

In the development of stroke spasticity treatment, patients will no longer be referred to Glasgow services. By 2020, a service model comprising of a central

Lanarkshire clinic with hospital in-reach is planned. This will be a collaborative venture with colleagues in the traumatic brain injury team through reorganising current staffing and other resources.

Stroke education will continue to play an important role, with education initiatives for the Scottish Ambulance Service, emergency departments and community teams helping to ensure effective knowledge, skills, attitudes and confidence in stroke care provision.

Evidence suggests that the most benefit for a stroke population comes if carotid surgery is performed early. There is a national standard that 80 percent of patients should undergo surgery within this timeframe and NHS Lanarkshire, in common with the rest of Scotland, currently misses this standard. By 2020, through collaboration with radiology and vascular colleagues and with service redesign and pathway optimisation NHS Lanarkshire will consistently meet this target.

What Will Success Look Like?

- **Delivering more utilising current resources:** By delivering a service across Lanarkshire comprising high-quality care for patients and continuing to respond to more challenging evidence-based standards.
- **Improve the capacity and capability of community teams to deliver comprehensive stroke rehabilitation in a community setting supported by a Specialist Stroke Practitioner whose main role is supporting Vocational Rehabilitation (including working with Occupational Health Services) and delivering self-management to patients across Lanarkshire.**
- **By delivering more intensive rehabilitation for complex cases supported by specialist practitioners working with generic community teams to build capacity and capability into these services through mentoring, practical support and ongoing education.**
- **By delivering efficient secondary prevention clinics in line with the National Stroke Standards which facilitate the provision of cutting edge services. These will be led by highly trained specialists, across NHS Lanarkshire.**
- **Delivering targeted early intervention:** by providing speedy access to the latest clot-busting treatments, either locally or regionally, in line with emerging national standards.
- **Consistently provide carotid intervention to all appropriate patients within two weeks of symptoms in line with the national standard.**

- Delivering a more responsive neurovascular clinic: providing patients with speedier access to imaging and appropriate secondary intervention, thus reducing stroke rates.
- Delivering a local tone management service: providing a local service for patients, improving the outcome for patients with spasticity following stroke.

References

- 1 Implementing a Simple Care Bundle is Associated With Improved Outcomes in a National Cohort of Patients with Ischaemic Stroke. Turner, M. et al, Scottish Stroke Care Audit, 2015

4.12 Palliative Care

Vision

NHS Lanarkshire and its partners will meet palliative care needs and provide services in the setting of patient/carer choice, wherever possible. For the majority of people this will be in their own homes or their care home of residence. Admission to an inpatient bed will only happen where absolutely necessary, with discharge facilitated as quickly as possible. There will be an increased range of suitable alternatives to hospital admission, involving partner organisations (NHS Lanarkshire, North and South Lanarkshire Councils, health and social care partnerships, hospices, voluntary and independent sectors and other West of Scotland NHS Boards).

Current Services

Palliative care is an approach to improve the quality of life of people facing life-limiting illness. It is no longer provided just at the end of life, rather needs are identified from diagnosis onwards based on the entirety of a person's circumstances. Palliative care is not just concerned with physical symptoms, it extends beyond the patient to their families as well.

The majority of palliative care needs are met by generalists (e.g. carers, community nurses, GPs) supported by a small team of palliative care specialists. Cancer is covered in section 4.10, but other people transition into palliative care with their own condition-specific teams (e.g. respiratory, heart failure, renal). Additional advice/input is available from palliative care specialists, mostly towards the end of life, and supported by the national palliative care guidelines published in 2014.

The scope of palliative care services has grown in recent years, in line with our 2013 strategy¹. The focus has been on greater availability of a range of supports for dying people and their carers, including expansion of the community Macmillan service to seven-day working, Integrated Community Support Teams in South Lanarkshire, Locality Modelling/Response Teams in North Lanarkshire and anticipatory prescribing via 'Just in Case' boxes.

The Need for Change

There are a number of factors which mean the service must continue to improve:

- People's wishes: around 70 per cent of people say they want to die at home (Dying Matters²), yet only a quarter did so in Lanarkshire in 2011
- Changing personal circumstances: smaller families providing support, or no family living locally (5 per cent of people aged over 85 lived alone in 2012) and the ageing Lanarkshire population (see section 2)
- Publication of the national 'Strategic Framework for Action'³ and 'Realistic Medicine': the Palliative Care Managed Clinical Network is exploring how these can help to further develop the quality of our services, with a focus on end of life interventions and greater public discussion of bereavement,

death and dying. Realistic Medicine⁴ involves information and choice, and not providing interventions which do not add value for patients.

- Transfer of responsibility for healthcare provision from NHS Greater Glasgow & Clyde to NHS Lanarkshire: there is a need to assess the preferred place of care for people from Rutherglen/Cambuslang and the Northern Corridor

What Will Change?

- More support is needed to enable those people who wish to die at home. This may include a rapid response to avoid breakdown of care at home, help for elderly carers who cannot currently cope with palliative care at home and dedicated palliative care hospital discharge support
- In line with the shift of care to increase support for care at home or in a homely setting the HSCPs commissioning strategies may change the configuration of palliative care inpatient (hospice) beds
- New supports are being introduced to inform decision-making towards the end of life to ensure optimal care and treatment choices e.g. Hospital Anticipatory Care Planning⁵, Record of End of Life Care. A good experience of hospital palliative care can provide the assurances that facilitate discharge and maintain care at home
- Lanarkshire has been delivering a structured conversation to enable people to be more comfortable talking about death, dying and bereavement. This will be rolled out further to support Strategic Framework for Action implementation
- Early discussions have taken place around the potential impact of telehealth in palliative care. Initially this may involve simple text messaging to allow palliative care specialist nurses to maintain contact with some patients remotely, thus increasing service efficiency. The range of other telecare support for people at home provided through care packages continues to evolve and improve in quality and sophistication.

What Will Success Look Like?

- People are routinely asked what matters to them and this forms the basis of all palliative care planning i.e. people are at the centre of their care plan
- People access the palliative care services that meet their needs in all care settings, including future developments such as telehealth
- People die in their own homes, if they wish this, with the level and range of supports they require, including support for their carers
- People approaching the end of their lives undergo only those interventions that are effective, thus optimising their quality of life
- All staff are comfortable talking about death, dying and bereavement

References:

- 1 NHS Lanarkshire (2013) Palliative Care Strategy www.nhslanarkshire.org.uk/Services/PalliativeCare/Documents/Palliative%20Care%20Strategy%20Aug%202013.pdf [accessed 29.6.16]
- 2 Dying Matters [accessed 9.12.15] www.dyingmatters.org/page/frequently-asked-questions
- 3 The Strategic Framework for Action on Palliative and End of Life Care. Edinburgh: Scottish Government, 2015
- 4 Chief Medical Officer (2016) Realistic Medicine: CMO Annual Report 2014-15. www.gov.scot/Resource/0049/00492520.pdf [accessed 29.6.16]
- 5 Taylor, DR (2014) COPD, end of life and Ceiling of Treatment. *Thorax* 69: 1-3. doi:10.1136/thoraxjnl-2013-204943

Cross Cutting Services



5

5 CROSS CUTTING SERVICES

5.1 Pharmacy

Vision

All patients, regardless of their age and setting of care, will be supported to ensure they get the best possible outcomes from their medicines while avoiding waste and harm. This will be delivered through pharmacy working in collaborative partnerships with patients, carers, medical and nursing colleagues and the other relevant health, social care, third and independent sector professionals.

Pharmacy Services will support NHS Lanarkshire, North and South Health and Social Care Partnerships to deliver the most appropriate and cost effective, evidence-based treatments, interventions and services to meet the needs of patients. Clear procedural and governance systems which quality assure how services are developed and resourced will be part of the routine practice.

Current Services

Treatment with medicines is the most common healthcare intervention in the NHS. Within NHS Lanarkshire over 11 million prescriptions are dispensed each year at a cost of over £150 million. This indicates that the vast majority of people who seek healthcare advice and treatment will access pharmacy services at some point during their care journey.

Teams of pharmacists and support staff within each of the 143 community pharmacies located across NHS Lanarkshire dispense these medicines to patients and provide advice and help to prescribers, patients and their carers about how to use their medicines safely and to the best effect. The community pharmacy service is governed by a series of national and local contracts which set out the standards for these services. In addition to dispensing medicines community pharmacists also provide complete packages of care without the need for referral to others, this includes smoking cessation, emergency contraception and the supply of medicines to treat self-limiting minor ailments. Many pharmacists are now also contracted to work as independent prescribers across a broad range of areas such as addiction services and polypharmacy reviews.

These themes are replicated within hospital pharmacy practice where teams of pharmacists, technicians and support staff provide a range of services including medicine procurement and supply and specialist dispensing services such as aseptic and cancer chemotherapy dispensing. This is supported by well established clinical pharmacy and medicines information services in which clinical pharmacists are fully integrated into the speciality medical and nursing teams to provide care for patients that is focussed on achieving the best outcomes from medicines. As in community practice many of our hospital pharmacists are qualified independent prescribers.

The Prescribing Management Team works within primary care to provide analysis, advice and support to management teams, general practitioners and other healthcare professionals in order to promote high quality and cost effective prescribing. The Prescribing Management Team is participating in the Primary Care Transformation Programme which will see the introduction of general practice clinical pharmacist independent prescribers into a substantial number of GP practices across NHS Lanarkshire (see section 4.1).



The Need for Change

Across the NHS the use of medicines has continually increased over recent years. While medicines have a significant impact on improving patient outcomes there are risks and the potential over use of medicines is a cause for concern. Taking more medicines than required may be harmful in that it can increase the risk of drug interactions and adverse drug reactions, together with impairing medication adherence and quality of life for patients. Unless the drugs prescribed to patients are reviewed regularly by clinicians with up-to-date knowledge there is a risk that treatment may be ineffective at best and harmful at worst. Indeed each year in Scotland it is estimated that 61,000 non-elective admissions are due to a medicine-related issue¹. To support the continued safe, effective and efficient use of medicines requires that there are robust medicine governance systems in place so that all prescribers in Lanarkshire have access to information and support necessary.

Figures recently released by HIS suggest that 20 percent of the Scottish population is taking five or more prescribed medicines on a regular basis¹.

Lanarkshire has an unenviable and consistent position of seeing a higher volume of prescribing per head of population than any other NHS board area.

There are drivers at both UK and Scottish Government levels which will direct changes in practice and it is essential that we take this opportunity to improve the use of medicines for the benefit of our patients. Recent documents published by the Scottish Government such as 'Prescription for Excellence'² and 'Realistic Medicine'³ make this clear. In particular it is realised that there is scope for pharmacists and other healthcare professionals to work together to better utilise their considerable training and expertise and contribute more to how our healthcare system and patients use medicines to best effect. The Medicines Act 1968 is the basis for much current practice and this is reserved to the UK Government. In 2013 the UK Government established the Rebalancing Medicines Legislation and Pharmacy Regulation Programme Board⁴. This is due to report in late 2016 with recommendations to remove some of the barriers that exist within current legislation.

What Will Change?

Within NHS Lanarkshire we will embrace the opportunities provided and will adopt them to our local environment. For example:

- The pharmacy workforce will be supported and developed to ensure that its unique skill-set is able to be utilised to deliver safe and effective patient care and service efficiently across all health and social care settings.
- We will continue to develop and build upon our foundation of locally negotiated contracts with community pharmacists, particularly in the areas of minimising harms from medicines and providing support for vulnerable patients in their own homes. Increasingly this work will be coordinated with Health and Social Care Partnerships so that the contribution of the pharmacists augments the contribution of all other members of the health and social care teams.
- We will develop services and support materials to help patients and their carers understand the benefits and risks of medication and so pave the way to empower patients to make fully informed decisions about their medication treatments.
- We will be key partners in the Primary Care Transformation programme and deliver services which will see pharmacists and support staff contribute more to the safe and effective treatment of patients, and which will also empower other health care professionals such as nursing staff, physiotherapists and optometrists to do likewise when they access and use medicines to care for their patients.
- The new Prescribing Quality and Efficiency Programme will refresh the governance and financial management systems for medicines within NHS Lanarkshire to ensure they remain fit for purpose for the new opportunities and challenges which changing legislation, structures and the availability of new medicines will bring.

What Will Success Look Like?

- Every person is able to get the best health outcome that they can from their medicines
- Patients are able to make informed decisions about their medicines and discuss them with anyone involved in their care
- Patients are able to ask for help if they have a question or a difficulty with their medicines
- Harm from medicines is reduced
- Treatments of little value are not used
- Medicines no longer required are stopped
- Lanarkshire achieves greater value for the money invested in medicines

References

- 1 www.scottishpatientsafetyprogramme.scot.nhs.uk/Media/Docs/Medicines/SPSP%20Medicines%20Infographic.pdf
- 2 Prescription for Excellence; Scottish Government, 2013
- 3 Realistic Medicine – Annual Report by the Chief Medical Officer; Scottish Government, 2016
- 4 www.gov.uk/government/groups/pharmacy-regulation-programme-board

5.2 Property

Vision

All facilities will be designed to meet the clinical and care needs of the population we serve. We are investing in primary care facilities that support the drive towards delivering care closer to home, without affecting longer term changes being considered for acute and elderly care service models. There will be continuing investment in existing buildings that will improve the quality of health and social care provision and patients' experience.

NHS Lanarkshire's Existing Estate¹

NHS Lanarkshire has a relatively large existing estate comprising a geographically and functionally diverse property portfolio providing over 296,000m² of accommodation.

Primary health care is provided in the community from health centres/clinics, community health centres/day hospitals, as well as from premises housing general practitioners (GPs), dentists, pharmacists, optometrists, health visitors and a wide range of allied health professionals. Some of these represent high quality estate that is designed for modern healthcare while others do not. Overall, NHS Lanarkshire services are provided from 59 locations with a total of 174 buildings on these sites ranging in size from 15m² to 65,000m². However, the majority of these buildings are relatively small, with 112 buildings less than 1,000m² valued at circa £155 million. In addition we deliver healthcare from properties which are not owned by the NHS Board through Private Public Partnership (PPP)/Private Finance Initiative (PFI) agreements and commercial leases.

An analysis of the existing property ownership shows that the PPP/PFI hospitals at Wishaw, Hairmyres and Stonehouse account for over one third of the gross internal area (GIA) occupied by the Board. This is one of the highest proportions for any NHS Board in Scotland and so the proactive performance management of PFI Contracts is a key feature of the work of Property and Support Services. Figure 11 shows that non-hospital space is approximately a third of the estate, reflecting a trend of moving services into the community. However, it must be recognised that NHS Lanarkshire will continue to have a higher ratio of hospital areas to primary care areas than those comparable NHS Boards which have only one or two district general¹ hospitals.

Figure 11: An analysis of the existing estate by building type 2014/15

	Area (GIA) sq.m	% of Total Area
Hospitals – Acute (3)	171,093	58%
Hospitals – Community (12)	35,438	12%
Corporate Sites*	19,134	6.5%
North Lanarkshire: Health Centres, Clinics and Offices	39,660	13%
South Lanarkshire: Health Centres, Clinics and Offices	31,089	10.5%
Total	296,414	100%

28th April 2016, Source: Estate Management System

*Corporate Premises: Kirklands HQ, Law House, Beckford Street, West Laundry

Monklands DGH has greatly exceeded its design life which poses many operational and financial challenges. By 2018 a major £20m project will be completed which will see the refurbishment of Monkland’s operating theatres and Intensive Care Unit (ICU). However, there remain tens of millions of pounds of upgrading which would be necessary in order to bring all areas of Monklands accommodation and services up to 21st century standards.

What Will Change?

KEY POINT

In January 2017 NHS Lanarkshire approved the first stage in the business case to replace the current facilities at Monklands District General Hospital with new hospital accommodation – either on the current site or on a new location in North Lanarkshire.

With the approval of the Scottish Government, this will provide a facility which will serve the people of the whole of Lanarkshire for the next 40 years, and will likely see over £400m invested in the Lanarkshire healthcare system. The planning and approval process has begun on this exciting new project, with expectation the new facilities will be opened in seven years’ time.

Across Lanarkshire, we will develop a fit-for-purpose estate that supports a shift in the balance of care from acute/residential facilities to community/primary care settings.

With the continuous development of digital technologies there will be an increase in the number of clinical contacts which do not need dedicated specialist facilities. At the same time there will be a reduced need for staff office accommodation and clinical (paper) records storage.

Maintaining our existing estate to ensure a safe patient environment is a key priority including:

- Investing in backlog maintenance and statutory compliance to continue the trend towards reducing the associated property related risks
- Rationalising the existing building portfolio to ensure the most effective and efficient use of buildings to support service delivery
- Incorporating all assets into the investment prioritisation and decision making process so that resources can be focussed on greatest need and benefit
- Continued investment in improving facilities to further reduce backlog maintenance and statutory compliance risks at Monklands Hospital, with knowledge of the intent to replace this key facility in due course
- Continued delivery of a risk based approach to improvements to other existing facilities with outstanding backlog maintenance and statutory compliance challenges.



The limitations on capital funding (see section 8) will have an ongoing impact on the ability of NHS Lanarkshire to provide new healthcare premises. Nevertheless some priorities will be progressed which will include:

- Planning the permanent replacement of Monklands DGH;
- Consolidation of South Lanarkshire inpatient mental health at Hairmyres Hospital;
- Primary and community care premises improvements in the Northern Corridor (Stepps, Muirhead and Moodiesburn);
- Improved ophthalmology, dermatology and neonatal facilities in our DGHs;
- Regional/shared aseptic pharmacy production;
- Changes to accommodation which help to improve patient flow in our DGHs.

In this rapidly changing environment of health and social care, revised governance arrangements will be used to ensure the correct allocation of space to services are being refreshed and a standardised and consistent approach shall be applied to ensure the correct allocation of space to clinical need. This will reflect national healthcare standards and the actual needs of services which align for effective delivery of the healthcare strategy.

There have been major changes in the healthcare estate in the last decade, especially across the primary care, administration and mental health functions. With recognition that approximately one-third of the Board's expenditure is still on property and associated maintenance, there is identified scope to make best use of the estate. Building upon information which will be collated in the property gazetteer relating to how space is currently allocated, a rolling programme of space utilisation surveys shall be undertaken. This will identify any potential over or under allocation of space, with a view to reallocating this space to clinical priorities or, where applicable, consideration of declaring some space surplus for disposal, with associated savings. This work will be undertaken in partnership with the community planning partners.

What Will Success Look Like?

- Monklands will be replaced by a facility designed to be an integral part of delivering 21st century health and social care
- Primary and community care will be provided from fit-for-purpose buildings able to meet the future needs of the population
- All of our properties will be fully efficiently used with little under utilisation or overcrowding
- NHS Lanarkshire will meet or exceed our carbon-reduction targets in terms of heating, light and power
- Optimise opportunities for shared accommodation with other public and third sector partners

References

- 1 NHS Lanarkshire Property & Asset Management Strategy 2013–2017

5.3 eHealth and Digital Technologies

Vision

Meeting the 2020 Vision for Scotland and the ambitions set out in the National Clinical Strategy for Scotland¹ requires a well-trained and highly motivated workforce that is supported with modern, adaptive and sustainable eHealth and digital technologies. We need to strengthen our ambition to use technology to enable safer, more efficient delivery of services and provide the ability to collect and analyse data to guide service planning and treatment decisions.

eHealth and digital technologies will support the transformation of patient care enabling further self-care /management supporting patients and their carers.

NHS Lanarkshire recognises the growing impact that eHealth and Digital Technologies (eHealth) is bringing to the delivery of healthcare around the world today. eHealth and Digital Technologies are making healthcare systems more efficient and more responsive to changing healthcare needs and expectations.

Current Service

NHS Lanarkshire has successfully implemented a range of eHealth and digital technologies to support the provision of care. eHealth systems are operational across primary and secondary care. Rather than inventing local solutions, where possible national IT systems have been adopted.

The Need for Change

Our long term vision is to provide a single electronic health record for our patients, however, more work is required to digitise paper records and case notes, share summary information between services and partners, and manage workflow across boundaries.

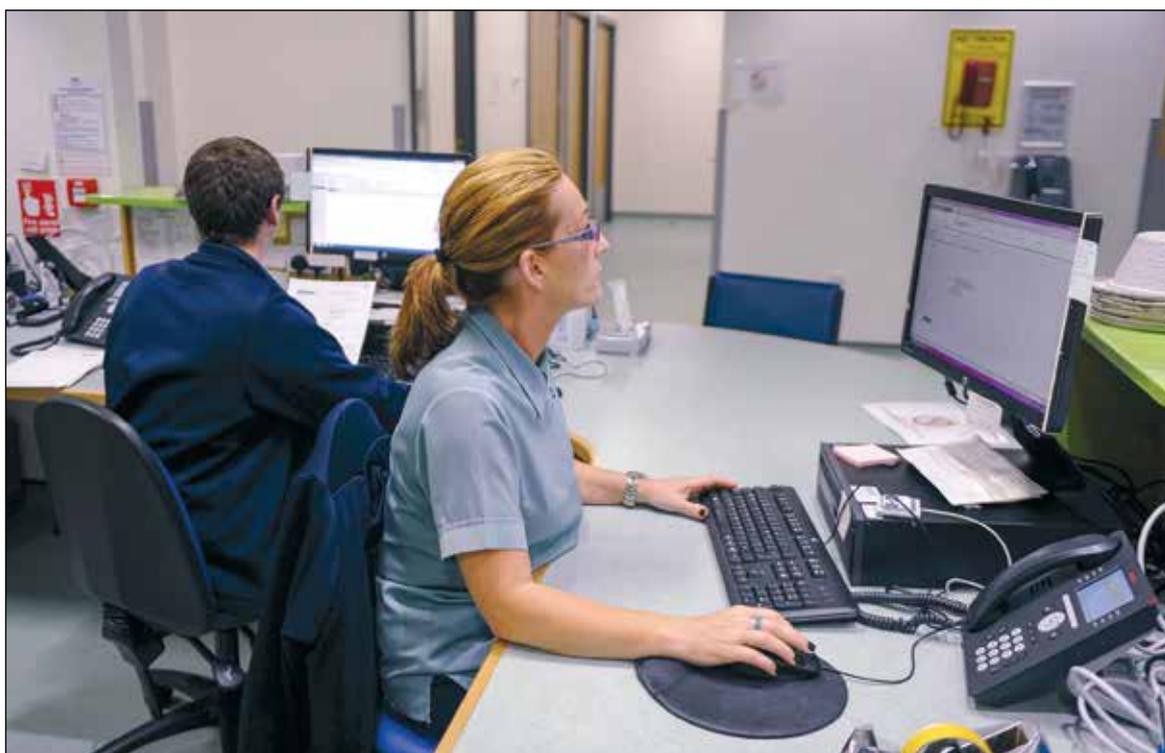
The current limited use of electronic hospital prescribing and administration systems needs to be extended to replace existing paper based systems to ensure patient safety; and work is in hand to do so. Electronic reconciliation of medication records is required between hospitals, GP systems, and community pharmacists to ensure that a common up to date electronic medication view is available.

Improved electronic information sharing is required between health and social care providers and their third sector partners to ensure that the patient receives the right level of care based on all the information available. Electronic systems will increasingly need to support cross boundary working as we concentrate and integrate resources to deliver the best available care, and support mobile access to meet patient and clinicians' needs.

What Will Change?

Modern clinical information systems can help to contribute to improvement in patient care, efficiency and clinical effectiveness. Adoption of digital technologies presents the opportunity to redesign and standardise healthcare processes to meet healthcare practitioner and patient needs. When applied in the right settings IT systems can deliver efficiencies and free up much needed resources to support frontline services.

Telehealth can help support patients live longer lives at home or in a homely setting. More advanced digital services including eConsultation, and home monitoring and video conferencing could support GPs and enhance capacity within community services over time but will require whole systems change. The world of wearable technology incorporating medical devices represents enormous potential to revolutionise current models of care. Over the next 5 years, there will be a seismic shift towards proactive healthcare monitoring and management. This will be driven in part by the consumerisation of the market place providing advanced capability at low cost. This technology will be disruptive; it will begin to truly empower patients with medical grade information. The NHS will need to harness this capability and adapt models of care accordingly.



Clinical portal development has facilitated electronic information sharing across the West of Scotland providing staff with easy access to essential patient information and history, and is increasingly being made accessible to GPs and staff in the community. Clinical Portal is a critical tool in providing access to patient records as patients cross boundaries for care to Glasgow, the National Waiting Times Centre and beyond.

The opportunity to include digitised “live” health records within the Clinical Portal will provide a single view of the patient’s record, accessible real-time 24/7

and will eradicate many of the problems experienced with the traditional paper record.

The introduction of a hospital electronic hospital prescribing and administration system (HEPMA) will provide clinical decision support improving patient safety; the system will reduce drug errors, speed up the medication reconciliation and improve the notification of allergies, drug interactions and duplicate treatments.

We will start to capture clinical information electronically at the point of care. This will reduce the need for handwritten patient records. Significant benefits will be delivered including; legible records, increased availability, easier to share, easier to secure, manage and monitor.

Primary care represents an area where there are considerable opportunities to improve patient care, efficiency and clinical effectiveness through the introduction of modern IT systems. Modern systems provide full integration between General Practice and the wider community setting. The need to adopt a commercially viable community IT solution will enable the shift in the balance of care and support the 2020 Vision and implementation of the Healthcare Strategy. Improved electronic information sharing is required between health and social care and their third sector partners to ensure that the patient receives the right level of care based on all the information available. Electronic systems will increasingly need to support cross boundary working as we concentrate and integrate resources to deliver the best available care, and support mobile access to meet patients' and clinicians' needs.

Patient online access to their personal health record is still only possible in Lanarkshire in very limited circumstances. For example some diabetes patients can access their records on-line. The need to extend access to patient records is a key strategic objective.

Plans are in place to significantly improve the situation with patient access in Scotland within the next few years through the creation of a patient portal. This will give access to a summary electronic patient record, personalised health information and digital services for every citizen in Scotland.

There is a great opportunity to ensure IT systems are in place that will make the NHS safer, more efficient in delivery of services, more easily accessible and provide the ability to collect and analyse data to guide service planning and treatment decisions.

The introduction of real time business intelligence dashboards has made performance management much more effective. This approach should be extended to cover critical areas for example improving patient flow and providing key performance information.

We aim to deliver a single electronic patient record that is accessible by all appropriate clinical staff, operating in multiple clinical settings, to support the delivery of timely, consistent and high quality patient care.

The NHS Lanarkshire eHealth Strategy is about balancing priorities to deliver improved service outcomes around the seven aims in the Scottish Government eHealth Strategy 2014–2017².

This is particularly important as we reshape services to meet the changing needs of our patients and staff: increasing demand; providing 24/7 services; more care away from the larger hospitals; and patients having access to key information to help them better manage their own care. Resources will continue to be used to ensure the service and the patient can make the best use of technology around safety, quality, efficiency and effectiveness.

An element of the population is ‘digitally excluded’ because they lack internet access or have low levels of digital literacy. Digital exclusion is a key barrier to progress because the people with the greatest healthcare needs are often less likely to have the technology and skills to engage with and benefit from digital services.

NHS Lanarkshire will aim to ensure that our patients are not disadvantaged if they are digitally excluded. This means, for example, that we will not assume all patients, relatives and carers have access to (or can make full use of) internet services when developing digital services.

What Will Success Look Like?

- Safer, and more dependable health and social care services
- Person centred information across sectors and boundaries of care which speeds up care
- Digital patient information with minimal use of paper, and more efficient clinical services
- Ultimately, a single digital health and social care record with the many benefits to patient care this will bring
- Increase use of structured digital data to enable clinical decision support, leading to better care and treatment
- Increased home monitoring allowing earlier clinical interventions and supporting care at home

References:

- 1 Scottish Government. A National Clinical Strategy for Scotland. Edinburgh: Scottish Government, 2016
- 2 Scottish Government. eHealth Strategy 2014–2017. Edinburgh: Scottish Government, 2015

5.4 Transport

Vision

NHS Lanarkshire is committed to supporting patients, carers, visitors and staff to access our facilities in a manner which is as straight forward and cost effective as possible. We will work with our partner organisations and a wide range of stakeholders to develop and implement a sustainable transport and travel policy.

Current Situation

A very large proportion of the responses to the 2016 consultation on the Healthcare Strategy focussed on transport to or between our sites.

Patients, carers, visitors and staff travel to healthcare sites by a number of different modes of transport. Survey information, initially undertaken by Strathclyde Partnership for Transport (SPT) then followed up in a hospital survey in 2016, indicated the following:

Mode of transport	Patients/Visitors/Carers	Staff
Private car – as driver	71.53%	81.82%
Private car – as passenger	10.57%	3.38%
Private car – car share	0.00%	0.78%
Bus	5.70%	4.68%
Train	0.80%	4.16%
Taxi	5.70%	0.78%
Walk	5.70%	3.12%
Cycle	0.00%	0.78%
Other	0.00%	0.50%

The above table indicates preferred mode of travel for patients, carers and visitors and also for staff. The results for the various groups are very similar and set out the context within which a sustainable transport and travel policy requires to be developed and implemented. The survey data confirms that 82% of patients, carers and visitors and 85% of staff travel to our sites by private car.

The Need for Change

As “Achieving Excellence” is implemented, the work to establish further centres of excellence (see section 4.7) needs to be underpinned by continued improvement in access to public transport and improved management of car parking at our sites. This will make it easier to move between our hospital sites and assist patients, carers, visitors and staff to access these sites. This reflects the Scottish Government strategic intention to reduce reliance on car use and to improve our carbon footprint by improving sustainable transport.

There is also recognition that supporting people to use their own preferred choice of transport is a key element of ensuring patient choice. Within this

process there is a need to improve access to patient transport which may be provided by a number of agencies, including the Scottish Ambulance Service. The Scottish Ambulance Service will continue to provide transport for patients who have a clinical requirement, and will work collaboratively with healthcare partners and transport providers to formulate a cohesive transport strategy. Our formal engagement with a range of stakeholders has identified that the primary areas of concern for patients, carers, visitors and staff are access to car parking and availability of public transport. The majority of people accessing our sites do so by private car and their specific concerns relate to availability of parking and congestion within our sites.

What Will Change?

Our implementation programme will focus initially on the following four areas of work as these are seen as key elements which will deliver an improvement for stakeholders:

1 Parking at our Sites

It is our intention to develop in conjunction with all relevant stakeholders a definitive parking policy during 2017/18, as a means to resolve a number of issues which have been raised by people as barriers to them accessing clinical services. In particular the policy will consider and set out mechanisms to provide (where appropriate):

- Designated patient parking,
- Designated staff parking,
- Arrangements to prevent inappropriate parking e.g. rail commuters,
- Protected parking for specific patient groups e.g. renal dialysis, cancer,
- Protected parking for particular staff groups e.g. on-call clinicians,
- Parking for car share vehicles,
- Parking for designated pool vehicles.

It is proposed that the final agreed policy will be implemented after completing an appropriate approvals process with effect from 1st April 2018.

2 Public Transport

We will continue to work with key stakeholders such as Strathclyde Partnership for Transport (SPT) to ensure that each of our sites is supported by appropriate public transports links, and that details of all available public transport are widely publicised via appropriate media. There are clear service criteria regarding the level and type of public transport available and it is our intention to ensure that these criteria are met for each of our sites.

A key element of this process is to ensure that communication for transport and travel information is delivered as effectively as possible, and it is our intention to develop and improve existing links to ensure that service provider and timetable information is available quickly and easily. This will take the form of improved access to TraveLine Scotland's live timetable and travel planning information with specific plans to ensure that this is readily

available on a number of platforms. This will include:

- NHS Lanarkshire public website,
- Traveline Scotland website
- Traveline Scotland smart phone apps,
- Access to live information on public transport services at key hospital locations.

3 **Scottish Ambulance Service**

Patient transport provided by Scottish Ambulance Service is a key element in the delivery of clinical services to the wider patient population. Whilst the number of patients who require this service is low, (recent survey data suggests 2%) this is a critical service for those patients who require medical/clinical support during their journey to, or from, healthcare facilities for treatment.

Scottish Ambulance Service have a commitment to provide appropriate transport for patients who meet their eligibility criteria, and we will ensure that there is appropriate parking and drop off facilities at our sites to enable Scottish Ambulance Service to continue this critical work. We will also work closely with the Scottish Ambulance Service to ensure that options are available for the patients who contact the ambulance service for transport but do not meet their eligibility criteria.

We will also improve our appointing systems to take cognisance of patients' geographical location when making appointments first thing in the morning or late in the afternoon as this can be affected by availability of public transport.

4 **Integrated Transport Hub**

The recurring theme from stakeholders through the consultation has been a concern that the wider provision of transport from all service providers is not well integrated and that access to information on service provision can be challenging to access quickly and easily. Third-sector and voluntary transport providers provide important services to patients and relatives, but planning for this is not integrated with ambulance and public transport options. There are also concerns that patients who have very limited access to public transport, are unable to access public transport or those who live in remote or rural locations and do not meet the Scottish Ambulance Service eligibility criteria, have no access to support to travel to healthcare facilities.

Our vision is to establish an integrated transport hub which will achieve the following:

- Improve the transport experience for users of transport services
- Improve the coordination and efficiency of transport for health and social care within Lanarkshire (NHS, third sector, commercial and local authority)
- Provide transport based upon need
- Reduce inappropriate journeys
- Demonstrate value for money

Within this strategic intention and recognising that most patients travel to hospital by car, it is key that:

- Patients who require transport via Scottish Ambulance Service are able to access this
- Patients who require public transport are able to access this easily and quickly
- Patients who do not meet the Scottish Ambulance Service eligibility criteria but do require some support are provided with an option which is effective and accessible (e.g. third sector)

Intention therefore becomes the development of a hub which will act as a single point of contact for booking, scheduling and planning all of NHS Lanarkshire patient transport. We will develop this proposal during 2017–18. This will:

- Increase capacity through more appropriate use of all patient transport
- Improve public transport information to patients, relatives and staff and prioritise SAS resources to ensure that the most appropriate patients are able to access them

We will develop this service in conjunction with SPT and other partners as they have significant expertise and knowledge of operating contact centre services. It is anticipated that the contact centre will be physically located within the existing SPT contact centre in Glasgow and will operate in parallel with the Scottish Ambulance Service contact centre. The intention is to promote a unique contact centre telephone number for patients, relatives, carers and staff in order that they can call the contact centre if they have a health related transport requirement. Contact centre staff will:

- Provide up to date accurate information on public transport availability to the caller,
- Transfer the caller to SAS contact centre if appropriate,
- Identify and arrange alternative transport provision e.g. community transport, volunteer driver, local authority capacity

What Will Success Look Like?

- Clear and understandable parking policy at our sites
- Improved public transport links to our facilities
- Improved patient and carer access to accurate and up-to-date travel information
- Improved joint-planning with ambulance service
- Development of an Integrated Transport Hub providing a single point of contact for patients, carers, visitors and staff

The Workforce of the Future



6

6 THE WORKFORCE OF THE FUTURE

Vision

The NHS in Scotland has one of the most skilled workforces in the world, and a proud tradition of education and training. Overall the numbers of doctors, dentists and nurses have increased but we know that in many specialties there are challenges in employing the numbers of highly skilled staff we need to meet ever changing levels of demand.

A National Clinical Strategy for Scotland, Scottish Government 2016

NHS Lanarkshire's workforce will be instrumental in the successful delivery of the Lanarkshire Healthcare Strategy through making best use of the skills and capabilities of its staff. The workforce, in all professions and at all levels, will have a part to play and staff will be supported and developed to ensure they can fully engage and commit to the revised service delivery models. The future workforce will be based on teams of staff rather than individual practitioners to develop effective multi-disciplinary teams working with the appropriate knowledge and skills. It will integrate more closely the work of hospital based specialties alongside community based teams, with a clear understanding and value of each other's roles and a culture which supports people with long term conditions and their carers to be the lead partners in decisions about their health and wellbeing.

The route map to the 2020 Vision for Health and Social Care outlines the Scottish Government's vision for improving quality and making measurable progress towards high quality, sustainable health and social care services in Scotland. In developing the Healthcare Strategy we will continue our actions to support the five priorities outlined within *Everyone Matters*¹.

Figure 12: *Everyone Matters* 5 Priorities



The future model for the workforce will be realistic and consider the workforce availability, adaptability and affordability to deliver the revised clinical model in the specified timeframe. In effect, the workforce model requires:

- Early projection and preparation of staff to meet the future demand if different skills sets are required
- Adequate opportunity for staff to be developed to meet these requirements
- All this to be framed within a financially viable workforce model

Staff Governance

NHS Scotland's commitment to staff governance was reinforced by the legislative underpinning within the NHS Reform (Scotland) Act 2004. The Staff Governance Standard Framework is the key policy document to support the legislation which aims to improve how NHS Scotland's workforce is treated at work. The fourth edition was developed to take into account developments within NHS Scotland, to reflect the implementation of the Healthcare Quality Strategy for Scotland, the three Quality Ambitions and Quality Outcomes and the Strategic Narrative setting out our 20:20 Vision for healthcare.

The Staff Governance Standards are:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

The Staff Governance Standards provide the foundation for engagement with our staff in shaping the future Workforce to deliver the Healthcare Strategy.

The Fair Work vision is that, by 2025, people in Scotland will have a world-leading working life where fair work drives success, wellbeing and prosperity for individuals, businesses, organisations and society. The Fair Work Framework reinforces the NHS Staff Governance standards as it describes the significance of providing an effective voice, opportunity, security, fulfilment and respect; that balances the rights and responsibilities of employers and workers and that can generate benefits for individuals, organisations and society.

Workforce Availability

Medical Staffing

Currently, there are ongoing issues with medical staffing availability in Lanarkshire and across Scotland. This is particularly acute in general practice (see section 4.2). With an increasing older population and subsequent increase in healthcare needs, the continuation of clinical services delivery based on the current workforce model, with the same level of reliance on medical staffing, is unsustainable. Most of the work streams in the Lanarkshire Healthcare Strategy recognise this and plan to adopt a workforce model whereby there is higher reliance on a range of Advance Practitioner roles. These roles will develop from

several professional backgrounds (nursing, allied health professionals, pharmacy and physician associates), will be trained to take on traditional medical roles/tasks and will become a significant component of the future NHS Lanarkshire workforce.

Ageing Population

The ageing population will not only change the service demands, it will also be reflected in the availability of the NHS Lanarkshire workforce. In effect, we will have an older workforce in 2025 and a higher volume of retirements year on year. With this, NHS Lanarkshire is considering approaches to support older staff to remain in employment (e.g. less physically demanding roles, reduced hours, etc.) while recognising and succession planning for potential loss of skills and knowledge. A Working Longer in NHS Lanarkshire webpage will be launched in Spring 2017.

Service Delivery

To provide safe, effective and person-centred care, the workforce of 2025 should match the workload demands in the care context, location and hours of service. This will see a shift in staffing into the community workforce and will require a change from the existing patterns of work towards 24 x 7 day working.

Recruitment & Retention

NHSL recognises the importance of being an Employer of choice which attracts and retains staff, supported by, recruitment, selections, induction, performance management, strong leadership and staff development processes.

To maximise workforce availability and reduce agency/locum spend, NHSL should promote Lanarkshire as a place to work and where possible review workforce strategies and policies to reflect and support this both for substantive and bank staff.

Workforce Adaptability

Commissioning New Roles

NHS Lanarkshire will undertake detailed multi-professional workload and workforce planning. Effective use of existing resources will be essential as will gaining an understanding of current utilisation of the workforce and the likely implications for retention of the existing workforce, many of whom will remain part of the workforce for the next 5-10 years. This will provide essential baseline data for future remodelling work. The identification of skills and competency gaps will be equally important in ensuring appropriate training and development is ongoing to ensure the workforce is appropriately prepared and supported for the future. It can take 18-24 months to train a qualified healthcare professional to advanced practice level and therefore it is critical that this is initiated as early as possible.

A similar approach will be required to define the generic support worker role. It may not be possible to determine the exact numbers of each role required and so an initial estimate of need should be agreed and used for the purposes of

development. To do this, it is essential that professions are able to define their unique professional contribution and identify tasks which can be prescribed and carried out effectively by support workers, thus building safe and effective capacity.

Influencing Undergraduate Programmes

Ongoing work is required with Regulators, Scottish Government and Higher Educational Institutions (HEIs) to ensure that the development of undergraduate programmes is designed in line with the future healthcare need, with sufficient focus on community care.

Development of existing staff skills

It is envisaged that advanced practice roles will be an integral part of building capacity and capability within the community. The developments for extended roles, such as intravenous therapy, advanced practice, non medical prescribing and extension of health care support worker roles to support the future community care will require engagement with HEIs in conjunction with NHS Lanarkshire’s Practice Development Team and GP practices. NHS Lanarkshire is fully engaged in the national agenda to develop the roles of community practitioners with a view to ensuring it meets the needs of people using our services. The framework below has been developed by NHS Education for Scotland for community nursing and outlines the elements required for safe, effective and person centered care and support in the community. While it focuses on nursing in the community, it reflects the direction of travel in our approach across all professions.

Figure 13: Framework for Modernising Nursing in the Community



Workforce Affordability

Improve efficiency

To maximise the efficiency of service delivery, several workforce redesign factors are being considered:

- **Avoid duplication** – opportunities to integrate and streamline patient pathways will be considered and where possible generic support workers introduced both across health and health / social care (AHP, nursing, social care). This also has the added benefit of providing a greater career structure for the staff involved.
- **Work to “top of licence”** (registered and support staff) – roles require to be reviewed with staff supported and developed to work to the “top of their licence”. This offers the potential to increase staff numbers and redistribute the workload to lower banded but appropriately trained staff, thus avoiding an increase in cost.
- **Extended scope** – to streamline the patient journey and minimise “hand-offs”, certain roles will require to extend their scope to provide some additional aspects of care and avoid referring on to a different healthcare provider or into acute services e.g. community nurses developing Intravenous (IV) therapy skills to allow patients to be cared for in the community; extending psychological care approaches, growing the resilience of people using services to effectively self-care and supporting concordance with agreed personalised treatment plans reducing demands on unscheduled care.
- **Roles appropriate to skill** – to ensure efficiency, appropriately skilled staff should undertake roles e.g. admin staff undertaking admin roles, not clinicians. Staff developed to conduct proactive engagement with patients, their families and carers about what matters to them and how they feel better supported to access services and to self-care when they are able; staff empowered to promote healthy lifestyles and provide support to patients and carers to meet social challenges such as financial security and employment.

In addition, there are other opportunities for efficiency which would support the workforce:

- Improvements in technology such as electronic patient records, mobile technology (tablet computers), etc. would support greater workforce efficiency
- Innovative practice using existing technology based platforms (e.g. NHS Inform MATS) and developing other web-based access to services for early advice and self-management, influencing a culture of self-efficacy which deflects demand away from healthcare services and into upstream services e.g. leisure, voluntary and third sector services.
- NHS Lanarkshire, North and South Lanarkshire Health and Social Care Partnerships will continue to work with third sector colleagues to focus on supporting and testing out new approaches for the delivery of community-based support for people with complex and multiple conditions. This will include delivering an integrated approach that complements mainstream services by other agencies, is fully linked into locality planning arrangements, continuing to focus on building community capacity and local infrastructure to support the delivery of local services and

further develops the commitment to carer support through a structured programme of assessment and support

- Integrate more closely all contractor disciplines such as community pharmacists, dentists, optometrists and care providers to enable patients to better access appropriate care and advice
- Introduce pharmacists in GP practices with advanced clinical assessment skills to support the care of patients with long term conditions and better manage their medications

The workforce to support the Lanarkshire Healthcare Strategy will not be “more of the same”. The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will work to the “top of their licence” with work aligned to their skills. The workforce may require to be redistributed to match the increased workload demand in the community.

It is difficult at this stage to indicate the exact numbers and development requirements for each role until more detailed workload and planning has been undertaken. The workstreams within this strategy have identified key areas of role requirements that have already been developed in other areas within NHS Lanarkshire and the approach can be used to support the development and extend the roles of our existing staff. In addition, leadership and team development approaches are well embedded within NHS Lanarkshire and can be utilised to further develop the knowledge and skills required to achieve the required outcomes.

References

- 1 Scottish Government. Everyone Matters: 2020 Workforce Vision. Edinburgh: Scottish Government, 2013.

Plans for Service Change



7

7 PLANS FOR SERVICE CHANGE

Introduction

In reviewing the future healthcare needs of the Lanarkshire population, there is a range of changes to the scope and disposition of clinical services necessary to achieve the objectives of the strategy, ensuring all of our services are person-centred, safe and effective.

Some of these changes represent an immediate challenge to these objectives and will be implemented soon, but others will take time to plan and develop before implementation is possible. NHS Lanarkshire, in conjunction with Health and Social Care North Lanarkshire and South Lanarkshire Health and Social Care Partnership, will develop a phased plan for service change over a number of years, beginning in 2017.

This section of the Strategy describes the possible timescales for the significant changes to services which are described earlier in the document. However, many of these changes are at an early stage of development and further engagement and discussion may be necessary, alongside clarity of the resourcing and financial impact of some of these developments.

4.1 Primary Care Transformation Programme

- Carry out tests-of-change 2017–18
- Implement changes required by new GP contract 2018–21
- Implement multi-professional workforce development plans 2018–21
- Implement a programme to spread changes across Lanarkshire 2021–26

4.2 Long Term Conditions

- New models of care finalised 2017–18
- Implement workforce plans to build community capacity 2017–20
- Spread good practice across Lanarkshire 2017 onwards

4.3 Older Peoples Services

- Enhanced Locality teams established by 2019
- Intermediate care services defined 2017 onwards
- Community support and interventions spread across Lanarkshire 2017 onwards

4.4 Mental Health and Learning Disability

- Develop integrated community mental health services 2017 onwards
- Develop and implement a Crisis and Distress Interventions service model 2017 onwards
- Develop two-site model for acute admissions for 2020
- Complete inpatient modernisation plan for older people's psychiatry 2017
- Review of forensic services 2017 onwards

- All wards will establish a Quality Improvement Group in 2017
- Review of rehabilitation and recovery service model 2017 onwards
- Enhance mental health liaison in DGHs by 2019

4.6 Alcohol and Drugs

- Implementation of agreed strategies as part of the Single Outcome Agreements 2017 onwards
- Monitor and report Lanarkshire's progress in accordance with the national recovery indicators 2018 onwards

4.7 Maternity, Early Years, Children and Young People

- Developing the roles and capacity of community paediatric teams 2017 onwards
- Changing service model for maternity and paediatrics to reflect changing demographics of the population 2017 onwards
- Ensure the neonatal unit accommodation is enhanced in 2017
- Develop a new service model for paediatric emergency care by 2019

4.8 Planned and Unscheduled Care

- Develop plans which shift clinical care from unscheduled to planned (but urgent) models of care 2017 onwards
- Prepare a business case for the replacement or redevelopment of Monklands DGH 2017–24
- Enhance emergency department capacity at Monklands in 2017
- Develop a proposal for a gastrointestinal bleeds centre of excellence 2017 onwards
- Further develop the cancer centre service model at Monklands 2017 onwards
- Enhance emergency department capability at Wishaw in 2017
- Develop the service model for major trauma services in the West of Scotland 2017 onwards

4.9 Orthopaedic Services

- Consolidate the interim changes to inpatient services during 2017
- In conjunction with national and regional strategies, in 2017/18 prepare a proposal for the establishment of a major trauma centre at Wishaw General Hospital
- Develop a service model for elective orthopaedics which will form part of the emerging proposals for diagnostic and elective centres of excellence through 2017/18

4.10 Cancer Services

- Review the service model for SACT to improve access and quality of care by 2017
- Prepare a proposal in 2017 for the establishment of a SACT centre of excellence at Monklands
- Implement the conclusions of the national shared services review of aseptic drug production by 2020

4.11 Stroke Services

- Develop a service model for advanced clot-busting treatments by 2020
- Implement an outpatient service for neurovascular conditions by 2019
- Develop a service model for local stroke spasticity treatment by 2019
- Enhance professional education for stroke care 2017 onwards
- Develop a service model for early carotid surgery by 2020

4.12 Palliative care

- Develop a rapid response service for support at home by 2020
- Agree a commissioning strategy for hospice inpatient services by 2018
- Improve support for hospital staff to assist patients' decision making by 2020
- Deliver a structured conversation package by 2019
- Develop the use of telehealth to support patients and families by 2019

5.1 Pharmacy

- Enhance the skills and capability of the pharmacy workforce 2017 onwards
- Maximise the roles of community pharmacists through revised contracting 2017 onward
- Develop improved information for patients and carers 2017 onwards
- Develop professional roles further as part of the extended primary care teams 2017-20
- Refresh the governance and financial management of medicines prescribing in primary care and hospitals from 2017 onwards

5.2 Property

- Support health and social care teams to develop the future accommodation needs for Monklands DGH 2017 to 2024
- Develop tools and techniques to improve the efficient use and allocation of space in our premises 2017 onwards
- Deliver a safe and efficient backlog maintenance programme across all areas 2017 onwards
- Support service developments in primary care, hospital services and support services 2017 onwards to support realignment of services

5.3 eHealth and Digital Technologies

- Provide a single electronic patient record which can operate in all clinical settings by 2020
- Develop ideas and proposals for the use of eConsultation 2017 onwards
- Adapt models of care to enable patients to personalise their health information by 2020
- Enhance the clinical portal system from 2017 onwards
- Introduce the hospital prescribing and administration system by 2020
- Develop the use of point-of-care information systems by 2020
- Provide a fully integrated primary care and community IT solution by 2020
- Provide wider electronic access for patients to their own healthcare records through the new patient portal by 2020
- Develop real-time business intelligence through online dashboards 2017 onwards

5.4 Transport

- Improve access to parking for patients and visitors at hospital sites by 2019
- Provide better information on public transport to those who use our facilities 2017 onwards
- Further develop effective use of the ambulance service 2017 onwards
- Support the development of an Integrated Transport Hub in 2017/18

Financial Resources



National Position

The Scottish budget sets out the overall Scottish Government funding for 2016/17 until 2019/20. Over that period the total revenue budget is set to increase from £26.098 billion to £26.468 billion, which averages out at 0.47% per annum. Health budgets have so far only been announced for 2016/17, with a 3–5 year budget expected later in the year. Meanwhile, NHS Boards have been advised to use a higher planning percentage of 1.8% per annum when submitting their future year plans.

NHS Lanarkshire Future Resourcing

NHS Lanarkshire receives a core allocation at the start of the year (£1105m in 2016), followed by a series of in-year funding adjustments for specific purposes. The details of the specific funding for 2016/17 have not yet been confirmed.

Health budgets have traditionally been given a degree of protection and in recent years Boards have been advised to plan on receiving an uplift equivalent to an economic indicator known as the GDP (Gross Domestic Product) deflator. If costs within the health service were rising at the same pace as GDP deflator, this would allow the health service to continue to provide the same level of service in future years. Any efficiency or productivity gains could then be used to provide additional service on top of that allowed by any new in-year allocations.

In 2016/17 health costs will rise faster than the GDP deflator of 1.7%. The paybill, which makes up just under 50% of the total costs is forecast to rise by 3.4% through the combined impact of national insurance increases, a basic pay rise of 1% and agreements to assist the lower paid.

Around 20% of the budget is now spent on drugs. Expenditure on drugs prescribed rose by 22.8% in hospitals during 15/16 and GP prescribing by 4.9% (see section 5.1).

Other factors driving an above inflationary cost rise include a national shortage of doctors, causing an increased reliance on higher cost locums and increased expenditure needed to maintain waiting times. Even with the general allocation uplifted by 1.7% NHS Lanarkshire will need to save £43m in 2016/17 in order to stay within budget. Apart from those areas that received specific additional funding (e.g. primary care) any clinical service change would need to be achieved within the existing budgets.

At present, the estimate of what the NHS Board's underlying financial position could be over the period to 2019/20 is as shown below.

	2016/17 (£m)	2017/18 (£m)	2018/19 (£m)	2019/20 (£m)
Allocation uplift at 1.8%		19.3	19.7	20.1
Pay bill increase		8.7	6.4	6.5
Other general supplies increases		6.7	6.8	6.9
Increase in drugs expenditure (low estimate)		10.3	11.2	12.1
Minimum gap to be met from efficiency savings	-43.0	-6.3	-4.7	-5.4

There are still multiple uncertainties about this projection.

The key variables are:

- The extent to which NHS Lanarkshire can generate £43m of recurring savings in 2016/17. As of June 2016 there was still a gap of £19m recurringly.
- Whether the Scottish Government would be able to give a budget rise of 1.8% to the existing health services given its own budget position and competing demands.
- Whether the rise in hospital drug costs will reduce from its rate of 22.8% in 15/16. The financial plan above assumes only 10.6% from 2016/17 onwards. A 22.8% rise would be over £7.7m more each year.

Given the context of continued constraint on public sector funding at a national level and the historic rise in drugs costs, the above forecast represents the more optimistic end of the range of realistic forecasts. Even still, it indicates that continued efficiency gains will be needed and each area of service delivery will have to maximise productivity and the use of existing resources.

Capital Investment

Various service changes may need capital or other transitional funding to support a service reconfiguration. A replacement for Monklands Hospital will be by far the most significant element of the capital requirement but in the shorter term there will be a range of smaller scale requirements. NHS Lanarkshire's 2016/17 core capital allocation of £12.9m, even once supplemented by an additional £3m of central support, is already overcommitted. The future capital requirements of the Healthcare Strategy will be mapped out in detail and discussed with the Scottish Government. In particular, a business case to secure £400m in investment in Monklands will be prepared.

Let Us Know What You Think



9 LISTENING TO YOUR VIEWS

Early Development Work

NHS Lanarkshire has been involving public, patient and carer representatives, as well as clinical staff, in developing its healthcare strategy since the outset of the development process.

In recognising the need for the development of a healthcare strategy for Lanarkshire, a strategy group was set up in 2015 to take this work forward. Individual workstreams were developed to review services led by NHS clinicians and managers, with involvement from patient representatives, special interest groups and the third sector.

Capturing the patient experience of services has been at the heart of the review process to ensure that any service proposals are aimed at providing better outcomes for patients. NHS Lanarkshire is grateful to those who took part in this early development work and for their investment and commitment to taking this work forward.

As part of the process, NHS Lanarkshire spoke to patients, families, carers and staff to explore how well current services meet their needs and identify ways we can do things differently to better meet these needs in the future.

Throughout the early development work engagement took place within the individual workstreams, in localities and on a Lanarkshire-wide basis. Two major stakeholder events took place in August 2015 and November 2015 to share and discuss the early emerging views on future service needs.

In addition, a Healthcare Strategy Engagement Group - which included patient, carer and third sector representatives - and a Clinical Reference Group – made up of lead clinicians from all professions - were established to review the outputs from the clinical workstreams and oversee the development of this document. An online questionnaire on SurveyMonkey was carried out in February and March 2016 to inform the development of the draft strategy.

Through this collaborative approach, the draft healthcare strategy 'Achieving Excellence' was produced in summer 2016.

The Consultation Process

A formal three-month consultation process on the draft strategy ran from 2 August to 1 November 2016 involving a wide range of stakeholders. NHS Lanarkshire's overarching aim for the consultation process was to consult on the draft healthcare strategy in order to receive meaningful feedback from stakeholders to shape the final strategy.

NHS Lanarkshire worked closely with the Scottish Health Council to ensure the approach taken was in line with CEL 4 (2010) 'Informing, Engaging and Consulting People in Developing Health and Community Care Services' sets out the process to be followed by NHS organisations in the planning and implementation of service changes.

The Scottish Health Council carried out quality assurance of the consultation process which includes seeking the views of stakeholders on the process itself. NHS Lanarkshire has received a report of the consultation process from the Scottish Health Council confirming that it was satisfied that the consultation process met the requirements of CEL 4 (2010).

NHS Lanarkshire set out to consult widely to ensure a wide range of stakeholders from across Lanarkshire had an opportunity to be informed of the consultation and comment on the proposals.

The consultation exercise aimed to provide the opportunity for the people of Lanarkshire, our partners, staff and political representatives to understand the context in which our services will develop in the next decade.

The intention was to initiate a conversation on what this would look like in terms of changing the ways in which these services may need to change as a result. The exercise therefore set out to gather a wide range of ideas and opinions that would be invaluable in completing a well-rounded strategic vision and implementation plan.

The consultation plan included a broad range of communication and feedback methods to ensure people had a range of opportunities to be informed and provide their comments on the contents of the strategy.

This included:

- Consultation documents in a range of formats.
- Consultation questions online as a SurveyMonkey questionnaire – 435 responses.
- E-Newsletter – Three issues emailed to 464 stakeholders during the consultation.
- Media releases.
- Advertisements for the public meetings in local newspapers.
- NHS Lanarkshire public website Achieving Excellence web pages.
- Digital posters on NHS Lanarkshire electronic display screens in the three acute hospitals.
- Printed posters with public meeting details displayed in hospitals, health centres and libraries.
- Awareness raising roadshows at the entrances and restaurants of the three acute hospitals reaching approximately 200 people.
- Five public meetings were held (Wishaw, East Kilbride, Cumbernauld, Lanark and Airdrie).
- 10 locality events were held by the South Lanarkshire Health and Social Care Partnership and Health and Social Care North Lanarkshire.
- 27 additional meetings featured the consultation.
- A range of staff communications.

Your Feedback

Through this activity feedback was received from a wide range of stakeholders including public, patients, staff, elected representatives and organisations during

the consultation process. Throughout the consultation, strong support was expressed for the direction of travel and vision in the healthcare strategy. There was also a great deal of useful and constructive comments about how best to achieve these (see link below). These views then informed the preparation of the final version of this strategy.

NHS Lanarkshire would like to thank everyone who took the time to participate in the consultation process for the thought and effort they put into providing a wealth of valuable and constructive feedback.

The full consultation responses were made available to members of the Lanarkshire NHS Board. In addition, all the specific and detailed comments made on the visions and plans for individual workstreams and cross cutting issues presented in the healthcare strategy were shared with the workstream leads to inform and shape this final version of the strategy along with the implementation plans and processes.

In addition to the consultation responses received, the Academy of Medical Royal Colleges and Faculties in Scotland was asked to undertake a review of Achieving Excellence. The academy outlined that the strategy was consistent with the National Clinical Strategy for Scotland and realistic medicine.

The full NHS Lanarkshire consultation report, which was endorsed by the NHS Lanarkshire Board on 30 November 2016, can be found at:
www.nhslanarkshire.org.uk/boards/2016-board-papers/Pages/November.aspx

We'll be publishing regular bulletins on how the implementation of the ambitions set out in "Achieving Excellence" are being taken forward; please check our website www.nhslanarkshire.org.uk for further updates.

If you'd like to contact us with any questions please write to:

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Glossary of Abbreviations

A&E	Accident and Emergency Department (now known as ED)
ADP	Alcohol and Drug Partnership
AF	Atrial Fibrillation
AHP	Allied Health Professional
CAHMS	Child and Adolescent Mental Health Services
CHD	Coronary Heart Disease
CHPs	Community Health Partnerships
CS	Caesarean Section
DAISy	Drug and Alcohol Information System
DGH	District General Hospital
ED	Emergency Department
ENT	Ear Nose & Throat
ERAS	Enhanced Recovery After Surgery
GDP	Gross Domestic Product
GI	Gastrointestinal
GIA	Gross Internal Area
GIRFEC	Getting it Right For Every Child
GP	General Practitioner
HEI	Higher Educational Institution
HIS	Healthcare Improvement Scotland
HoC	House of Care
HSCP	Health & Social Care Partnership
ICU	Intensive Care Unit
IJB	Integration Joint Board
IV	Intravenous
LENS	Lanarkshire Eye-health Network Service
LOS	Length of Stay (in hospital)
LTC	Long Term Condition
MCN	Managed Clinical Network
MH	Mental Health
MH&LD	Mental Health and Learning Disability
NHSL	NHS Lanarkshire
PFI	Private Finance Initiative
PPP	Private Public Partnership
QEUH	Queen Elizabeth University Hospital
SACT	Systemic Anti Cancer Therapy
SCP	Social Care Partnership
SPT	Strathclyde Partnership for Transport
SVD	Spontaneous Vaginal Delivery
TEC	Technology Enabled Care