

# Clinical Strategy



*Transforming Healthcare in Fife  
2016 - 2021*

## Foreword

This Clinical Strategy will shape the delivery of healthcare in Fife over the next five years and beyond and is our response to the changing needs of a rising and ageing population.

People are living longer, and whilst this is to be celebrated, models of care need to change to meet the evolving needs of our population. They also need to be sustainable for the future. People often experience multiple, complex health problems in later life and chronic conditions such as diabetes, heart disease and dementia are on the rise.

We know that prevention of ill health and early intervention if it occurs, improves people's outcomes. Anticipatory care planning will help keep people well at home or within their communities.

New technology can bring real benefits to clinicians and patients alike and we will make best use of it to improve patients care. Efficient, fit-for-purpose facilities are essential for the provision of 21st century health care and we will reconfigure our estate to provide safe, high quality, person-centred care from the most suitable locations.

Our staff is our most valuable asset and we will support them to develop new skills to enable them to continue to provide high quality services both now and into the future.

Health and care services are facing many challenges but there are opportunities too. By moving more care into our communities and closer to people's homes, by designing 'joined up services' that respond to individuals' needs and by embracing the opportunities afforded by technology we will help the people of Fife live long and healthy lives.

Our sincere thanks go to all the staff, patients, carers and partner organisations who worked incredibly hard to shape the Clinical Strategy for NHS Fife and to the public who took the time to contribute to the engagement process.



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## Executive Summary



### Drivers for Change

#### *Demographics*

The demographic landscape in Scotland is changing. Healthcare improvements mean that people are living longer often with significantly more chronic and complex conditions. In parallel however, the gap in health inequalities is widening with concern that people from hard to reach communities are not experiencing parity in terms of access and outcomes. It is essential that we develop a model for health and social care that enables us to provide a sustainable solution which can cope with the changing demands of our population and which positively address current health inequalities.

Projections suggest that the population of Fife will increase by 8% (30,729) by 2037; there will be a higher number of people aged over 65, many with multiple health conditions placing a greater demand on health and social care services. Older age is associated with an increased likelihood of living with a greater number of long-term conditions; however many younger people also live with one or more chronic conditions. In Fife in 2012-13, 46% of adults reported that they had one or more long-term condition.

It is estimated that every year mental health disorders affect more than a third of the population, the most common of these being depression and anxiety. An ageing population is leading to an increase in the number of people with age-associated mental health conditions such as dementia. In Fife, it is estimated

that 6,000 people are affected by dementia which is anticipated to increase to approximately 10,000 over the next 15 years.

The number of cancers diagnosed in Fife each year is projected to increase by 33%. In 2008-12 there were 153,000 cancers diagnosed. This is projected to increase to over 204,000 by 2023-27.

Many cancers and chronic conditions can be prevented by adopting healthy behaviours. The uptake of screening and vaccination programmes will continue to be promoted and this is especially important in the early years of life. Consideration will be given to how best to engage with patients to help them manage their own health and better engage with healthcare.

### *Strategic Direction*

The *Healthcare Quality Strategy for NHS Scotland*, the *Routemap to the 2020 Vision for Health and Social Care* and the *National Clinical Strategy for NHS Scotland* set the strategic direction and provided a framework for healthcare planning and delivery.

Relevant local and national strategic documents have been taken into account during the development of Fife's Clinical Strategy.

NHS Fife's *Strategic Framework* outlines the Board's vision, values and aims which underpin the Clinical Strategy. In addition, NHS Fife has worked in partnership with Fife Council through the Integrated Joint Board to develop the *Health and Social Care Strategic Plan for Fife* which was finalised in February 2016.

## Development of Fife's Clinical Strategy

Over a six month period, the strategy has been developed through seven workstreams under the direction of a Steering Group. Clinicians from primary and secondary care have led this work with support from multidisciplinary teams and other stakeholders. Each workstream has produced a fuller detailed report with recommendations.

The seven Clinical Strategy workstreams were:

- *Urgent Care*
- *Scheduled Care*
- *Chronic Conditions and Frailty*
- *Cancer, Palliative Care and Care in the Last Days of Life*
- *Women and Children's Services*
- *Mental Health and Learning Disabilities*
- *eHealth, Estates and Support Services*

Fife's Clinical Strategy is aligned with key national and local strategic plans and its recommendations sit within the values of NHS Fife's Strategic Framework. The Clinical Strategy has been developed in partnership with a wide range of stakeholders and describes a future model of effective and proactive healthcare within an integrated health and social care model.

There has been significant engagement with staff, public and patients to share thinking and incorporate their comments and experiences in the development of the Clinical Strategy. This has been done through established groups, social and other media, pop up sessions, a development day and other organised public events.

Following this extensive engagement, themes and principles have been identified. These underpin the recommendations of the Clinical Strategy.

### **What will the future of health and social care look like in Fife?**

In the future people will, with their clinicians and others, be supported to identify their health and well being outcomes that matter to them. Where appropriate, anticipatory care plans will be developed and shared. The plans will include realistic, appropriate and individualised goals. Models of care will be developed to better integrate physical and mental health care and to support people to become more self resilient enabling them to cope with exacerbations of ill health in order to live healthier lives.

Access models will be designed on the principle that care will be provided at home or close to home unless hospital admission is necessary. Review and follow up will where possible, be delivered in a community setting, using a variety of person centred methods including web based self management tools, tele-health, telephone and face-to-face contact.

Access to health and social care services will be through streamlined points enabling the public to obtain the most appropriate support or service for their needs in a timely manner.

A Community Hub model that provides health, social care and other partnership services delivered by a multi-disciplinary team will be explored. It will provide locally co-ordinated, services which may include triage and assessment, sign posting to other services and agencies, diagnostics, rapid access, treatment and review.

In line with the National Clinical Strategy, delivery of services will be planned to ensure sustainability, best outcomes and best use of resources. Specialist

services will be risk assessed and clinical pathways developed with consideration of the following:

- The most appropriate setting for service delivery - at local, regional or national level
- The health benefits from continued delivery of procedures of low clinical value
- The risk of continued delivery of procedures of low volume
- Unnecessary variation in practice when benchmarked against peers

### *Guiding Principles*

Guiding principles were agreed and formed the building blocks for the development of the Clinical Strategy's key recommendations.

1. The provision of services will be needs based, proportionate, person centred and developed in partnership with people.
2. A whole system approach to support and services will be adopted across health and social care and other agencies.
3. Where appropriate, support and services will be delivered as close to people's home as possible in a timely manner.
4. The provision of all health care will be value based in terms of outcomes, efficiency of resources and cost effectiveness.
5. People will take responsibility for their own health with a focus on prevention and early intervention and avoidable admission into hospital.

### *Patient experience*

We have used patient stories to increase the depth of our understanding and show how changes in service delivery could positively impact on patients' care and experience. The workstreams adopted this methodology to illustrate how their recommendations would change pathways of care.



# Executive Summary

## *How to Deliver the Future*

From the extensive workstream reports, patient, public and staff engagement, we developed and agreed the following key recommendations as our routemap to the delivery of the Clinical Strategy for Fife. Delivery of these recommendations will ensure its successful implementation.

## Key Recommendations

### *Person Centred*

1. Wellbeing will be promoted by focusing on the outcomes that matter to people, by listening, understanding and respecting their wishes for attainment of realistic, appropriate and individualised goals.
2. Appropriate care, proportionate to need and outcome-based, will be developed in partnership with patients and their care circle, ensuring people are kept informed and involved in the decisions relating to their care on an ongoing basis.
3. Where appropriate, person-centred anticipatory care plans will be developed, shared and updated through partnership between health, social care, patients and their care circle.

### *Prevention and Health Improvement*

4. Resources will be prioritised to improve our population's lifelong health and wellbeing including maternal and child health, where appropriate interventions may be particularly valuable in preventing ill-health. This includes early detection and vaccination initiatives to reduce the burden of preventable disease.
5. Models of care will be developed that will better integrate physical and mental health care and to support all people to become more self resilient and able to cope with exacerbations of ill health in order to live better lives.

### *Health Inequalities*

6. Health and Social Care will work with the Community Planning Partnership to develop and deliver tailored services which are appropriate to the needs of hard to reach, at risk and vulnerable groups. This work will aim to reduce the current inequalities gap through collaboration between health and social care, housing, education and employment.

### *Access*

7. Access models will be designed on the principle that care will be provided at home or as close to home as possible, unless the risks or need is such that hospital admission is required.
8. Access to health and social care services will be through streamlined points



- of access. This approach will enable the public to access the most appropriate support or service in a timely manner. These access points will be available 24/7 and will triage and direct people within timescales appropriate to need.
9. Access to timely palliative and end of life care in the setting that the patient wishes and that can meet their needs, regardless of age, diagnosis or location.

### *Ongoing Support/Follow Up*

10. Review and follow up for people will where ever possible, be delivered in a community setting, using a variety of person centred methods including web based self management tools, tele-health, telephone and face-to-face contact.
11. The practice of follow up as standard will be eliminated. Instead, follow up will be provided on a needs basis with agreed criteria to allow rapid access for advice or review, where necessary. This will simultaneously reduce the burden of unnecessary follow up appointments upon patients.
12. Self management will be encouraged as the norm using anticipatory care planning wherever possible. Access to enhanced levels of support and care will be available when required via the 24/7 access points.

### *Community Service Development*

13. We will explore a Community Hub model that provides health, social care and other partnership services delivered by a multi-disciplinary team. It will provide locally coordinated, person centred services which may include triage and assessment, sign posting to other services and agencies, diagnostics, rapid access, treatment and review. The aim of the Hub will be to deliver needs based care as close to home as possible.



14. Out of hours care will be developed in line with the recommendations of the National Out of Hours review. NHS Fife and the Health and Social Care Partnership will redevelop its model of out of hours urgent care, linked with community hubs and services, and the redesign of unscheduled care pathways.

### *Acute Service Development*

15. Where appropriate, health care will be provided in the community rather than in the acute hospital. Alternative Health and Social Care models will be developed to support people to manage their health and well being more effectively. This will help support people to remain at home wherever possible by reducing unnecessary emergency department attendances, avoidable emergency admissions and delays at the point of discharge.

16. In line with the National Clinical Strategy, delivery of services will be planned to ensure sustainability, best outcomes and use of resources. Specialist services will be risk assessed and clinical pathways developed with consideration of the following:

- The most appropriate setting for service delivery - local, regional or national level
- The health benefits from continued delivery of procedures of low clinical value
- The risk of continued delivery of procedures of low volume
- Unnecessary variation in practice when benchmarked against peers

### *Health and Technology*

17. We will optimise the use of digital and mobile technologies to enable people to self manage their health, to enable monitoring, diagnostics, advice and access to enhance ongoing care and decision making closer to home where ever possible.
18. There will be fit for purpose systems for the seamless transfer of clinical information. This will improve communication between health and social care professionals and other partners, and enhance quality of care and experience for patients.

### *Workforce and Estates*

19. The Workforce and Estates strategies for NHS Fife will underpin the strategic aims of the Clinical Strategy.

The Workforce Strategy will consider skill mix, training and education to redesign our workforce to support the delivery of high quality, sustainable, future models of care.

The Estates Strategy will rationalise NHS Fife's estate taking cognisance of the opportunities to work collaboratively with Fife Council and other public sector agencies. It will consider co-location, utilisation and future unified service models and facilities efficiency, to define a future estates plan.

## Summary

Greater demand for health and social care requires us to give consideration as to how best to develop our health and care services to meet the need that is already occurring and which will continue to increase in future years. In the foreseeable future, there will be more people living longer with multiple health conditions and it is known that chronic conditions such as diabetes and cardiovascular diseases are more prevalent in areas of greater deprivation.

The Clinical Strategy provides the vision for the provision of clinical services in Fife over the next five years and will be delivered in partnership with staff and public. The Strategy has been developed reflecting the content and recommendations of the National Clinical Strategy, Fife's Health and Social Care Strategic Plan and the Chief Medical Officer's report Realistic Medicine.

The effective implementation of the key recommendations and the transformational care they represent will allow us to provide an effective and sustainable health and social service for Fife in the years ahead.

# 1. Drivers for Change





### 1.1 Introduction

The landscape of health and social care provision is changing. There is recognition that both locally and nationally care needs to be provided closer to home. The demographics of our population are also changing. People are living longer with multiple complex conditions and the care which we provide needs to react accordingly. Across Fife, as with the rest of Scotland, there exists significant health inequality with some of our population having a shorter life expectancy than people living in neighbouring areas - this must change.

The NHS Fife Clinical Strategy provides us with an opportunity to take stock of where we are currently and to focus our efforts on developing a health and care service that is both sustainable into the future and meets the needs of our local population. The financial climate in which we seek to drive change is challenging but also ensures that recommendations we make are carefully considered and designed to deliver the best from available resources.

### 1.2 Context and Drivers of Change

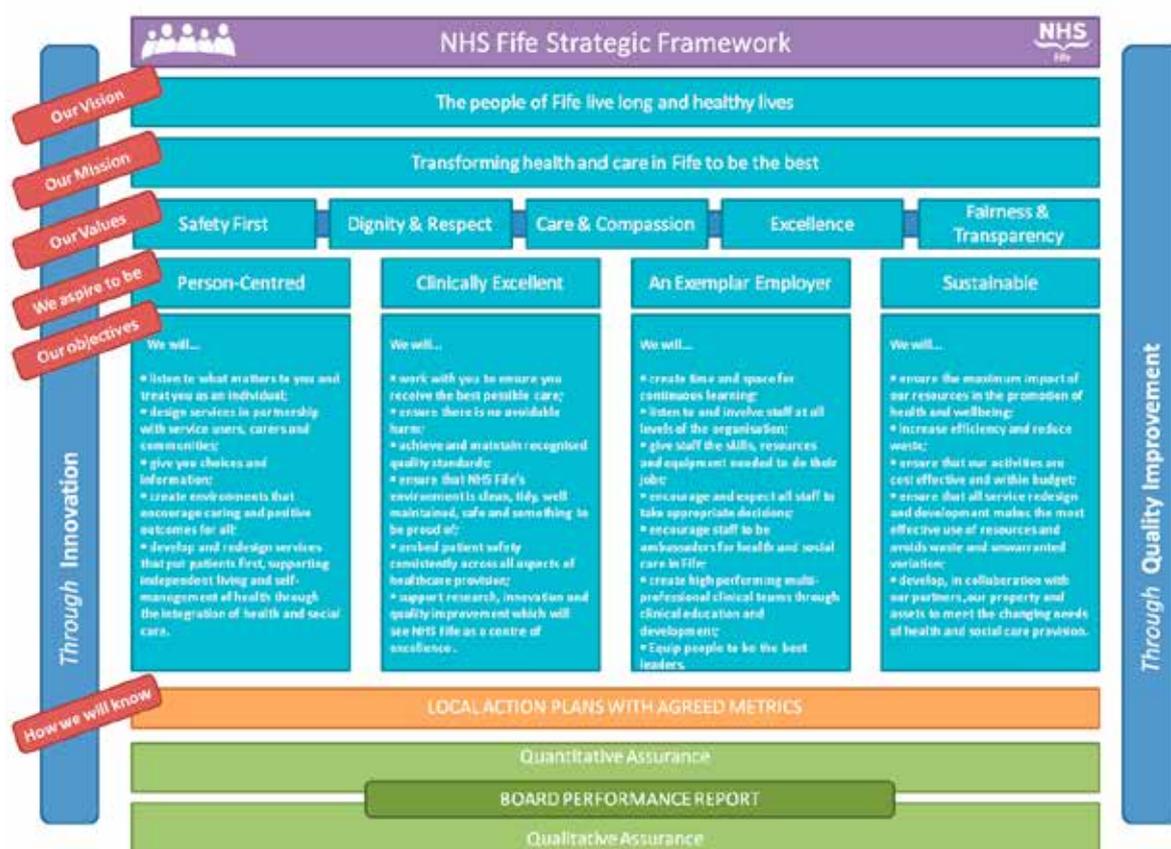
#### *Strategy Documents*

The overarching health aim of the Scottish Government, as detailed in its 2020 vision, is to provide the majority of health and social care in the community, close to home with a focus on prevention, anticipation and supported self

# 1. Drivers for Change

management. Safe, effective and person-centred care which supports people to live as long as possible at home or in a homely setting is desired. This is echoed in the recently published *NHS Scotland National Clinical Strategy*. Where hospital treatment is required this should be for as short a time as possible. Prolonged admissions are disadvantageous to patients as dependency is fostered, risk of hospital associated infection is increased and there is an opportunity cost entailed to the provision of other services.

The Clinical Strategy for Fife is underpinned by enabling principles which are set out within NHS Fife's Strategic Framework (below) and provide a clear statement of purpose for the people who use our services, their family and carers, our partners and staff.



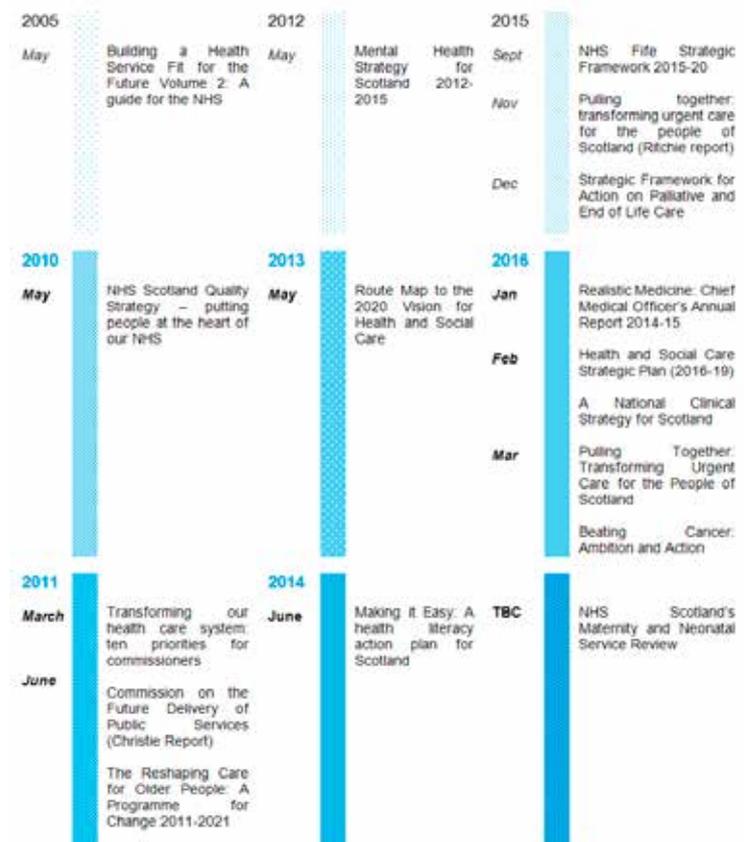
A number of national and local strategies have been considered during the development of the Clinical Strategy for Fife and the diagram (overleaf) illustrates these strategies and policy documents.

Where specialised health services are necessary, the National Clinical Strategy requires us to think about the delivery of these services and to ensure they are 'planned at a national, regional or local level on a population rather than geographical boundary basis'. Services need to be configured so that they can provide health and social care of high quality but which are also sustainable. In delivering care we need to ensure that we are providing excellent value for public money.

# 1. Drivers for Change

Themes from the National Clinical Strategy echo the Mental Health Strategy for Scotland where working more closely with families and carers, supporting patients in understanding more about their condition and treatment and developing a holistic outcomes approach are advocated. *What Matters to You?* (the joint mental health strategy for Fife) builds on the recommendations in the National Mental Health Strategy and emphasises the need to reduce the reliance on hospital beds and building capacity in the community across the range of partner agencies and promoting and maintaining mental health and wellbeing.

*Timeline for Scottish (and other) strategies impacting on Clinical Strategy*



The Clinical Strategy links both horizontally and vertically with other key local strategies and plans such as the Financial Strategy, the Workforce Strategy and the Estates Strategy.

## *Health and Social Care*

Health and Social Care Integration was introduced to support people to live well at home for as long as possible facilitated through the shared delivery of health and social care in the community.

**Fife Health & Social Care Partnership**



Supporting the people of Fife together

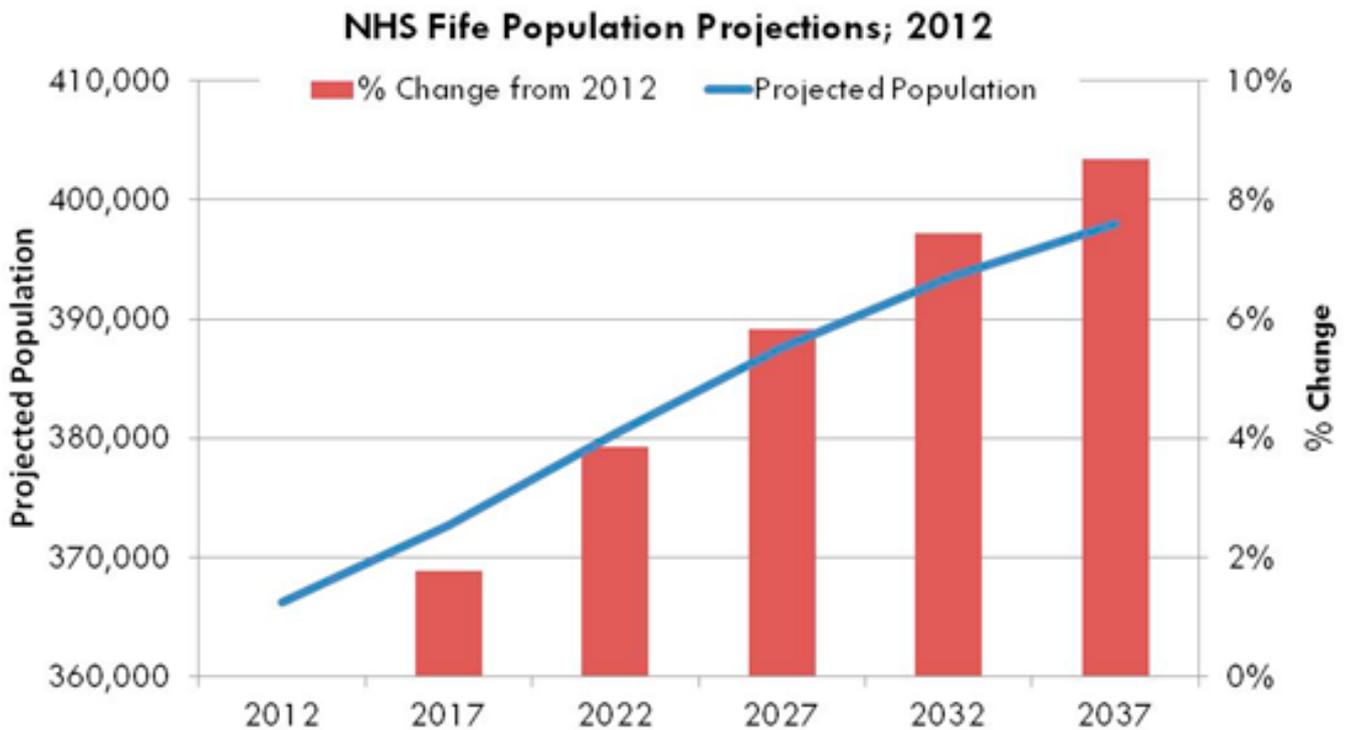
The vision of the Health and Social Care Strategic Plan for Fife (2016-2019) is: "accessible, seamless, quality services and support that is personalised and responsive to the

changing needs of individuals designed with and for the people in Fife". The strategic priorities for the Health and Social Care Strategic Plan for Fife are: prevention and early intervention, integrated and co-ordinated care, improving mental health and wellbeing and tackling inequalities.

# 1. Drivers for Change

## 1.3 Changing demographics of Fife

One of the key drivers is the changing demographics of our population and most notably the increasing proportion of the population who are older. In 2014, the estimated population of Fife was 367,260. In 2013, approximately 19% of the population was aged 65 years and over, 64% aged 16 to 64 and 17% under 15.



The graph (above) shows that from now until 2037 it is estimated that Fife's overall population will increase by 30,729 (8%). However, the increase in population size will not be seen universally across all age groups. Some age groups will reduce in size, for example ages 30 to 64, but the greatest change will be a marked increase in size of the older age groups; the over 75 year old age group is predicted to increase by 44.6% by 2024. It is projected that in Fife between 2012 and 2035, life expectancy will increase from 75.4 to 77.2 years in men and 79.6 to 81.2 years in women.

### Aged 65 and over

The proportion of Fife residents aged 65 and over is expected to grow from 1 in 5 of the population in 2012 to one in four of the population by 2035

### Aged 75 and over

The number aged 75 and over is expected to rise from 29,632 (one in 12 of the population) in 2012 to 39,630 (one in seven of the population) by 2035

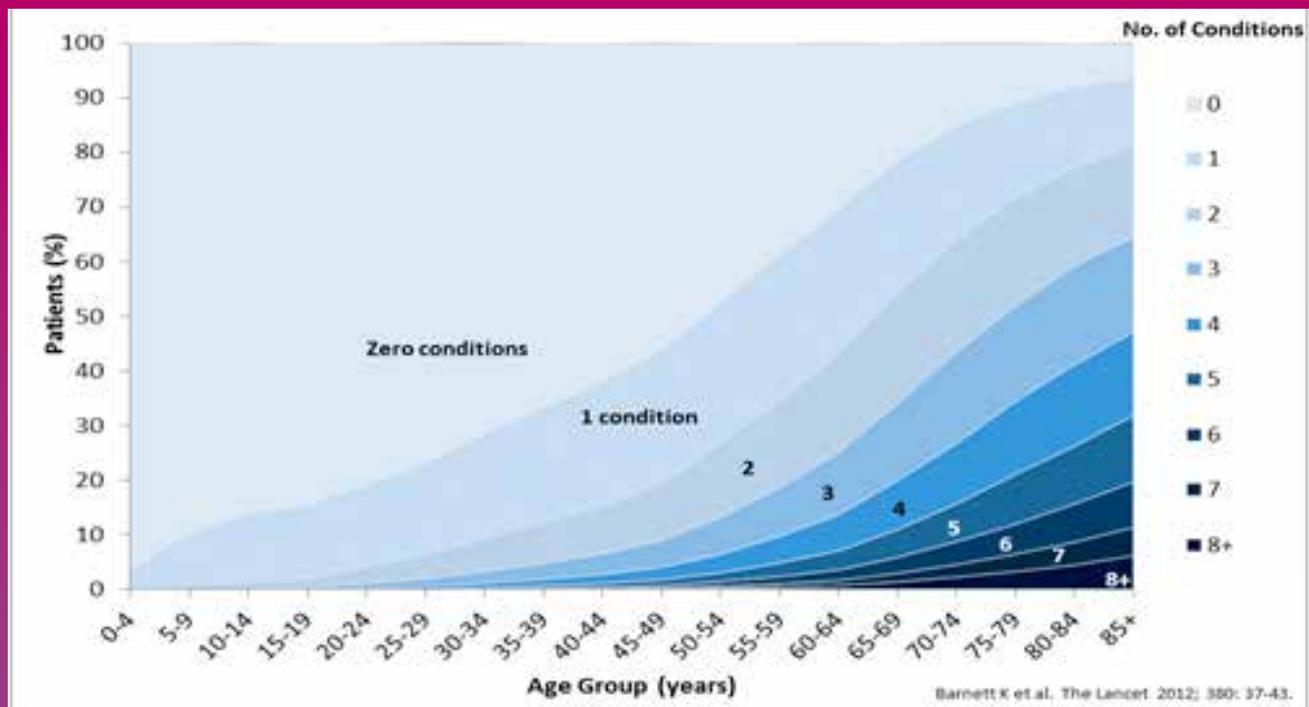
## 1. Drivers for Change

As the population gets older, there will be more people living longer with multiple health conditions. As a person gets older, the likelihood of developing a chronic health condition increases and with increasing age comes an increased risk of co-morbidities. Consequently, there will be a greater demand for healthcare both in terms of scheduled and unscheduled care. Furthermore, the likelihood that someone will be admitted to hospital increases with age and the time spent in hospital after admission is also longer on average.

The number of elective surgical procedures for conditions found more frequently in the elderly such as operations for cataracts and joint replacements will increase as will the number of cases of cancer and age-associated medical conditions such as heart failure, stroke and respiratory disease.

We need to continue to promote and encourage healthy behaviours such as increasing physical activity, reducing alcohol intake, eating healthily and stopping smoking to reduce the risk of ill health as we age but we also need to give consideration as to how best to develop our healthcare services to deliver appropriate care and meet the extra need that is already occurring and will continue to increase in future years.

### Multimorbidity is common in Scotland



- The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions
- More people have 2 or more conditions than only have 1

## 1. Drivers for Change



### *Long-term physical and mental health conditions*

Increasing age is associated with an increased likelihood of living with a greater number of long-term conditions. However, many younger people are also living with one or more chronic conditions. Overall in Fife in 2012-13, 46% of adults reported that they had one or more long-term conditions. The graph on the previous page shows the correlation between the number of conditions people are living with and their age - 80% of people 65 and over will be living with one or more medical conditions.

Chronic conditions such as diabetes and cardiovascular diseases are more prevalent in areas of greater deprivation. At the end of 2012 there were more than 19,000 Fife residents known to be living with diabetes (5.2% of the total population). Of those living with diabetes 53% were aged 65 and older, 89% had type 2 diabetes and 89% were either obese or overweight.

Many emergency admissions in people with long-term conditions - such as dementia, diabetes, respiratory and cardiovascular diseases - could be prevented by more effective community care.

Furthermore, multiple long-term conditions also include mental health illnesses in addition to physical ill health. It is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety. An ageing population is leading to an increase in the number of people with age-associated mental health conditions such as dementia. In Fife, it is estimated that 5961 people are affected by dementia which is anticipated to increase to approximately 9561 over the next 15 years.

### *Delivery of Care*

The bulk of health care need and delivery is located in the community. The National Clinical Strategy emphasises the requirement for increased diversion of resources to primary and community care. The strategy advocates that care should be delivered by increasingly multidisciplinary teams not limited to 'traditional' health services but to incorporate social services and independent and third sector providers where appropriate.

Integrated care across services both within health and between other services and partners is essential to high quality, person-centred, outcome-focussed care delivery. A person's journey from the initial contact with health services through to assessment, treatment and longer-term management should be seamless.

Health and Social Care Integration is designed to improve the balance of health and social care provision and provide a more cohesive service. The 2020 vision and National Clinical Strategy articulate the need for a community-based approach to deliver appropriate preventative and anticipatory care closer to home.

Sir Lewis Ritchie's report - the Review of Out of Hours Services, lays the foundations for consistent urgent and emergency care 24/7 throughout Scotland. Similar to the National Clinical Strategy, the report describes the need for expanded contributions from the nursing workforce, pharmacists, paramedical



## 1. Drivers for Change

practitioners, other allied health professionals, social services workers, third and independent sector personnel.

A potential new model of care where a multidisciplinary, multi-sectoral urgent care co-ordination and communication function will be provided at Urgent Care Resource Hubs. The aim is for healthcare to be delivered by the most appropriate member of a multi-disciplinary team in person, or remotely according to need and circumstances.

Nearly half of emergency hospital admissions arise from social inequality. In Fife, there are marked differences in the health of the population across the region associated with deprivation. For example, first admission rates to hospital with coronary heart disease in the most deprived areas are approximately double the rates in areas of least deprivation. The impact of deprivation and resulting health need must be taken into account when planning services.

However, in addition to 'standard' service development, we need to consider carefully how best to facilitate the engagement of people with managing their own health and engaging with healthcare.

Health improvement interventions play an important role. In Fife, lung cancer is still the most common form of cancer death, accounting for 26% of all cancer deaths and although there have been successes in reducing smoking approximately a quarter of adults still smoke.

Other statistics from the Scottish Health Survey in 2012-13 highlight that currently 10% of adults in Fife report eating no portions of fruit or vegetables on average in a day. 31% of adults are obese (the third highest of all mainland Health Boards) and average alcohol consumption on the heaviest drinking day in the past week was 5.8 units for men and 3 units for women.

Achieving healthier lifestyles not only reduces the incidence of many chronic conditions but also has a beneficial impact on disease progression and is not exclusive to medical conditions. Outcomes following surgery have been shown to be much improved where a patient does not smoke, is not morbidly obese and is physically active.





Supporting people to achieve good health through lifestyle changes is, however, only one piece of the jigsaw. Healthcare services need to be accessible but not just in a physical way. Navigating a health service can be complex, overwhelming, disempowering and ultimately, if unachievable, leads to poorer health outcomes. As healthcare providers it is our duty to ensure that we can give people the knowledge, understanding, skills and confidence to use health information and health services.

Only by doing this can we achieve the aim of providing health care tailored to the individual which provides greatest value to them in a way that has the least potential to harm, and is most in line with people's wishes. The provision of 'realistic medicine' is the core theme of the most recent Chief Medical Officer's report. Too often in medicine care is delivered because it can be and not because it should be, occasionally with detrimental effect. The delivery of healthcare that focuses on what is of best value to the person and engages them in their healthcare management is paramount to good-quality, person-centred, safe and effective care.

### *Workforce*

The Healthcare Quality Strategy for Scotland emphasises the importance of supporting and developing staff and staff wellness, in the delivery of quality care. The promotion of staff health and wellbeing is also core to the vision of Health Promoting Health Service which sees every interaction a patient has with a healthcare professional as a health improvement opportunity. A Health

## 1. Drivers for Change



Promoting Health Service is one supporting person centred care, improving staff health and creating a healthier care environment.

Without healthy, well staff, a service will falter and lack resilience. Staff need to feel engaged and empowered. Currently there are challenges across the healthcare landscape not only in Fife but also nationally in terms of recruitment and retention of staff. Arranging and developing services must be done with workforce health and wellbeing at its core.

### *Health and Technology*

Technology provides the backbone to the delivery of our services. Technology facilitates the communication within and between services and with patients. With increasing partnership working it is vital now more than ever that our IT infrastructure can support this and aid in the delivery of a seamless patient journey.

Technological advances have the potential to change dramatically the way in which healthcare is delivered in future. It may be that we use it to help manage clinical care, identifying adverse signs quickly for earlier intervention both in hospital and the community. Routine follow-up appointments could be provided closer to home by using telemedicine. There is tremendous scope in this rapidly evolving field.

### *Resources*

The financial resources available to support healthcare services are finite. The care which we deliver must be good value for the public. The Quality Strategy advises disinvestment in drugs or treatments which are of low value in terms of cost versus benefit to patients. Where resources are spent delivering one type of service the opportunity costs to other services and ultimately patient benefit must be considered. This NHS Fife Clinical Strategy provides us with the opportunity to challenge our current models of care and consider the best possible use of resources to deliver best care for all the population in Fife.

### **Key Points**

- **Our population is getting older and more people are living with multiple health conditions**
- **Age increases demand for operations such as joint replacement and cataract surgery**
- **Behaviours like eating a healthy diet, not smoking and taking the recommended levels of physical activity each week reduces the risk of ill health**
- **Use of technology will help deliver new models of patient care in the future**
- **Our workforce will be trained and highly skilled to meet the changing needs required by health and care services in the future**

## 2. Development of the Clinical Strategy

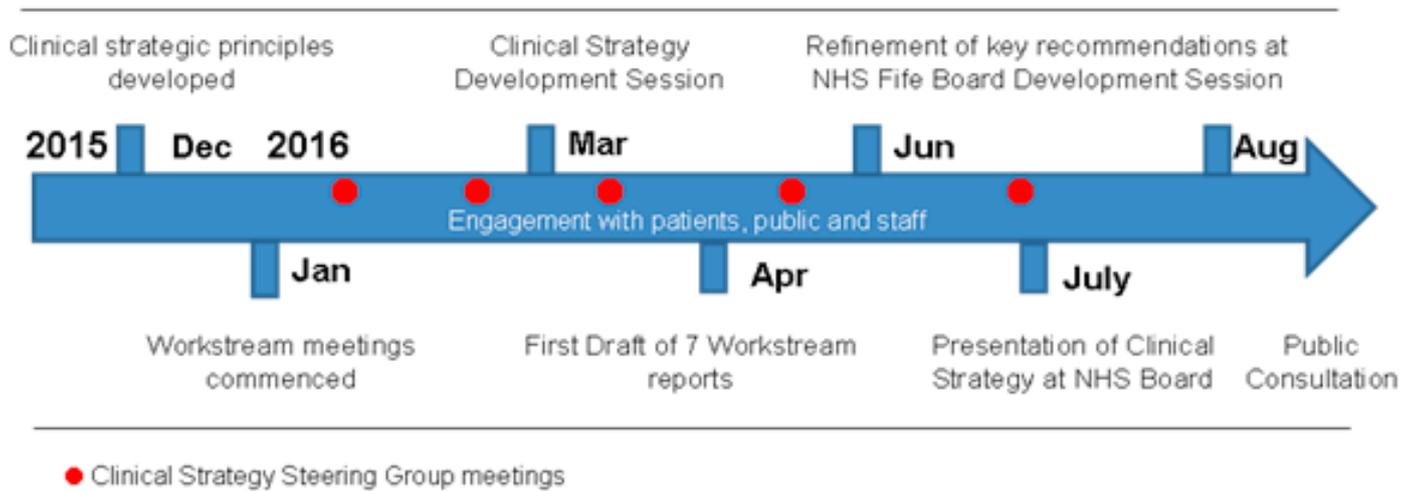


## 2. Development of the Clinical Strategy

### 2.1 Clinical Strategy Timeline

The Clinical Strategy has been developed in partnership with staff, patients, carers, public and partners and by providing an understanding of the context and metrics around current state, develops the case for change and defines the vision for clinical services that will be capable of adapting to future demands. The timeline below illustrates key milestones.

#### Clinical Strategy Timeline 2015/16



NHS Fife aspires to be clinically excellent in delivery of services. This aspiration and the values and aims within NHS Fife's Strategic Framework sit at the heart of the Clinical Strategy.

The NHS Fife Clinical Strategy promotes population health and the development and maintenance of sustainable services. Alternative models of care are considered which harness advancing eHealth and digital technologies and focus on providing the lowest level of intervention required to keep individuals well and resilient within their home and community. A key principle is that services must be designed on a needs basis.

### 2.2 Stakeholder Engagement

NHS Fife aspires to be clinically excellent in delivery of services. This aspiration and the values and aims within NHS Fife's Strategic Framework sit at the heart of the Clinical Strategy.

## 2. Development of the Clinical Strategy

The NHS Fife Clinical Strategy promotes population health and the development and maintenance of sustainable services. Alternative models of care are considered which harness advancing eHealth and digital technologies and focus on providing the lowest level of intervention required to keep individuals well and resilient within their home and community. A key principle is that services must be designed on a needs basis.

During the development of the Clinical Strategy, we asked you:

- What is important to you when you need healthcare?
- What currently works well when you receive healthcare?
- What would make healthcare better in the future?

What you told us:

*"You should be told all your options when you are ill"*

*"Cancer aftercare treatment needs to be closer to home."*

*"Mental health should be considered equally as important as physical health"*

*"I think that the sick people need to pay more attention to their responsibilities"*

*"IT systems that allows results to be shared by all relevant parties including other health boards"*

*"More technology to help keep carers/ patients involved in updates about patients"*

*"More local services"*



Views and comments on the recommendations contained in the Clinical Strategy were also obtained from a variety of sources (including those mentioned above) and through a number of public meetings held in local health centres. These meetings, held locally, ensured that each of the seven GP localities in Fife was represented. In addition, an online questionnaire resulted in over 1000 responses which also provided 300 written comments.

## 2. Development of the Clinical Strategy

During the public consultation, we asked you:

- To consider the recommendations contained in the Clinical Strategy for the provision of healthcare services for the next five years and beyond

What you told us:

*"Providing effective information to people in the places where they live will be a key"*

*"24/7 care should be available for urgent health care but not routine things."*

*"The emphasis on a person-centred approach to making decisions about care is very welcome."*

*"I do agree that patients must take more responsibility for their own health and should not derogate all responsibility."*



*"There should also be consideration for an ageing population that may or may not be good with technology."*

*"Excellent to have a clinical plan and direction of travel to follow and use to guide service outcomes."*

*"Technology has to be forefront with systems being innovative and properly funded. Duplication needs to be avoided."*

In total, over 2,500 people took part in the engagement and consultation process. The reception to the Clinical strategy was broadly positive with most people understanding and approving the general direction of travel. It was noted that clear, measurable objectives for its delivery would be required.

## 2. Development of the Clinical Strategy



### 2.3 Patient Stories

Patient stories play a significant and powerful role in illustrating current service provision and the impact it can have on an individual's experience of healthcare and their eventual health and well being outcomes. 'Before' and 'after' stories to show how services are currently and how they could look in the future - delivering better outcomes for the people of Fife following the implementation of the Clinical Strategy recommendations.

A selection of 'before' stories for Mary and John are presented right, with 'after' stories on page 56 showing how the people of Fife might experience health and social care in the future.

#### “Before” – Mary’s story

Mary is an 87 year old retired teacher from Glenrothes who lives alone with no package of care. She falls whilst getting ready for bed at 10pm and sustains minor injuries to her leg but no fracture. She presses her community alarm and help is sent; she is found to be mobile with a stick and a little dizzy and shaken but still independent and no further action is thought necessary. 3 weeks later Mary falls again at home and sustains a fractured neck of femur (broken hip). She is admitted to the acute hip fracture ward via A&E and undergoes hemiarthroplasty (similar to a hip replacement) with subsequent protracted rehabilitation complicated by development of pneumonia and a deep venous thrombosis (blood clot in the leg). 8 weeks later she is discharged from community hospital to a local nursing home.

### “Before” – John’s story

John is a 25 year old from Leven, with prior history of deliberate self-harm and mood disorder, who has recently felt more depressed after being made redundant from his job at the paper mill. He takes a paracetamol overdose following an argument with his partner at 11pm on Saturday night and calls NHS24 who advise him to attend A&E. John attends A&E where he waits until 3am surrounded by some intoxicated and agitated patients and their friends. When finally reviewed by the A&E junior doctor at 3am he is anxious and upset, and refuses medical treatment although is assessed as having taken a potentially toxic dose of paracetamol, with inpatient treatment advised. There is a several hour delay in Psychiatry assessment because of competing demand elsewhere, during which John becomes increasingly agitated and eventually aggressive, culminating in his being detained under the Mental Health (Scotland) Act by A&E staff. He is forced to stay for treatment against his will, being brought back by security when he tried to leave, and 24 hours later is reviewed by Psychiatry but struggles to engage with the consultation. He is later discharged and offered Psychiatry follow up, but doesn't attend his appointments as he found his recent experience very distressing and would rather try to forget it and not risk having a similar experience again.

# 3. Principles and Key Recommendations



## 3. Principles and Key Recommendations

### 3.1 Guiding Principles

The following guiding principles were agreed and formed the building blocks for the development of the key recommendations.

*The provision of services will be needs based, proportionate, person centered and developed in partnership with people.*

*A whole system approach to support and services will be adopted across health and social care and other agencies.*

*Where appropriate, support and services will be delivered as close to people's home as possible in a timely manner.*

*The provision of all health care will be value based in terms of outcomes, efficiency of resources and cost effectiveness.*

*People will take responsibility for their own health with a focus on prevention and early intervention and avoidable admission into hospital.*

### 3.2 Key Recommendations

The recommendations from the seven workstreams of the Clinical Strategy have been distilled, refined and consulted on. These key recommendations have been themed and alongside the Health and Social Care Strategic Plan will guide the development and delivery of health and care services in Fife going forward.

The workstream recommendations have been themed under the headings:

- Person Centred
- Prevention and Health Promotion
- Health Inequalities
- Access
- Ongoing Support and Follow Up
- Community Service Development
- Acute Service Development
- Health and Technology
- Workforce and Estate

#### Person-Centred

Being person-centred is about focusing care on the needs of the person rather than the needs of the service. Many people who need health or social care aren't happy just to sit back and let staff do what they think is best. They have their own

### 3. Principles and Key Recommendations

views on what's best for them and their own priorities in life. So as health and care workers, we have to be flexible to meet people's needs - we have to make our system suit them, rather than the other way round. Being person-centred means that when we plan care with the person, we think about the effect of what we're doing on the person as a whole.

#### *Recommendations*

1. Wellbeing will be promoted by focusing on the outcomes that matter to people, by listening, understanding and respecting their wishes for attainment of realistic, appropriate and individualised goals.
2. Appropriate care, proportionate to need and outcome-based, will be developed in partnership with patients and their care circle, ensuring people are kept informed and involved in the decisions relating to their care on an ongoing basis.
3. Where appropriate, person-centred anticipatory care plans will be developed, shared and updated through partnership between health, social care, patients and their care circle.



#### *What this means to you?*

1. *We will listen to what matters to you and respect your wishes.*
2. *You will be a partner in all decisions about your care and we will develop plans with you and your family to help you remain well.*
3. *The care offered to you will be based in your level of need.*

### Prevention and Health Improvement

The main function of health improvement is to find ways of preventing ill-health, protecting good health and promoting better health. This is achieved by working with local communities and organisations across public, private and voluntary sectors to address the personal, socio-economic and cultural factors that influence the health of each person.

#### *Recommendations*

4. Resources will be prioritised to improve our population's lifelong health and wellbeing including maternal and child health, where appropriate interventions may be particularly valuable in preventing ill-health. This includes early detection and vaccination initiatives to reduce the burden of preventable disease.
5. Models of care will be developed that will better integrate physical and mental health care and to support all people to become more self resilient and able to cope with exacerbations of ill health in order to live better lives.

## 3. Principles and Key Recommendations



*What this means to you?*

- 1. We want everyone to be able to live better lives and be able to cope with times when they are unwell.*
- 2. We will provide information and services to help the people of Fife to improve their health and wellbeing and prevent health problems.*
- 3. Looking after children in their early years will improve their health and well being later in life.*

### Health Inequalities

Tackling health inequalities is challenging. Health inequalities are influenced by a wide range of factors including access to education, employment and good housing; equitable access to healthcare; individuals' circumstances and behaviours, such as their diet and how much they drink, smoke or exercise; and income levels. Given the complex and long-term nature of health inequalities, no single organisation can address health inequalities on its own.

*Recommendations*

- 6. Health and Social Care will work with the Community Planning Partnership to develop and deliver tailored services which are appropriate to the needs of hard to reach, at risk and vulnerable groups. This work will aim to reduce the current inequalities gap through collaboration between health and social care, housing, education and employment.*



*What this means to you?*

- 1. We will plan health and social care services to be accessible to all members of the community.*

### Access

We have a responsibility to ensure that all people have access to appropriate services when they need them and to ensure that treatment offered is based upon the best interests of each individual.

*Recommendations*

- 7. Access models will be designed on the principle that care will be provided at home or as close to home as possible, unless the risks or need is such that hospital admission is required.*

### 3. Principles and Key Recommendations

8. Access to health and social care services will be through streamlined points of access. This approach will enable the public to access the most appropriate support or service in a timely manner. These access points will be available 24/7 and will triage and direct people within timescales appropriate to need.
9. Access to timely palliative and end of life care in the setting that the patient wishes and that can meet their needs, regardless of age, diagnosis or location.



*What this means to you?*

1. We will design our health and care services to be delivered as close to where you live as possible.
2. We will develop simple points of access that help direct you to the support or care you need.
3. When specialist care is needed there will be timely access to provide the right care for you.

### Ongoing Support/Follow Up

There is evidence that patient action plans and education for self-management can lead to improvements in quality of life and a reduction in utilisation of health and care services. The use of care plans is a key component of integrated care programmes and have shown to have positive outcomes such as improved functional health status and a reduction in hospitalisation, dependency and mortality.

#### *Recommendations*

10. Review and follow up for people will where ever possible, be delivered in a community setting, using a variety of person centred methods including web based self management tools, tele-health, telephone and face-to-face contact.
11. The practice of follow up as standard will be eliminated. Instead, follow up will be provided on a needs basis with agreed criteria to allow rapid access for advice or review, where necessary. This will simultaneously reduce the burden of unnecessary follow up appointments upon patients.
12. Self management will be encouraged as the norm using anticipatory care planning where ever possible. Access to enhanced levels of support and care will be available when required via the 24/7 access points.



*What this means to you?*

1. You will be encouraged and supported to look after yourself at home.
2. We will reduce the amount of routine follow up. Instead we will provide rapid access to services when you need them.

### Community Service Development

We know that it is better for people to be supported to stay in their own homes and communities for as long as possible and we also know that many services that are currently provided from a hospital setting would be better provided in the community.

#### *Recommendations*

13. We will explore a Community Hub model that provides health, social care and other partnership services delivered by a multi-disciplinary team. It will provide locally coordinated, person centred services which may include triage and assessment, sign posting to other services and agencies, diagnostics, rapid access, treatment and review. The aim of the Hub will be to deliver needs based care as close to home as possible.
14. Out of hours care will be developed in line with the recommendations of the National Out of Hours review. NHS Fife and the Health and Social Care Partnership will redevelop its model of out of hours urgent care, linked with community hubs and services, and the redesign of unscheduled care pathways.



#### *What this means to you?*

1. We will develop Community Hubs in local areas where you can access information and care from a variety of organisations including health, social care, housing and voluntary services.
2. We will develop new models for Out of Hours care to help match your need with the best care or support.

### Acute Service Development

Acute hospital care can be highly complex. We will work to implement the recommendations contained in the National Clinical Strategy to ensure the best health outcomes for the people of Fife.

#### *Recommendations*

15. Where appropriate, health care will be provided in the community rather than in the acute hospital. Alternative Health and Social Care models will be developed to support people to manage their health and well being more effectively. This will help support people to remain at home wherever possible by reducing unnecessary emergency department attendances, avoidable emergency admissions and delays at the point of discharge.
16. In line with the National Clinical Strategy, delivery of services will be planned to ensure sustainability, best outcomes and use of resources. Specialist services will be risk assessed and clinical pathways developed with consideration of

### 3. Principles and Key Recommendations

the following:

- The most appropriate setting for service delivery - local, regional or national level
- The health benefits from continued delivery of procedures of low clinical value
- The risk of continued delivery of procedures of low volume
- Unnecessary variation in practice when benchmarked against peers



*What this means to you?*

1. *There may be changes to where you are seen and treated. Services will be provided locally, regionally or nationally to ensure we provide the best care, experience and outcomes for you.*
2. *We will design services to provide better alternatives to hospital attendance and admission.*

### Health and Technology

eHealth is the overarching term that is used for Telehealth and Telecare, Telemedicine, Digital Health, Mobile Health and Health Informatics all used to help meet the needs of individuals and improve the health of citizens. It enables:

- Information sharing and improves the safety and quality of care.
- Support for people to manage their own health and wellbeing and live longer, healthier lives at home or in a community setting.
- Efficient working practices, minimisation of wasteful variation,

*Recommendations*

17. We will optimise the use of digital and mobile technologies to enable people to self manage their health, to enable monitoring, diagnostics, advice and access to enhance ongoing care and decision making closer to home where ever possible.
18. There will be fit for purpose systems for the seamless transfer of clinical information. This will improve communication between health and social care professionals and other partners, and enhance quality of care and experience for patients.



*What this means to you?*

1. *We will use technology to make sure that the person you are seeing will be the right information about you to make the best possible decision about your health.*
2. *We will use technologies in many different ways to help you keep well at home and access services closer to home.*

### Workforce and Estates

Fit for purpose estate will be realised by co-locating services and utilising the most efficient, suitable council and health premises available. This new approach will ensure efficient use of resources and provide good quality accommodation for staff and the people of Fife.

Our workforce will be developed to meet the changing needs of the service and provide the highest quality patient care.

#### *Recommendations*

19. The Workforce and Estates strategies for NHS Fife will underpin the strategic aims of the Clinical Strategy.

The Workforce Strategy will consider skill mix, training and education to redesign our workforce to support the delivery of high quality, sustainable, future models of care.

The Estates Strategy will rationalise the NHS estate taking cognisance of the opportunities to work collaboratively with Fife Council and other public sector agencies. It will consider co-location, utilisation, and future unified service models and facilities efficiency, to define a future estates plan.



#### *What this means to you?*

- 1. Our staff are valuable. We will train them and use their skills in the best way possible.*
- 2. We will put services into buildings that are close to your home and makes the best use of what we have.*

# 4. Workstream Recommendations



# Urgent Care

## 1. Urgent Care Workstream Recommendations

### *eHealth*

Electronic information sharing must be improved so that electronic records becomes the norm, with seamless transfer of information between all healthcare professionals involved in the patient journey and with inclusion of relevant social care partners, to ensure a cohesive system.

Digital technologies should be explored and exploited to facilitate person-centred care closer to patients' homes, reducing demand to attend acute hospitals and follow up clinics.

### *Access*

Streamlined points of access for public and healthcare professionals for accessing urgent care, including Mental Health, should be developed.

Community resilience should be strengthened by the development of multi-disciplinary Community Hubs.

Multi-professional teams in the community should be optimised to support patient care at or closer to home, including use of community pharmacists to manage minor conditions and undertake polypharmacy review. There is potential to redesign Intermediate Care, to review provision of STAR and emergency respite beds, and develop models of See and Treat by Paramedics.

## 4. Workstream Recommendations

### *Acute Hospital Service Provision*

Unnecessary transfer of patients from care homes to the acute hospital should be minimised by ensuring all such patients have Anticipatory Care Plans in situ, standardisation of documentation and extension of Hospital at Home hours to allow more access for referrals.

Delivery of healthcare in the community rather than in the acute hospital should become the norm, with people being directed to specialty advice which will be more readily available. Education and signposting will empower people to manage their own health. Prompt, safe discharge from hospital should be facilitated, including timely turnaround of prescriptions and availability of transport.

Acute hospital services should be optimised including bolstering and centralisation of services out of hours, and ensuring trained staff are supported and enabled to work at the top of their abilities.

### *Mental Health Services*

The Liaison Psychiatry Service should be further developed and expanded.

### *Out of Hours Review*

The Ritchie Report recommendations should be explored and implemented where appropriate to NHS.

## Recommendations in Practice

*Urgent care pathways will be developed to optimise the patient experience through the input of the multi-disciplinary team.*

*Urgent care hospital services will be restructured to ensure they provide the best care for the people of Fife.*

*More urgent care services will be provided in the community rather than the acute hospital.*

*An electronic patient record accessible to urgent care professionals in all sectors will be developed.*



# Scheduled Care

## 2. Scheduled Care Workstream Recommendations

### *Service Review*

- To undertake an extensive review of the current services and treatments offered within NHS Fife.
- To perform an in-depth review of low volume procedures, low surgeon volume and procedures of low clinical value.
- To perform an in-depth review of services at risk from workforce related issues and analyse the difficulties retaining and recruiting specialist staff.
- To analyse secondary care specialties that might be suitable for regional working through managed clinical networks as identified in the National Clinical Strategy.
- To explore the systematic use of comparative information about GP practice and referral rates by specialty to reduce inappropriate referrals.
- To continue the ongoing review of theatre efficiency across all sites through the existing Theatre Action Group (TAG) and Day Surgery Users Group. To perform a robust review of the pre-assessment process and optimise the day case/ 23hr stay facilities at Queen Margaret Hospital.
- The robust adoption of value based healthcare for all healthcare treatments and interventions.

### *Community Hub*

Perform an in-depth feasibility study and risk assessment towards the creation of a community based multi-professional team based around General Practice

## 4. Workstream Recommendations

including generalists working alongside specialists to support the delivery of Scheduled Care. This may include referral triage, diagnostics, self-management tools and sign posting for other services and agencies focusing on case management and support to home-based care.

### *Needs Based Care*

Clinicians in primary and secondary care will agree clinical management plans with patients that are proportionate to their needs and help address their health concerns. This may or may not involve offering any treatment or medical intervention.

### *Technology Enabled Care*

Future planning of Scheduled Care services must be supported the latest technology available. Clinical information between health and social care professionals, regardless of location, must be made available via one portal in order to provide the safest and most appropriate care. Technological care solutions must be implemented as alternative methods of providing care and support.

### *Health Improvement and Prevention*

Prioritise resources to deliver evidence based health improvement and prevention to improve health and well being of the people of Fife. Behavioural change programmes must be instituted to encourage patient lifestyle change and resources put in place to support self management closer to home.

### **Recommendations in Practice**

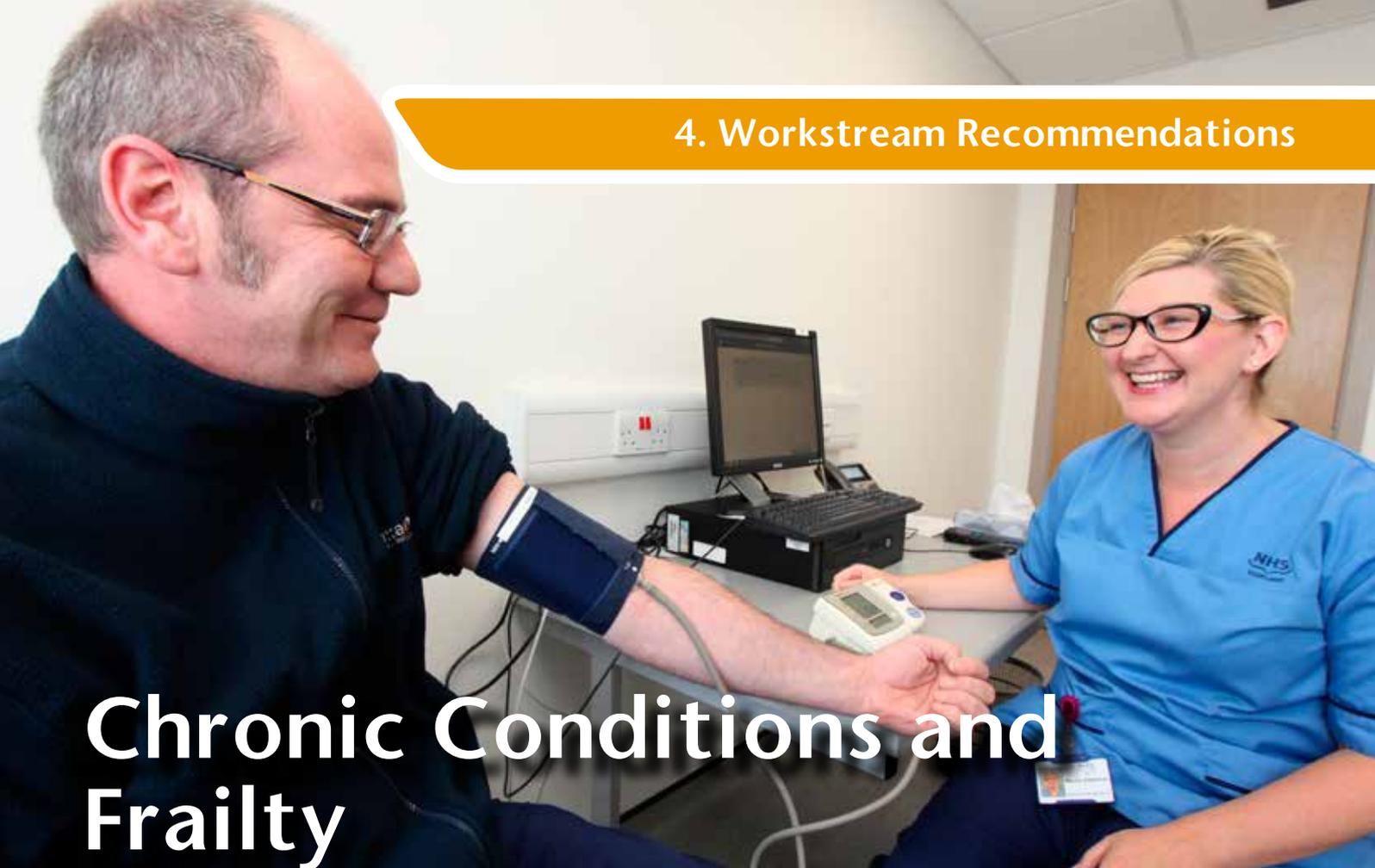
*Reconfigure scheduled care services to optimise the achievement of best patient outcomes.*

*Better joined up pathways of care for scheduled care through primary and secondary care will be developed.*

*Develop one stop community investigation clinics.*

*Locality based clinics will be supported by specialist consultants.*

*Make better use of technology to provide care and support and avoid unnecessary return outpatient appointments.*



# Chronic Conditions and Frailty

### 3. Chronic Conditions & Frailty Workstream Recommendations

The group has made a key assumption, which is that the focus for managing long term conditions and frailty should be in the community, not the hospital. The recommendations are based on this assumption.

#### *Workforce Development*

- Development of a Workforce which delivers care co-ordination via a single point of access to develop individualised care planning based on personal outcomes.
- The care coordinator will have autonomy to make decisions necessary for that patient.
- Different long term conditions may need a specialist 'care coordinator'.
- Patients with a single long term condition or a predominant condition might need a different type of 'coordinator' to those with multiple conditions and/or frailty.

#### *eHealth*

- Development of IT systems which have capacity at different levels to share information across systems and to process patient generated data.
- To allow mobile working such as in Hospital at Home.
- To allow sharing of anticipatory care plans between primary and secondary care and community pharmacy.
- To allow sharing of care plans between health and social care.

## 4. Workstream Recommendations

### *Community Resilience & Redesign*

- Development of locality based clinics run by appropriate professionals supported by dedicated specialist consultant time via virtual clinics for each of the long term conditions (including frailty).
- Patients with multiple conditions should be seen in a single multi-specialty clinic e.g. combined heart/diabetes/renal clinic or breathlessness clinic or frailty clinic.
- Clinics may be run by GPs, nurses, pharmacists or any other member of the clinical workforce.
- The concept is that the clinic should be run nearer the patient. The locality might be a GP cluster and this will involve redesign of systems.

### *Anticipatory Care Planning*

- Each patient with long term condition(s) should have a unified and shared anticipatory care plan.
- Anticipatory care plans for those living in Care Homes have worked well, but are not currently accessible to all.

### *Community Hub*

- Set up a short life working group to develop the Hub model further and institute a pilot in NHS Fife in 2016/17.

## Recommendations in Practice

*Make better use of technology to help and support people to manage their own health conditions at home.*

*All patients in care homes will have standardised health related documentation and anticipatory care plans.*

*Single multi-specialty clinics will be developed for people with multiple conditions.*

*Redesign of chronic management to be needs led and not age based.*

*Develop a sustainable workforce with appropriate skill mix and strong links to the 3rd sector to support people with chronic conditions and frailty.*



# Cancer, Palliative Care and Care in the Last Days of Life

## 4a. Cancer Workstream Recommendations

### Communication & Care

#### *Person Centred Communication and Care*

- All care will be planned and delivered with the person at the centre; ensuring care reflects their wishes, priorities and goals for treatment.
- The patient will have access to clearly defined point(s) of contact appropriate to their treatment and care plan.
- The patient and where appropriate their carer, will be enabled to oversee and manage their care in partnership with health and social care providers.
- All letters will be written to patients and copied to the appropriate clinicians.

#### *Prevention, Screening and Early Detection*

- Protect and prioritise resources to deliver evidence-based health promotion and ensure continued delivery of audited national cancer screening and vaccination programmes.
- Reduce the burden of preventable cancer incidence by a minimum of 10% in Fife over the next 10 years.
- Improve screening uptake in order for Fife to be a top performing Board in Scotland in relation to breast, bowel and cervical cancer screening uptake.
- Improve early detection of cancer through effective public education to identify signs and symptoms of potential cancers.

## 4. Workstream Recommendations

### *Cancer Diagnosis and Treatments*

- To provide timely, evidence based and cost effective access to diagnostic and treatment services in the most appropriate place of care.
- Provide rapid access to clinical investigation with clear diagnostic pathways to enable clinicians in primary and secondary care to refer patients via the most appropriate referral route.
- Develop and expand the acute oncology provision within Fife to provide urgent access to specialist cancer advice, treatment and care, for patients without a clearly defined cancer pathway.
- Define agreed performance indicators for the delivery of treatment for all Fife patients with cancer regardless of place of care.

### *Care after Treatment*

- Following treatment and where treatment isn't an option, ongoing care and support is important to ensure optimum outcomes for patients and their families.
- Enable people that survive cancer to return to their pre cancer lives, recognising the difficult journey they've been on and enabling them to return to meaningful and fulfilled lives.
- Living well with a life limiting illness, having access to best supportive care and palliation as required, directing their own anticipatory plan of care in partnership with their healthcare support team.
- Service Development Care Provision
- Evaluate models of point of care testing as an opportunity to optimise efficient use of resource and improve patient experience.
- Scrutinise the value and effectiveness for all cancer referral, diagnosis and treatment pathways.

### *Workforce*

- Review the current multi disciplinary workforce to meet the needs of the service.
- Develop a workforce that has the appropriate training and education to deliver specialist tasks, considering key roles and responsibilities and role development.

### *Technology*

- Maximise the utilisation of existing e-health infrastructure to break down local, regional and national barriers to enable free flow of information between health and care providers, patients and their carers.

### 4b. Palliative Care and Care in the Last Days of Life Workstream Recommendations

#### *Reduce Inequalities*

- Improved identification of all people who may benefit from palliative and end of life care resulting in reductions in inequalities and enabling future care planning across all health and social care settings.

#### *Realistic Medicine*

- Timely, sensitive and focused conversations for those identified with palliative care needs and their carers. This ties in with Realistic Medicine and enables person-centred goals for care, including anticipatory care planning. It requires trained staff and adequate resource and time to deliver.

#### *Workforce - Improve Capacity and Capability*

- Improve the competence and confidence of all health and care staff in the delivery of high quality palliative care by addressing educational, developmental and support needs, including communication skills.

#### *Improve Communication and Information Sharing*

- Ensure communication and information transfer between patients, healthcare, social care, third and independent sector professionals. This requires robust systems and initiatives such as maximising eHealth opportunities and copying healthcare correspondence to patients.

#### *Access*

- Access to robust seven-day generalist palliative care provision, embedded in routine practice, that is able to meet the general palliative care needs of people and those important to them in all health and social care settings in Fife.
- Robust seven-day specialist palliative care service able to meet the needs of the most complex patients and their carers in all settings (including hospice, community and hospital) as well as to support and lead the development, education and support of generalist palliative care delivery across Fife.

## 4. Workstream Recommendations

### Recommendations in Practice

*All opportunities to promote healthy lifestyles, screening uptake and early detection of cancer will be taken by health professionals.*

*We will develop and expand acute oncology services in Fife in line with the National Clinical Strategy.*

*We will develop single points of contact to help people with life limiting conditions access the right services, support and advice at the right time .*

*Where possible, patients will have a unified and shared anticipatory care plans.*



# Women and Children's Services

## 5. Women and Children's Services Workstream Recommendations

### *General*

- Focus on prevention with recognition of the significant relationship between adverse childhood experiences and future adult health.
- Ensure adequate priority given to high quality services in relation to women, children and reproductive health in the context of competing priorities and service pressures.

### *Workforce*

- Review skill mix and redesign pathways for delivery of clinical services, maximising input of Allied Health, Pharmacy, Support, Admin and Nursing and other staff, and implementing best practice models.

### *Community and Mental Health Services*

- Deliver enhanced women and children's services in the community where possible closer to communities to improve access to services and reduce inequalities. Local services will be better linked to social care and third sector organisations, where appropriate with clear service information for staff and patients.
- Closer alignment across physical and mental health services for women and children using clinical pathways.

## 4. Workstream Recommendations

### *eHealth*

- eHealth develops a single health record and access to tertiary care records using innovative telemedicine developments.

### *Implications of National Review and Quality Improvement Programmes.*

- Further scoping required for maternity and neonatal service configuration following publication of National review, anticipating greater regional working for specialist services.
- Further embed quality input methods and learning where appropriate from Early Years Collaborative, Maternity and Children Quality Improvement Collaborative, and Fife Children's Improvement Collaborative.

### Recommendations in Practice



*Redesign maternity and paediatric pathways with appropriate multidisciplinary workforce skill mix for the delivery of clinical services.*

*Develop a workforce that has the appropriate training and education to deliver future maternity and paediatric services.*

# Mental Health and Learning Disabilities

## 6. Mental Health and Learning Disabilities Workstream Recommendations

### *Parity of Services*

- There is no health without Mental Health. There needs to be parity of resources, workforce (including strategies to attract/retain staff) and esteem for Mental Health and Learning Disability (LD) services.
- Reduce Health Inequalities
- Reconfigure services and resources so that there is equity of access to services across Fife and across all patient groups.

### *Access*

- Care should be provided at home or as close to home as possible unless the risks or need is such that hospital admission is required.
- Increase access to Child and Adolescent Mental Health Services (CAMHS) and psychological therapies in line with the Local Devivery Plan (LDP) standards by developing primary care multidisciplinary teams but not at the expense of secondary care teams.
- Access is by a single point of referral to co-located multi-disciplinary Health and Social Care Partnership (HSCP) teams in a suitable community base, working with shared electronic notes and shared governance systems. In recognition of multi-morbidity these teams are to be aligned to GP clusters and thus also to the physical health community teams, across all the age ranges.

## 4. Workstream Recommendations

### *eHealth*

- eHealth developments are crucial to effective community working (an existing example might be the IT investments in diabetes care) and need to be developed for community working in Mental Health and Learning Disability. Developments need to be clinically led and coordinated across the relevant agencies and disciplines.
- Develop an accessible 'Clinical Monitoring Service'.

### *Outcome Based Service*

- The services work to national guidelines, evidence-based practice and the appropriate use of nationally agreed outcome measures that are known to be of benefit to patients.

### *Mental Health Community Resilience*

- Review and rationalisation of mental health inpatient sites.

### *Transitions between Mental Health Services*

- A review of timing of transitions between mental health services.
- Review of ADHD & ASD service with CAMHs and paediatrics and reconfigure services so that an appropriate and sustainable model is developed with smooth transition to adulthood.

### *Mental Health Service Development*

- Invest in older adult's multidisciplinary liaison psychiatry service which covers acute and community hospitals and develop a liaison psychiatry services for care homes.
- Integration of physical and mental health services and develop a biopsychosocial model of care. Co-locate older adults' inpatients beds with care of the elderly medicine inpatient beds.
- Review of how best to monitor those with severe and enduring mental disorder and physical multi-morbidity in the community with consideration of 'one stop shop' community investigation clinics.
- An established care pathway for those with personality disorders and consideration of linking with other boards on a regional level for those with severe personality disorder so that those treated outwith Fife (and often Scotland) can be treated securely closer to home with evidence-based therapies.
- Better integration of subspecialty services so that expertise can be shared and improve training and skills in mainstream services.

### *Mental Health Anticipatory Care Planning*

- Focus on recovery, anticipatory care planning and rehabilitation with primary, secondary and tertiary prevention. Promote self management where appropriate.

## 4. Workstream Recommendations

### *Learning Disabilities Service Development*

- Further develop Tier 3 multi-disciplinary intensive support team for those in crisis, with complex needs in terms of mental health, forensic or challenging behaviour with extended hours availability.
- Continue Tier 3 best practice development and pathway work around people with challenging behaviours in order to improve quality of life and reduce restrictive interventions.
- Review of how physical needs are best met for those with PMLD in adulthood.

### *Children and Young People Learning Disability (CYPLD) Service Development*

- Review of CYPLD services so that a single CYPLD multidisciplinary team which has a single management structure and single set of case notes which is co-located and works closely with other agencies is established.
- Development of a tier 4 CYPLD intensive multidisciplinary community team.
- Support for an inpatient unit in Scotland for CYPLD who require admission.

### Recommendations in Practice

*We will reconfigure mental health and learning disability services to ensure equity across Fife.*

*A single point of access for emergency mental health advice and assessment will be available.*

*We will review and where appropriate reconfigure mental health inpatient sites across Fife.*

*Development of the liaison psychiatry service and community based multi-professional teams.*



# eHealth, Estates and Support Services

## 7. eHealth, Estates and Support Services Workstream Recommendations

### *Information Sharing*

- Assess the benefits of the Health and Social care data sharing portal and complete formal evaluation and future rollout plan.
- Ensure electronic records via portal are accessible to all who require access.

### *Development of Systems to Support Service Redesign*

- Complete local business case for a community system to 'mobilise' community staff and enable their contribution to an Electronic Patient Record.
- Complete implementation of core Patient Administration System (PAS) and support streamlining of existing processes via order communications.
- Modernise the laboratory management system and explore point of care initiatives to manage increased workload.
- Use of Telecare at scale to redesign service delivery.
- Continue the drive to remove paper where electronic information already exists, in turn supporting Health Records redesign.

### *Estates*

- Rationalise existing office space currently utilised by adopting defined space management principles.

## 4. Workstream Recommendations

- Co-locate services within Fife Council and NHS Fife facilities based in the community.
- Utilise the most efficient and suitable locations and ensure they are fit for purpose.
- Develop an overarching Estates Strategy to facilitate the future models for delivery of clinical services

### *Support Services*

- Develop and implement a Pharmacy Strategy aligned to the Clinical Strategy which supports patient safety and reduces harm and variation in the use of medicines.
- Promote effective, efficient prescribing and use of medicines to enable patients to achieve the best outcomes from their medication.
- Build capacity across primary and secondary care settings to support the safe and effective use of medicines and ensure the role of the pharmacist and pharmacy team is maximised.

### Recommendations in Practice

*Telehealth and Telecare will be used to aid self monitoring of health condition.*

*Estate and facilities will be flexible and fit for purpose.*

*We will move to a paper-light system with an electronic patient record.*

*We will work to increase the uptake of people booking appointments and ordering repeat prescriptions using technology.*

# 5. The Future: Health and Social Care in Fife





## 5. The Future: Health and Social Care in Fife

NHS Fife recognises the need to adapt in order to provide a health and care service for its people that is sustainable and fit for the future. The stories below illustrate how Mary and John's care may look in the future.

### *'After' - Mary's story*

Mary is an 87 year old retired teacher from Glenrothes who lives alone with no package of care. She falls whilst getting ready for bed at 10pm and sustains minor injuries to her leg but no fracture. She presses her community alarm and help is sent. She is found to be mobile with a stick and a little shaken but still independent, and so admission is not felt to be required, but an electronic referral is sent by the reviewing Paramedic to the Community Hub who arrange for review within 48 hours. She is seen there by a multi-disciplinary team, including social work, who complete frailty screening and arrange for Day Hospital attendance to work on a Falls Pathway, plus arrange a twice daily package of care to help get out of or get ready for bed each day and some meal assistance. The community pharmacy identifies polypharmacy including drugs that may contribute to falls, and these are rationalised, reducing from 8 to 5 medications including the addition of "bone protection" medication. Mary continues to live at home. With support from family and friends in the community she tries to keep as active as possible and attends a weekly lunch club run by a local voluntary organisation.

Mary does not fall again until she is 93, at which point she sustains a hip fracture and is admitted to the Acute Hip Fracture Ward for hemiarthroplasty. Despite her stay being complicated by pneumonia, she is discharged after 7 days with Hospital at Home for a course of antibiotics and oxygen in her own home, and community rehabilitation with an enhanced package of care.

### *'After' - John's Story*

John is a 25 year old from Leven with prior history of deliberate self-harm and mood disorder, who has recently felt more depressed after being made redundant from his job at the paper mill. He takes a paracetamol overdose following an argument with his partner at 11pm on Saturday night and calls NHS24 who advise him to attend A&E, where he is greeted by a nurse who has been pre-notified by NHS24 and who promptly triages him and automatically notifies the Mental Health out of hours service, who arrange a telephone conversation with the Unscheduled Care Psychiatry Team whilst he is waiting for his blood results in a quiet room. When his paracetamol levels come back high, he is assessed and admitted with a joint Psychiatry and Medical plan with input from Liaison Psychiatry as required, and does not require detention under the Mental Health (Scotland) Act. The following day John is discharged. His situation is automatically flagged up to his

local Mental Health team for follow up and he is given information on who to contact for future support, including signposting about suitable voluntary/third sector organisations and how to access NHS24 and Primary Care Emergency Service should a crisis arise in the future. He feels calm about how his crisis has been managed and develops a good therapeutic relationship with his Community Psychiatric Nurse.

### Summary

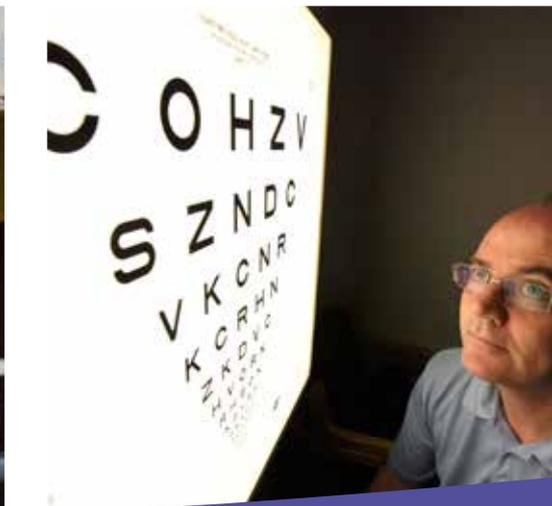
Greater demand for health and social care requires us to give consideration as to how best to develop our health and care services to meet the need that is already occurring and which will continue to increase in future years. In the foreseeable future, there will be more people living longer with multiple health conditions and it is known that chronic conditions such as diabetes and cardiovascular diseases are more prevalent in areas of greater deprivation.

The Clinical Strategy provides the vision for provision of clinical services in Fife over the next five years and will be delivered in partnership with staff and public. The Strategy has been developed reflecting the content and recommendations of the National Clinical Strategy, Fife's Health and Social Care Strategic Plan and the Chief Medical Officer's report Realistic Medicine.

The effective implementation of the key recommendations and the transformational care they represent will allow us to provide an effective and sustainable health and social service for Fife in the years ahead.

# NHS

## Fife



If you would like further information or this document in an accessible format please use the contacts below;

[Fife-UHB.EqualityAndHumanRights@nhs.net](mailto:Fife-UHB.EqualityAndHumanRights@nhs.net)

NHS Fife Equality and Human rights Department on 01592 648151 or for those who are speakers of BSL please use the NHS Equality and Human rights SMS text service 07805800005 or you can contact the Fife Centre for Equalities who will help you.

[www.nhsfife.org/clinicalstrategy](http://www.nhsfife.org/clinicalstrategy)

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