PURPOSE OF REPORT

1.1 To seek endorsement for NHS Lanarkshire's healthcare strategy, "Achieving Excellence".

BACKGROUND AND CONTEXT

2.1 NHS Lanarkshire has been developing a healthcare strategy over the course of the last year that sets out the vision as to how health services should and could change over the next ten years. It considers a range of healthcare services, both integrated and non-integrated, developed through work streams that have had representation from North and South Lanarkshire IJBs, staff and major stakeholders. Table one sets out the areas “Achieving Excellence” considers and their links to integrated services,

Table One. Health care strategy work streams

<table>
<thead>
<tr>
<th>Healthcare Strategy</th>
<th>Position with regards to integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Integrated Service</td>
</tr>
<tr>
<td>Long term conditions</td>
<td>Integrated except for hospital based care for patients with conditions that are treated by medical specialties that are not integrated (e.g. Cardiology)</td>
</tr>
<tr>
<td>Older people services</td>
<td>Integrated service</td>
</tr>
<tr>
<td>Mental Health and Learning Difficulties</td>
<td>Integrated service</td>
</tr>
<tr>
<td>Alcohol and Drugs</td>
<td>Integrated service</td>
</tr>
<tr>
<td>Maternity, Early years, Children and Young People</td>
<td>Maternity services are not integrated, all other areas are integrated</td>
</tr>
<tr>
<td>Planned and Unscheduled Acute Care</td>
<td>Unscheduled care is integrated, planned care is not</td>
</tr>
<tr>
<td>Orthopaedic Service</td>
<td>Not integrated</td>
</tr>
<tr>
<td>Cancer Services</td>
<td>Not integrated</td>
</tr>
<tr>
<td>Stroke services</td>
<td>Not integrated</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>Integrated service</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Community based pharmacy and prescribing is integrated, hospital based is not</td>
</tr>
<tr>
<td>Property</td>
<td>Not integrated</td>
</tr>
</tbody>
</table>

11 July 2016
<table>
<thead>
<tr>
<th>eHealth</th>
<th>Not integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport</td>
<td>Some elements of this are integrated</td>
</tr>
</tbody>
</table>

2.2 NHS Lanarkshire has asked that the North and South Integration Joint Boards endorse "Achieving Excellence" before consultation with the public, stakeholders and staff begins.

3. SUMMARY OF KEY ISSUES

3.1 NHS Lanarkshire is asking the Board to endorse "Achieving Excellence".

4. RECOMMENDATIONS

4.1 Due to the time pressures of drafting "Achieving Excellence" the following changes, agreed with NHS Lanarkshire's Chief Executive, have not yet been made. Officers recommend that the IJB endorses "Achieving Excellence", noting the two changes set out below;

   Current text
   "This will, in turn, allow us to allocate a greater proportion of our resources to the delivery of planned care including urgent scheduled care as outpatient appointments or day case procedures or investigations."

   Revised text
   "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."

5. CONCLUSIONS

5.1 The IJB is asked to endorse "Achieving Excellence" noting the two agreed changes

6. IMPLICATIONS

6.1 NATIONAL OUTCOMES

The setting of the strategic vision for health services will impact on all national outcomes

6.2 ASSOCIATED MEASURE(S)

The performance framework that has been presented to the IJB covers all integrated service areas noted in this report

6.3 FINANCIAL
There are no direct financial consequences from this report

6.4 PEOPLE

There are no direct people consequences from this report

6.5 INEQUALITIES

There are no inequality consequences from this report

7. BACKGROUND PAPERS

None

8. APPENDICES

Health Care Strategy, Achieving Excellence

..........................
CHIEF ACCOUNTABLE OFFICER (or Depute)

Members seeking further information about any aspect of this report, please contact ............... on telephone number .................................
ACHIEVING EXCELLENCE
A plan for person-centred, innovative healthcare to help Lanarkshire flourish

DRAFT 3.1
FOREWORD

It is over four 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 an important change 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 also have moved on. Therefore, in early 2017, NHS Lanarkshire will revise and refresh the Healthcare Strategy, based the healthcare needs of the population, and make plans for improving services to meet these changing needs. We will ensure these services are safe, effective, person-centred and sustainable.
During 2015 and 2016, Lanarkshire NHS Board collaborated with patients, staff and partners to refresh the vision as to how services should and could change over the next ten years. This draft Strategy summarises this work to shape our future plans, and is the basis for consulting with the people of Lanarkshire on these emerging plans. The plans 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. Another key influence on this work is The National Clinical Strategy for Scotland, published by the Scottish Government in 2016.

Some of the work described in this Strategy has already started. Some is in the planning stage. Some of it puts forward ideas about how the healthcare system could change to meet the challenges we face.

We now invite you to give us your views on the content of this draft Healthcare Strategy. Details on how you can do this is set out in section 9.

We welcome your views as the start of a conversation about the Strategy. What questions do you have? Have we missed anything that is important to you? Do you have ideas that can help us to improve?

You can respond about the whole Strategy, a particular service, or about a particular locality. Your response will be part of the evidence base informing the decisions we will take at the end of the year.

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
August 2016.
1

THE CASE FOR CHANGE AND LANARKSHIRE QUALITY APPROACH

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 that 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 Commission; the Healthcare Quality Strategy for Scotland; Everyone Matters: 2020 Workforce Vision, the National Clinical Strategy for Scotland (2016) 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.

Aims

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 appropriate use of health and care services to 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.

The plans are based on the assessed needs of our communities and are designed to ensure that the right mix and volume of services is 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 which sets out the principles that will underpin clinical service changes across Scotland. Future services, locally and nationally, will have:

- 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 that 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 that 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 Objectives**

We have five high-level Corporate Objectives that are the focus of the work we do:

- Ensure focus on prevention, self and home care reducing reliance on hospitals – shifting the balance of care
- Deliver services that listen and respond to the needs of individuals, patients and carers continuously improving experiences and outcome
- Deliver high quality services that are person-centred, safe, effective and sustainable
- Ensure that resources are deployed to best effect, achieving desired outcomes and best value for money
- Deliver excellence in employment, partnership working and engagement with stakeholders

**Our Values**

It is not only what we do that is important; the way that 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 that staff is 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.*
References
1. NHSL Online survey 2016
2.1 Population Profile

The population of Lanarkshire is 653,310 with 337,950 people living in North Lanarkshire and 315,360 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 NHS Lanarkshire by age group and health and social care partnership areas](image)

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 7,121 babies born in Lanarkshire in 2014. This will fall to 7,034 by 2025. The overall birth rate in Lanarkshire was 56.7 births per 1,000 women compared to the Scottish birth rate of 54.8.

#### Deaths

There were 6,688 deaths recorded in NHS Lanarkshire residents in 2014. 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 28%, 13% and 7% respectively of all deaths in Lanarkshire. Respiratory disease was also a significant cause of death in 2014, being responsible for 13% 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 35.3% 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 17% by 2020 and 38% 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, 18% of people in Lanarkshire live in one of Scotland's 15% 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 NHSL 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 below 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

2.6 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 24.5% compared to the national average of 23% 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 Would 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 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.

<table>
<thead>
<tr>
<th>Community based health services</th>
<th>Hospital based health services</th>
<th>Community based Social work services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community based Geriatric Medicine</td>
<td>Traumatic Brain Injury</td>
<td>Accident &amp; Emergency (A&amp;E)</td>
</tr>
<tr>
<td>Community based Palliative care</td>
<td>Health and Homelessness</td>
<td>General Medicine</td>
</tr>
<tr>
<td>Community based Paediatrics</td>
<td>Diabetes service</td>
<td>Hospital based Geriatric Medicine</td>
</tr>
<tr>
<td>Community Children’s Health services</td>
<td>Continence service</td>
<td>Rehabilitation Medicine</td>
</tr>
<tr>
<td>Health Visiting</td>
<td>Prisoner Healthcare</td>
<td>Respiratory Medicine</td>
</tr>
<tr>
<td>Community Learning Disability services</td>
<td>Dietetics</td>
<td>Hospital based Palliative Care</td>
</tr>
<tr>
<td>Psychology</td>
<td>Care Home Liaison service</td>
<td>Hospital based Paediatrics</td>
</tr>
<tr>
<td>Mental Health and Learning Disability</td>
<td>Pharmaceutical services</td>
<td>Psychiatry of Learning Disability</td>
</tr>
<tr>
<td>Community Addiction services</td>
<td>Primary Medical services</td>
<td>Hospital based Mental Health services (including low secure forensics)</td>
</tr>
<tr>
<td>District Nursing</td>
<td>Primary Care out of hours</td>
<td>Hospital based Addiction / Dependence services</td>
</tr>
<tr>
<td>Sexual and Reproductive Health and Blood Borne Viruses</td>
<td>GP out of hours</td>
<td>GP inpatient services</td>
</tr>
<tr>
<td>Allied Health Professionals in an outpatient department, clinic or outwith a hospital</td>
<td>Primary Care Administration</td>
<td>Speech and Language Therapy</td>
</tr>
<tr>
<td>Public, General and Community Dental services</td>
<td>Ophthalmic services</td>
<td>Occupational Health</td>
</tr>
<tr>
<td>Public Health – Health Improvement</td>
<td>Podiatry</td>
<td>Equipments and Adaptations, Technology, Equipment and Telecare</td>
</tr>
<tr>
<td></td>
<td>Physiotherapy</td>
<td>Day opportunities and day services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homecare services</td>
</tr>
</tbody>
</table>

**Figure 4** Responsibilities of the two HSCPs in Lanarkshire

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 CamGlen), 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. Locality modelling (developing integrated locality teams and community rehabilitation model)
2. Usage of non-acute beds and pathways from hospital to home
3. Services for patients with severe neurological damage
4. Mental health improvement
5. Home support
6. Falls prevention
7. Children’s services improvement
8. Weight-loss and obesity prevention
9. Self-directed support care packages
10. Self-management of long term health conditions
11. Primary care transformation
12. Urgent primary care (out of hours).

What would 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;
• Increase the choice and control people have over the care and support they receive;
• Help people to stay safe;
• Improve the support to carers;
• Reduce the administrate burden of joint working.
4 WORKSTREAM SUMMARIES

4.1 Introduction

During 2015/16, Lanarkshire NHS Board asked service leads 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 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.

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 or other allied health professionals. 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 problem. Primary health care is based on caring for people rather than specific diseases. This means that 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. The GP is often seen as the ultimately responsible professional.

An important role 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 doctor 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, perhaps to the surprise of others whether they are 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 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. In the UK, the number of people with three or more long-term conditions (LTCs) is set to rise from 1.9 to 2.9 million from 2008 to 2018. 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.

The type of health and social care that individuals need is changing. The number of older people with multiple and complex conditions – the section of the population that needs health and social care services most – is growing rapidly. Lifestyle factors, such as obesity and physical inactivity, are increasing the burden of multiple chronic diseases. Finally, in health care, while developments in treatments and drugs increase our ability to treat disease and prolong life, this increases the demand for 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’ need to be addressed. It 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.

**What Will Change?**

The current presumption that the GP alone is the default clinician for all activity outside hospital will change. This change is likely to be made explicit in the 2017 and then continued in the 2020 GP contract reviews. The opportunities afforded by the formation of Health and Social Care Partnerships (HSCPs) in North and South Lanarkshire will change the relationships and services for our people, whose lives deserve more than simply addressing health.

The assumption that all more complex care has to be delivered in a hospital will continue to change and there will be increased skills across a wide variety of professionals. For example, this includes non-medical prescribing, advanced assessment skills, extended delivery of a wide variety of therapies and advanced interventions. This includes mental health practitioners, nurses, pharmacists and other therapists.

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.
Prescribing will be understood as a system wide process while in primary care prescribing will be developed to ensure maximum benefits for patient outcomes while avoiding wastage. Wastage includes unused, unwanted, ineffective and unnecessary medications.

Service integration across health and social care will be in place and delivered as part of normal routine practice. Teams working in the community will be transformed to ensure there is a match between the assessed needs of people and the right care and support professionals. Locality teams including GPs will be configured to co-ordinate and manage multi-morbidity and complexity, 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 care will be sustained, with clear linkages between these services and other emergency care services (Emergency Departments, NHS 24, Scottish Ambulance Service). The HSCP will commission Urgent Care Services (out-of-hours) that deliver safe, effective and sustainable services in accord with the Independent Review of Urgent Primary Care Services. 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 implemented to implement some of these changes, many of which are collected together as the Primary Care and Mental Health Transformation Program. 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 LTCs, no matter what their conditions. It is being introduced currently. 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.

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.
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 will begin to be introduced and their impact assessed in 2016.

Mental Health Transformation.

Funding has been awarded within the mental health transformation bid to link up and support the delivery care in many ways close to practices and at an early stage in the patient journey. There will also be provision for the mental health needs of those with primarily physical problems. From a patient point of view, this will impact beneficially on both the delivery of complex mental health interventions and the ability to reduce the duration of impact of problems within a mental health field. It will begin to be effective later in 2016 and will be refined for the two - three years thereafter.

WebGP/eConsult

This initiative uses existing processes developed 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.

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 understood as a suite of work have the potential to create significant change and, given the description of need for change, have to have an impact.

This section shows that there is already work going on which has the potential to transform primary care and we are at an exciting point in development of healthcare in Lanarkshire.

When Will It Change?

As described, some strategic changes are already happening as part of the transformation programme. Additionally, this section within the Health 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 predicated on changes in 2017 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: 2016-2017:** Tests of change in preparation for 2017 contract: Embedding the structures and opportunities from integration to 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: 2017-2020:** 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 2017 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.

However, the GP contractual timescales will not hold back the strategic changes which are described here, or included as part of broader work, as these changes represent the right courses of action for the people of Lanarkshire, and an appropriate response to the challenges outlined. Therefore, 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.

**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.

**References**
Pulling together: transforming urgent care for the people of Scotland; Scottish Government, 2015
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 conditions, coupled with more effective management of people living with LTCs, will be pivotal to the 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 served 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:**

- 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 workforce available 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.

• 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 that 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.

We will provide support at 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 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;

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 coordinated 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 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, i.e. other alternatives and self-management of long term conditions has 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.

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.
- Worsening of a LTC will be identified early, through self monitoring or enhanced community monitoring and treated appropriately.
- Community based staff will be 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 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 Scotland¹ 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 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 time spent in hospital.

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 Strategy, 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.

**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 do will receive the majority of these services 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.

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 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 (301 beds) based over eight sites across Lanarkshire as well as two contracted services (142 beds). 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.

Hospital care remains a vital aspect of the model of care but is increasingly being used only where necessary, and 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. 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.

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
- 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. Further detailed stakeholder involvement will take place as part of the process of moving towards this goal.

In 2016 we saw the bringing together 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, 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.
- 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 ecovery inpatient and community services.
- Increase capacity of mental health liaison service in DGHs.

We will also do:

- 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, unaffected by stigma.
- Provision of easily available and consistent information; advice; support; and 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.
4.6 ALCOHOL AND DRUGS

Ambition

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 2009, and the national drug strategy, The Road to Recovery: A New Approach to Tackling Scotland’s Drug Problem 2008, will continue to provide the framework for delivering alcohol and drug prevention, treatment and support services in Lanarkshire. The Lanarkshire Alcohol and Drugs 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.lanarkshireadp.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 multiply 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, 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?

- Reduction in drug and alcohol related deaths
- Reduction in drug related harms (such as blood borne viruses)
- Recovery orientated system of care are developed within our communities
- The interests of children, young people and young carers affected by substance misuse are safeguarded and promoted
- 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.
- Speedy access to wider health care services (such as primary care, sexual and reproductive health)

References:
3. Lanarkshire Alcohol and Drug Partnership Strategy
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 Collaborative\(^2\) 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 newborn 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 by services, offering 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 focussed 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?

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. Specifically 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.

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 Looked-After Children to improve their health, wellbeing and life chances.

- 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 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

4.8 PLANNED AND UNSCHEDULED 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’ 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:

<table>
<thead>
<tr>
<th>Monklands DGH</th>
<th>Hairmyres Hospital</th>
<th>Wishaw General Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT surgery</td>
<td>Vascular surgery</td>
<td>Paediatric services</td>
</tr>
<tr>
<td>Urology surgery</td>
<td>Ophthalmology surgery</td>
<td>Maternity &amp; neonatal</td>
</tr>
<tr>
<td>Infectious disease medicine</td>
<td>Optimal cardiac reperfusion</td>
<td>Intensive Psychiatric Care</td>
</tr>
<tr>
<td>Renal medicine</td>
<td>Interventional radiology</td>
<td>Bariatric surgery</td>
</tr>
<tr>
<td>Histopathology</td>
<td>Specialist Lab services</td>
<td></td>
</tr>
<tr>
<td>Lanarkshire Beatson (radiotherapy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haematology (cancer)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 beds; mostly in Lanarkshire, but also some 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 Strategy, 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 first instance therefore, we will reconfigure 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.

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

<table>
<thead>
<tr>
<th>Key Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each DGH will have staffing and infrastructure to deliver emergency care that includes:</td>
</tr>
</tbody>
</table>

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

We will 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 allocate a greater proportion of our resources to the delivery of planned care including urgent scheduled care as outpatient appointments or day case/ambulatory procedures or investigations. This will reduce the need for inpatient stays in hospital.

We will ensure we deliver Realistic Medicine\(^1\) eliminating procedures with low clinical effectiveness and reduce variation in clinical practice\(^2\).

b. Monklands

<table>
<thead>
<tr>
<th>Key Point</th>
</tr>
</thead>
</table>

NHS Lanarkshire is 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. 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 will 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 create a single centre of excellence for the GI bleeding service.

We will 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 will be co-located with the existing cancer services at Monklands Hospital (see also section 4.10).

Longer-term, elective orthopaedics will be concentrated on a single site which is likely to be either Hairmyres or Monklands (see section 4.9).

c. Hairmyres

The outcome of the NHS Lanarkshire orthopaedic review will see Hairmyres Hospital becoming the second inpatient unit in Lanarkshire, alongside Wishaw General Hospital in an interim reconfiguration of orthopaedic services. As stated above, longer-term, elective orthopaedics will be concentrated on a single site which is likely to be either Hairmyres or Monklands (see section 4.9).

d. Wishaw

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

In the longer term NHS Lanarkshire will create a single trauma site at Wishaw alongside a second elective site. This site will serve as the Boards 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
- 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
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 on an outpatient, day case (surgery) and inpatient basis from Lanarkshire’s three district general hospitals – Hairmyres Hospital, Monklands District General Hospital and Wishaw General Hospital. 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). Six acute wards are currently allocated to orthopaedics, two at each of the three DGHs. Nearly 1000 Lanarkshire patients are also treated at the Golden Jubilee National Hospital each year for elective surgery (mainly hip and knee replacements).

The Need for Change

Safety, Effectiveness and Sustainability

Healthcare Improvement Scotland (HIS) made a series of recommendations to the NHS Lanarkshire Board in 2013 following a Rapid Improvement Review, which had been triggered by higher than expected reported rates of hospital mortality in the three Lanarkshire DGHs. One recommendation was to have a comprehensive review of the provision of orthopaedic services in Lanarkshire.

A key element of the HIS Report’s findings was that the current configuration of inpatient services across three hospital sites was not sustainable and that an alternative configuration should be determined which ensures the provision of safe, effective and sustainable services - taking account of the available workforce.

In response to the HIS Report, NHS Lanarkshire carried out a formal review of trauma and orthopaedic services. As one part of that review, an expert team from the Academy of Medical Royal Colleges and Faculties in Scotland was invited to provide feedback. The Academy review team were clear in their view that the current configuration of services was unsatisfactory on a number of areas and must change.

Key Point

In 2016, the average time spent in a Lanarkshire hospital after orthopaedic surgery was over eight days. The norm for other hospitals in Scotland and the rest of the UK was only five days. We aim to reduce lengths of stay in hospital to five days in Lanarkshire. Unnecessary time in hospital after an operation hinders the rehabilitation process. We will develop a more efficient and intensive treatment and rehabilitation care pathway, with better joined-up care between surgeons, elderly care teams and other highly skilled health and social care staff. This will not mean discharging people from hospital too early.
In the period since the HIS report there have also been inspection visits by NHS Education Scotland looking at the quality of training provided to doctors in training in the orthopaedic service in Lanarkshire. As a consequence of the current three site configuration, senior medical staff is required to spend a disproportionate amount of their time staffing out-of-hours rotas and this limits their availability to supervise formal training. This has resulted in formal external assessments criticising a less than satisfactory level of training quality being provided to junior doctors in Foundation and General Practice programmes attached to the service as well as Core Surgical and specialist Orthopaedic training programmes.

**Summary of Main Concerns**

- The time inpatients (particularly trauma patients) spend in hospital after surgery compared to other services in Scotland;
- The variation of practice between the clinical teams operating on three hospital sites and the previous lack of a shared vision amongst clinicians as to how services can be improved in the future;
- The sustainability of the medical workforce (consultants and trainees) and the quality of care being provided by a medical workforce fragmented across three hospitals;
- The resultant ongoing failure of the orthopaedic service to meet waiting time standards, leading to longer waits despite a large proportion of elective surgery being carried out by both the independent sector and the Golden Jubilee National Hospital.

Planning for the future needs of our patients

*Planning the future needs to take account of significant changes in population which will impact upon the demand for the service (see section 2). The largest factor affecting orthopaedics is the increase in the number of people aged over 75: older people will use these services more than younger age groups (for example, knee and hip replacements, and fractures due to falls and brittle bones). Overall, the demand for orthopaedic surgery is expected to increase by over 12 percent by 2020 and by a further 12 percent by 2025.*

*In addition, planned changes taking place across hospital services in Scotland change the shape of the service in the future. With the proposed plans to create a major trauma network across Scotland, one major trauma centre will be created at the Queen Elizabeth University Hospital (QEUH) in Glasgow. NHS Lanarkshire’s proposal is that there will be a single designated Trauma Unit at Wishaw General Hospital as part of the West of Scotland major trauma network. 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.*

*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 location of these centres is not yet agreed, but whatever their configuration this will change the future service configuration for elective orthopaedic surgery for Lanarkshire.*

**What will change?**

Interim Changes to Inpatient Services
The National Clinical Strategy\textsuperscript{2} and the National Trauma Network Report\textsuperscript{3} 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 Wishaw without causing significant disruption to other hospital and community services. The NHS Lanarkshire Board agreed on 14\textsuperscript{th} July 2016 to move towards this strategic objective in a phased manner by first moving to two combined trauma and elective units, which can be 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 will have no impact on outpatient clinics, fracture clinics and fractures treated in the three local Emergency Departments.

**Key Point**

In light of the pressing concerns of safety and sustainability of the current service, the NHS Lanarkshire Board has decided that the move to the interim configuration for orthopaedic surgery should be completed during 2016/17. Work to make the necessary changes is now underway.

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. 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 will be concentrated on one site, either Monklands or Hairmyres.

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.
The transitional model of care will deliver the same significant benefits as described above. This will utilise 96 inpatient beds on two sites - Wishaw General and Hairmyres - with access to outpatient services being retained on all three DGH sites. Both inpatient sites will provide a mix of elective and trauma services of similar size. This can be accommodated within the current orthopaedic bed and theatre footprint on each site. There will also be a move towards dedicated beds and theatres for orthopaedic services to ensure that the capacity required for service delivery is always available.

Another important part of this change is additional investment in in-hospital and community rehabilitation/care for orthopaedic patients.

Impact at Monklands DGH

**Key Point**

Any changes to services which affect Monklands tend to be portrayed as a reduction or downgrading of emergency services. 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 will take 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 will be stabilised, transferred and admitted to either Hairmyres or Wishaw.

In total this will mean 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 percent, and so will not affect the sustainability of the department.

This is the same process which allows patients who present at a Lanarkshire hospital site without 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 DGH.

**Key Point**

As part of this consultation we seek the views of the patients, carers and the public on the proposed development of a major trauma unit at Wishaw General Hospital and an elective orthopaedic centre at one of the other Lanarkshire acute hospitals (see section 9).

**What will success look like?**

- Improved quality of care and outcomes for patients
- Shorter hospital stays for patients
- 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 http://www.gov.scot/Publications/2015/03/7764/8
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 and with documented evidence to reflect the discussions and outcome.

Current Services

The number of people diagnosed with cancer is rising, thus 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 Strategy 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 from, for cancer treatment.

NHS Lanarkshire has a Cancer Strategy 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. Last year NHS Lanarkshire saw a 24 percent increase and the SACT Regional Executive Committee project an increase of at least eight percent 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 hourly to five hourly 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.

Patients continue to receive treatment until progression of the disease with the addition of advanced biologic therapies which are given alongside the chemotherapy this has resulted in a ‘longer chair time’ and increased intensity of the work involved for the day unit staff through intensive monitoring of patients.

Why does it need to change?

NHS Lanarkshire has a strong track record over several years of delivering care in accord with the national cancer diagnosis and treatment waiting time standards, 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 percent was seen in colorectal cancer, with an increase in activity across all specialties as illustrated in Figure 10.

<table>
<thead>
<tr>
<th>Year</th>
<th>Average monthly treatment episodes</th>
<th>Increase from previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/2013</td>
<td>674</td>
<td>N/A</td>
</tr>
<tr>
<td>2013/2014</td>
<td>745</td>
<td>10.5%</td>
</tr>
<tr>
<td>2014/2015</td>
<td>925</td>
<td>24.2%</td>
</tr>
</tbody>
</table>

Figure 10: Patient Treatment Episodes per Month

We currently have adequate chair numbers across three sites, but this capacity is not used efficiently. By smarter scheduling, and changes to the skill mix within the workforce, we can best match our current resources to future demand for cancer therapy.

How Will The Service 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 the best possible chance 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 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 commenced 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 specialty 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 and 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 community or within an individual’s home.
• Improved skills development of staff
• Improved pharmacy aseptic services supporting centre of excellence

References
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 Managed Clinical Network (MCN) 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 percent 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 2014, 995 inpatients were discharged in Lanarkshire.

Rapid access to time-critical stroke care is important as 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 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 NHSL improving compliance with the stroke bundle from 46 percent in 2010 to 83 percent in 2015. Through the cooperative working of stroke clinicians, stroke unit staff and the Stroke MCN, 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 have been 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 DGH.

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. Best models to deliver this intervention nationally are not yet clear, and work is going on 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 site Lanarkshire clinic with hospital in-reach is planned. This will be a collaborative venture with colleagues in Traumatic Brain Injury through reorganising current staffing and other resources.

Stroke Education will continue to play an important role within the MCN, with education initiatives for Scottish Ambulance Service, Emergency Departments and Community Teams helping to ensure effective knowledge, skills, attitudes and confidence in stroke care provision.

Evidence suggests that 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 time frame and NHSL, 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 NHSL will consistently meet this target.

**What will success look like?**

**Delivering more utilising current resources:**
- By delivering a service across Lanarkshire compromising of 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.

**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.

**Deliver a local tone management service:**
• Providing a local service for patients, improving the outcome for patients with spasticity following stroke.

**Reference**
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 & social care partnerships, hospices, voluntary and independent sectors).

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, and 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 strategy. 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 percent of people say they want to die at home (Dying Matters), yet only a quarter did so in Lanarkshire in 2011
- Changing personal circumstances: smaller families providing support, or no family living locally (5 percent 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’ 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 & dying
- 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 Planning, 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
   http://www.nhslanarkshire.org.uk/Services/PalliativeCare/Documents/Palliative%20Care%20Strategy%20Aug%202013.pdf [accessed 29.6.16]


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 £115 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.

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 issue. 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 basis. Lanarkshire has an unenviable and consistent position of seeing a higher volume of prescribing per head of population than any other NHS board area, see graph below which compares NHS Lanarkshire to the Scottish average.

![Items per 1000 patients Apr13 - Jun15](chart)

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 medicines for the benefit of our patients recent documents published by the Scottish Government such as 'Prescription for Excellence' and 'Realistic Medicine' 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 Board. 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 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?**

- Patients will be supported to make informed decisions about their medicines and to discuss them with anyone involved in their care. Patients will therefore be able to get the best outcome they can from their medicines.

- Harm from medicines will be reduced. Treatments of little value will not used or will be discontinued. Care will therefore be safer and less wasteful.

- A broad range of healthcare professionals including pharmacists and support staff will be equipped to treat patients with medicines in a quality assured and safe way.

- Service efficiency and patient access options will be optimised.

- NHS Lanarkshire, North and South Lanarkshire Heath and Social Care Partnerships will have clear systems for governing the use of medicines, managing the medicines budget and making associated investment decisions.

- Both managed and contracted pharmacy services within NHS Lanarkshire will have adopted all of the opportunities which national and local developments enable

**References**


2. Prescription for Excellence; Scottish Government, 2013

3. Realistic Medicine - Annual Report by the Chief Medical Officer; Scottish Gov. ,2016

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, ophthalmists, 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 15 m² to 65,000 m². However, the majority of these buildings are relatively small, with 112 buildings less than 1,000 m² 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. Table 8 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 with only one or two District General Hospitals¹.

Figure 11: An analysis of the existing estate by building type 2015/16

<table>
<thead>
<tr>
<th>Building Type</th>
<th>Area (GIA) sq.m</th>
<th>% of Total Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals-Acute (3)</td>
<td>171,093</td>
<td>58%</td>
</tr>
<tr>
<td>Hospitals-Community (12)</td>
<td>35,438</td>
<td>12%</td>
</tr>
<tr>
<td>Corporate Sites *</td>
<td>19,134</td>
<td>6.5%</td>
</tr>
<tr>
<td>North Lanarkshire- Health</td>
<td>39,660</td>
<td>13%</td>
</tr>
</tbody>
</table>
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 early 2016 NHS Lanarkshire announced its intention 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

**Vision**

*Meeting the 2020 Vision for Scotland and the ambitions set out in the National Clinical Strategy for Scotland 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. Where possible the adoption of national systems has been taken place.*

**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 online. 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 2014-2017.

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.

What will success look like?

- Person centred information across sectors and boundaries of care
• Digital patient information with minimal use of paper
• Ultimately, a single digital health and social care record
• Increase use of structured digital data to enable clinical decision support
• Increased home monitoring allowing earlier clinical interventions
• An improvement in the six dimensions of care:
  o Safe
  o Effective
  o Efficient
  o Timely
  o Patient Centred
  o Equitable

References:
5.4 TRANSPORT

**Vision**

Working with partner organisations and stakeholders, we will continue to develop a sustainable transport and travel policy. This will ensure that access to clinical services for the people of Lanarkshire is as straightforward and cost effective as possible.

**Current Situation**

Patients accessing healthcare and their carers and visitors travel to our facilities by a number of means:

<table>
<thead>
<tr>
<th>Mode of transport</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private car</td>
<td>70</td>
</tr>
<tr>
<td>Taxi</td>
<td>7</td>
</tr>
<tr>
<td>Public transport</td>
<td>15</td>
</tr>
<tr>
<td>Walking</td>
<td>6</td>
</tr>
<tr>
<td>Ambulance</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Survey by Strathclyde Partnership for Transport

The above table is a reflection of peoples preferred mode of travel generally rather than a reflection on the extent of public transport services available. This premise has been validated as part of the survey process.

**The Need for Change**

It is the strategic intention to continue to improve access to public transport and through this to facilitate movement between the major hospital sites. This reflects Scottish Government strategy to reduce reliance on car use, improves our carbon footprint and increases options available to patients, carers, visitors and staff. There is also a recognition that many people will wish to continue to use their own transport because of the flexibility this allows them.

With the continuing specialisation of certain key services at specific sites it is key that access to our sites can be improved and that existing concerns, for example parking, are addressed. There is also recognition that transport for a small group of patients who do not meet Scottish Ambulance Service criteria but do require a level of assistance could be improved.

**What Will Change?**

As the Healthcare Strategy implementation programme is developed, work to improve transport and travel access will be undertaken across the following areas:

1. **Parking at our sites** – A definitive policy will be developed, in conjunction with all relevant stakeholders, to ensure that parking at NHS Lanarkshire sites is protected for patients and staff and that all of the available parking is used to the best advantage of all stakeholders. This process will include, for example, consideration of staff only parking areas and arrangements to protect parking for specific patient groups. This process will be taken forward in conjunction with stakeholder representatives.
2. **Public Transport** – our engagement with Strathclyde Partnership for Transport (SPT) will continue and the outcome of this work will be to ensure that each of our sites is supported by appropriate public transport links which are recognised as proportionate and accessible. This work will also consider how communication of transport and travel information can be delivered more effectively and will aim to develop and improve existing links to ensure that service provider, and service information, is available quickly and easily. This will include extending the information available via services such as Traveline Scotland and improving the means by which this information is made available.

3. **Scottish Ambulance Service** – It is a necessary requirement of any strategy development process to engage with statutory authorities such as Scottish Ambulance Service. This is a key element and will be critical in ensuring that service provision takes place in facilities which can be adequately supported by Scottish Ambulance Service from a routine patient transport perspective and an emergency perspective. This engagement will continue with a focus on ensuring that service provision is taken forward in a manner which reflects patient need.

4. **Community Transport Provision** – Much work has been undertaken to determine how patients who are unable to access public transport yet do not meet the Scottish Ambulance Service eligibility criteria can be provided with support to travel to hospital. This work is demonstrating that the community transport sector have an ability, and a willingness, to provide services for this particular patient group. It is also noted that increasing the general public transport infrastructure will not meet this groups requirements and a targeted approach engaging with existing service providers but in a much more integrated and transparent manner will deliver benefits for this key group. This work has started and will continue in conjunction with SPT, Community Transport service providers and, importantly, stakeholders within this patient group.

**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
- Responsive Community Transport service
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.


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 multidisciplinary teams working with the appropriate knowledge and skills and 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 5 priorities outlined within Everyone Matters:

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 time frame. 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

Workforce Availability

Medical Staffing Sustainability
Currently, there are on-going 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 NHS Lanarkshire workforce. In effect, NHSL will have an older workforce in 2025 and a higher volume of retirements year on year. With this, NHSL should consider 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.

Service Delivery
To provide safe, effective and person-centred care, the workforce of 2025 should match the workload demands both 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.

Workforce Adaptability
Commissioning New Roles
NHSL 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 are 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
On-going 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 NHSL’s Practice Development Team and GP Practices. NHSL 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

Improving 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.
- NHSL, North and South Lanarkshire Health and Social Care Partnerships will continue to work with 3rd 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 work streams within this Strategy have identified key areas of role requirements that have already been developed in other areas within NHSL 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 NHSL and can be utilised to further develop the knowledge and skills required to achieve the required outcomes.
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 draft 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 2016-17
- Implement changes required by new GP contract 2017-20
- Implement multi-professional workforce development plans 2017-20
- Implement a programme to spread changes across Lanarkshire 2020-25

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

4.5 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 accord 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, prepare a proposal for the establishment of a major trauma centre at Wishaw General Hospital by 2018
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

5.3 eHealth
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
Develop ideas and proposals for enhanced community transport provision 2017 onwards
8. 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 £26.098bn to £26.468m, 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 but it is believed that there will be around £0.9m extra for mental health and health visiting and additional funding for transforming primary care.

Health budgets have traditionally been given a degree of protection and in recent years Boards have been told 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 pay bill, 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 in hospital rose by 22.8% in the hospital 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. So 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.

<table>
<thead>
<tr>
<th></th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation uplift at 1.8%</td>
<td>£19.3</td>
<td>£19.7</td>
<td>£20.1</td>
<td></td>
</tr>
<tr>
<td>Pay bill increase</td>
<td>£8.7</td>
<td>£6.4</td>
<td>£6.5</td>
<td></td>
</tr>
<tr>
<td>Other general supplies increases</td>
<td>£6.7</td>
<td>£6.8</td>
<td>£6.9</td>
<td></td>
</tr>
<tr>
<td>Increase in drugs expenditure (low estimate)</td>
<td>£10.3</td>
<td>£11.2</td>
<td>£12.1</td>
<td></td>
</tr>
<tr>
<td>Minimum gap to be met from efficiency savings</td>
<td>£-43.0</td>
<td>£-6.3</td>
<td>£-4.7</td>
<td>£-5.4</td>
</tr>
</tbody>
</table>

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 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 strand 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. Nevertheless, a business case to secure £400m in investment in Monklands will be prepared.
9. LET US KNOW WHAT YOU THINK

Purpose

The Healthcare Strategy is a shared vision that complements the three-year plans of the North and South Health and Social Care Partnerships and the National Clinical Strategy for Scotland. It aims to set out the emerging conclusions to deliver a whole system approach to care. The intention of this draft strategy is to promote wider discussion in order to shape the final version.

Who has been involved in the early development work?

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. Our thanks go to everyone who has taken part in this early development work for their investment and commitment to taking this work forward.

We have been speaking to patients, families, carers and staff to explore how well current services meet needs and identify ways we can do things differently to better meet these needs in the future.

Throughout this early development work engagement has been taking 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 (patient, carer and third sector representatives) and a Clinical Reference Group (lead clinicians from all professions) were established to review the outputs from the clinical workstreams and oversee the development of this document. An on-line questionnaire was carried out in February and March 2016 to inform the development of the draft strategy, which resulted in 422 responses.

We have been working and continue to work closely with the Scottish Health Council to ensure our approach is in line with Scottish Government guidance in relation to informing, engaging and consulting on service proposals.

How to get involved

NHSLanarkshire welcomes your views and comments on the Healthcare Strategy and wants to ensure that everyone has the opportunity to get involved. The formal consultation period runs from 1 August to 31 October 2016.

You can let us know your feedback before 31 October 2016 in one of the following ways:

- By completing the consultation questionnaire at www.nhslanarkshire.org.uk/involved/consultation/healthcare-strategy
- By emailing your comments to hcsviews@lanarkshire.scot.nhs.uk
- By posting your comments or paper copies of the questionnaire to FREEPOST RTEJ-HZLK-AETZ, NHS Lanarkshire, Kirklands, Fallside Road, Bothwell, GLASGOW, G71 8BB
PDF copies of the full consultation document and summary document are available at www.nhslanarkshire.org.uk/involved/consultation/healthcare-strategy.

There will be a wide range of ways to get involved during this period as we engage with patients, local communities, staff and other stakeholders to seek views on the emerging models of care and to help shape and further refine them.

You can contact us by emailing hcsviews@lanarkshire.scot.nhs.uk or calling 01698 858111 to:

- Find out more about opportunities to get involved in your area
- Request a presentation on the Healthcare Strategy proposals at a meeting to your organisation
- Request a copy of the Healthcare Strategy or summary document in another document in another language or format.

Next steps

NHS Lanarkshire will consider all feedback received during the consultation period as one part of the decision making process on the strategy’s proposals. Your response will help inform and shape the final strategy to ensure it best meets the needs of the Lanarkshire population.

Following the consultation, NHS Lanarkshire will prepare a report taking into account of the public consultation process, affordability and any practical issues. This is expected to have formal consideration of the Healthcare Strategy by the end of 2016.
Glossary of Abbreviations

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