Strategic Clinical Direction for NHS Fife

1 Strategic context

The health needs of our population are changing and we need to do more to support people to manage their own health and prevent crisis. There is pressure in all parts of our healthcare system. The current models of care are not delivering the integrated approach we need to meet the health and care needs of our population and to make sure that care is always provided in the most appropriate setting. Fife needs to provide the highest quality specialist care and to balance that with the need for coordinated care which takes an overview of the patient, their needs and their wishes for care. Healthcare is also changing and we need to keep pace with best practice and standards.

Government strategic direction is set out in the 20:20 vision:\n
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<th>Our vision is that by 2020</th>
<th>everyone is able to live longer healthier lives at home, or in a homely setting.</th>
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<td>We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.</td>
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This has been augmented by the Route Map\ setting out 12 priority action areas to deliver this vision. Our clinical strategy for the future should start in localities to build resilience and community assets to support individuals remain well.

2 Our challenge

Fife, in line with the rest of Scotland, has an ageing population with increasingly complex health and care needs. Our population is also growing and this will require consideration of future capacity in both primary and secondary care. See figures 1 & 2 below.

This will require models of care that enable integrated health and care teams across primary and secondary care to deliver the care that people need, where they wish to receive it, with them playing a key role in determining what that care is. This care must be able to deal with the complexity of morbidity that patients present with and be able to manage any concurrent mental health issues including cognitive impairment and frailty. See figure 3 below.
NHSFife will continue to work towards achieving health equity for our population. Taking "action on the social determinants of health should be a core part of health professionals’ business, as it improves clinical outcomes, and saves money and time
in the longer term. But, most persuasively, taking action to reduce health inequalities is a matter of social justice.iii

Figure 3: Conditions affecting Scotland’s adult populationiv.

![Graph showing conditions affecting Scotland’s adult population](image)

The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions.

More people have 2 or more conditions than only have 1 but our system is largely set up to deal with single conditions as a result of our existing care pathways and guidelines.

The clinical strategy will sit within our strategic framework and emphasise how we will deliver clinical excellence

3 Building sustainable models for clinical excellence

Our starting point - the strategy will be based on the premise of delivering as much care as possible where the population lives – in communities. An aim will be to ensure necessary specialist expertise is available in our acute hospitals when this is required. We will develop models of care that are person-centred; safe and are effective and make the best use of existing resources and are affordable. The models will be predicated on good integration across primary and secondary care as well as health and social care.

Any individual has care needs along a spectrum of care. Figure 2 below illustrates the continuum of where care is provided. Within the acute care element it is important to recognise that tertiary care will be provided outwith Fife from centres of expertise.
This will need strong integrated health and social care teams around the hubs of general practice, either as individual practices or clusters of practices where appropriate. This is where the best generalist care for the population can be provided across health and social care. This includes the assessment of need for care and support for people to manage their own care for longterm conditions. Good anticipatory care planning will identify those at risk of deterioration where more specialist input is required to prevent admission to hospital. Consideration will be given to the performance indicators necessary to demonstrate how good generalist care is being delivered. It will be provided by integrated practice and community based teams across many specialties (e.g. mental health, palliative care). The strategy will also consider the development of a range of health and care support workers to augment capacity in the community. This should be an early task for the Health & Social Care Partnership to deliver.

A second level of integrated care will enable specialist clinicians to support these integrated healthcare teams in the community with more direct care input. These include local specialist nurses, specialist pharmacists, AHPs and outreach from equivalent secondary care specialists including consultants to deliver more complex care for individuals. We have early examples of these models of care in place such as ICASS and Hospital at Home (H@H) to build on and spread systematically across
Fife. It is envisaged that localities will be able to consider what models best fit their population health and healthcare requirements. This will include developing a more comprehensive range of care settings for step up and step down care with appropriate generalist and specialist clinical support 24/7/365. New approaches to workforce planning, especially to providing medical cover from both primary and secondary care, will be required to support these models.

The third level of the model envisages new collaborations between specialists traditionally based in hospital across all disciplines and generalists in primary care and community teams. Key to this will be joint working between GPs and hospital consultants. This will be supported by good anticipatory care planning to identify individuals at high risk of a health or social care crisis. We have some early examples in our managed clinical networks and in mental health where this works well but we need to be innovative in considering other specialties and professional groups that can support primary care in a more integrated way with consultant outreach and potentially more ring fenced community clinical time for the future. Adding in telehealthcare options could increase the availability of specialist skills to wider community based clinicians and patients. Models are being developed such as the “Fit for Frailty” work which shares examples of best practice to ensure that older people are treated with dignity and respect and that wherever possible, older people live healthy, independent lives.

To improve the integrated team working to deliver the best care possible locally, our community resources such as community hospitals should be an integral part of this model with good input from GPs and community teams together with specialist nurse, AHP and consultants. This will require a review and development of our current models of integrated care so that a range of resources are available in the community.

In the fourth level of care in our acute hospital the model of care will change as these community based models are developed and implemented. Inpatient care will continue to focus on acute episodes of care, with comprehensive assessment at the front door to ensure patients do require admission to receive the most appropriate specialist expertise that cannot be delivered in the community. Within the strategy consideration will be given to who takes the lead for coordination of care where this is complex involving several specialties. This will be supported by early discharge planning for rehabilitation and return home — ensuring rehabilitation is available dependent on need not age, focused on ensuring return home at the earliest opportunity to continue in the community. Consideration should be given to how we enable community in-reach from GPs, nursing and AHP professionals to support early discharge after acute episodes of care.

When integrated care is no longer appropriate for an individual patient’s needs, GPs should be able to work with specialists to determine the need for admission to acute care particularly as patients may have fluctuating care needs that will require regular reassessment and review.
Part of the clinical strategy will require the identification of services where critical mass of workforce or specialist skills means we need to consider regional networks of care to ensure Fife patients can access the best clinical expertise possible. We have a number of specialties where this already takes place but with the increasing specialisation of care and interventions possible this may apply to other specialties in the future. Early identification of specialties where this may be the case will form part of our clinical engagement as we ask clinicians for the horizon scanning of new approaches to care delivery in their disciplines.

4 Development and testing of the new models

The senior teams in the Health and Social Care Partnership and the Acute Division will work along with the existing professional and staff side advisory structures to explore how new models could be developed and influenced by clinician and patient input. Work will commence with practices and clinical teams to test these models out with a view to adopting and adapting this approach across Fife in a coordinated way.

There will be infrastructure requirements to establish and sustain these new models of care. The models should influence our workforce development, OD strategy and eHealth strategies. It should also influence our corporate planning and service redesign agendas. In the longer term this model should also influence both the NHS and Council estates and facilities strategies with a key driver being the need to create fit for purpose community facilities for the future to mirror the major acute redesign that has taken place.

The strategy is also intended to shape future financial planning.

5 Discussion

The Board is asked to consider the strategic intent set out in this document and to work in partnership with the senior teams across Fife to take forward the engagement and consultation process this will require with clinicians, our eHealth, HR and estates and facilities staff and the public in Fife to develop the models of care to enable us to deliver sustainable care for the population for the future.

Dr Frances Elliot
Medical Director

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2 A Route Map to the 20:20 vision for Health and Social Care, Scottish Government, 2011
5 Fit for Frailty - consensus best practice guidance for the care of older people living in community and outpatient settings - a report from the British Geriatrics Society 2014