



Brief

Delivering for Health **Scottish Executive Health Dept. Nov. 2005**

This paper aims to;

1. Inform RCSLT members about “Delivering for Health” (DfH) and in doing so support local action by SLT leads and their staff.
2. Act as background for RCSLT members so they can identify both where they could add value to implementation of DfH and any issues they have with it.
3. Inform lobbying and other support activity by RCSLT Scotland Office – based on the issues and support needs identified by RCSLT members.

This paper can also be accessed on the Scotland pages of www.rcslt.org.

For any further information please contact;

Kim Hartley,
RCSLT Scotland Officer
0131-226-5250
kim.hartley@rcslt.org

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1. Where does Delivering for Health come from?

The full 67 page DfH document is available at www.show.scot.nhs.uk.

DfH was published in November 2005 as the Health Ministers response to the document “Building a Health Service Fit for the Future: a National Framework for Service Change” (or the “Kerr Report”).

The Kerr Report, produced following extensive public consultation can be considered a good reflection of what people in Scotland want from their health service.

DfH broadly reflects the recommendations of the Kerr Report.

2. General direction of travel for Scotland’s Health Services

DfH aims to deal with the combination of a **growing ageing population**; the **growth in numbers of people with long-term conditions**; the trend of **rising emergency admissions to hospital particularly among older people** and the **growing divergence in life expectancy** between Scotland’s most affluent and poorest communities.

DfH describes a **shift in the balance of care** away from the current model to evolving model described in the table below.

Current view	Evolving model of care and Actions
1. Geared towards acute conditions	<p>Geared towards long-term conditions See RCSLT Brief on Rehabilitation Framework at www.rcslt.org.</p> <p>To be stratified approach to care needs of patients with LTCs. 1. Supported self care group - (70-80% of people with LTC), 2. Shared Care group requiring professional input (15-20% of LTC population) 3. Intensive professional care group (3-5% of people with LTC). People in this group will have a care co-ordinator (possibly an AHP).</p> <p>Implementation</p> <ul style="list-style-type: none">▪ Development of Rehabilitation Framework – focusing on LTC, older people and vocational rehabilitation, emphasizing key role for AHPs. See RCSLT Brief on Rehabilitation Framework at www.rcslt.org.▪ Approach to be introduced for most vulnerable groups by all Boards and CHPs by the end of 2007.
2. Hospital centred	<p>Community based</p> <ul style="list-style-type: none">▪ More substantial services in Community Health Centres or Community Hospitals▪ Greater capacity for local diagnosis and treatment including day surgery and anticipatory care.▪ Radical review of community infrastructure eg. buildings and IT.

	<p>Hospital as last resort with shorter hospital stays.</p> <ul style="list-style-type: none"> ▪ More resources targeted at pre-admission, active management of hospital admissions. Discharge and follow up in community. See “Acute / Hospital Care” section below.
Doctor dependent	<p>Team based</p> <ul style="list-style-type: none"> ▪ Implementation of frameworks for role development for AHPs and nurses - extended roles in community services and hospital admissions, discharge and follow up. ▪ Development of Rehabilitation Framework – emphasizing key role for AHPs. (See separate RCSLT Brief at www.rcslt.org). 50% increase in non-medical prescribers by Spring 2008 – incl. AHPs ▪ Supporting innovation “But in doing so, we must seek to minimise clinical risks.”
3. Episodic care	Continuous care – see LTC and Community Based Care above.
4. Disjointed care	<p>Integrated care – Smoother, quicker journey of care wherever and however people access services.</p> <ul style="list-style-type: none"> ▪ Partnership approach at all levels - <ul style="list-style-type: none"> – NHS Boards and new CHPs to work with local authorities and the community planning machinery; – Collaboration and co-ordination between professionals across organizational boundaries. – See “Acute / Hospital Care” section below. ▪ Delivering waiting time commitments for 2007 ▪ Improve healthcare in remote and rural areas – see section on Rural Health below.
5. Reactive care	<p>Pro-active care –</p> <ul style="list-style-type: none"> ▪ Multi-agency and multi-disciplinary “anticipate and prevent” approaches to healthcare targeted at greatest risk groups, i.e. disadvantaged communities, LTC communities. Approach, to be piloted in 5 CHPs 2006 / 07, to include; <ul style="list-style-type: none"> – Strengthening capacity of primary care teams including examining scope for new roles for AHPs.
6. Patient as passive recipient	Patient as partner
7. Self care infrequent	Self care norm for majority
8. Carers undervalued	<p>Carers supported as partners.</p> <ul style="list-style-type: none"> ▪ Guidance issued on the implementation of NHS carer information strategies.
9. Low tech	<p>High tech</p> <ul style="list-style-type: none"> ▪ eHealth strategy <ul style="list-style-type: none"> – Picture Archiving and Communication Systems (PACS) – national roll out by June 2007. PACS allows separation of

	<p>image acquisition, analysis and reporting meaning the patient and reporter do not need to be in the same place.</p> <ul style="list-style-type: none"> – Emergency Care Summary – with key info. from GPs records. Roll out of access and extension of info. to be considered from June 2006. – Universal use of Community Health Index (CHI) by June 2006 – Electronic Health Records to record interventions directly rather than written records. – NHS Boards to be obliged to demonstrate local IT budgets grow (2005 – 2008) to ensure all staff have the right IT tools, support and training to deliver beneficial changes to patient care in line with the eHealth strategy.
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3. Acute / Hospital Care

a) NHS Boards **3 year improvement plans** to introduce following changes in 2006/2007;

- Treat day surgery (rather than inpatient surgery) as the norm for planned procedures.
- Improve referral and diagnostic pathways, i.e. electronic referral to a central point; direct referral from diagnostics to a specialist service
- Waiting list management
- Flexible and extended working days
- Introduction of new roles with agreed competences
- Protected time for reporting.

b) Separate Unscheduled (emergency) and Planned care

- To be separated as much as possible to protect capacity in both.
- Unscheduled Care Collaborative Programme includes development of a multi-disciplinary approach to make best use of all members of the clinical team.
- To maintain care at local level for the majority of unscheduled cases through multi-disciplinary teams working in Community Casualty Units and use of telemedicine.

c) Actively managed admissions to hospital.

“Nurse led pre-admission clinics to begin the process of planning patient discharges, agreeing with the patient the level of community support required and ensuring primary care and local authority colleagues are notified.”

d) Actively managed discharge and length of stay.

Introduction of a dynamic discharge process, possibly including discharges at weekends and more widespread discharge management by nurses and AHPs.

e) Actively managed follow up.

To review of current follow-up processes with maximum follow up in the community.

f) Specialist Hospital Services

To develop better evidence base about the relationship between the volume of a complex health care intervention and quality of outcome for the patient - early results by end 2006.

Systematic process to be developed for decisions on concentration of specialist cardiac and neurological care.

National Tariffs

Introduction of national tariff for limited range of hospital procedures to increase transparency of how NHS uses its money. Tariff will form the set price list for activity carried out by one NHS Board with patients from outside the Board area. Tariffs to be phased in starting in 2005-06, using a selection of specific procedures. The range of procedures to which the tariff will apply will be increased progressively over 2006-07.

g) Use of Independent Sector

£45 million pledged over 3 years to negotiate contracts with the independent sector to enable NHS patients to receive their operations more quickly in specialties such as cancer scanning, ENT, plastic surgery and general surgery.

h) Managed Clinical Networks

Revised guidance on MCNs (issued summer 2006) aims to at strengthen MCN authority and increase influence over the way in which resources are allocated for services. The guidance describes the way CHPs should link to MCNs, and how the networks fit with the approach to LTCs.

4. Rural Health Services

To develop a **Framework of care specifically for remote and rural communities**. The framework will focus on;

a) Community Health Care

To maximise and extend the role of local community health teams.

b) Development of Community Hospitals

Services to include pre-admission and routine testing, outpatient and specialist clinics, day surgery, convalescence, rehabilitation and palliative care.

c) Out of hours services

d) Rural General Hospitals

To expand range of services beyond trauma and acute care to include planned care. The North of Scotland Planning Group is taking the lead in agreeing a list of safe core services for Rural General Hospitals.

e) Training for Remote and Rural Area (Medical) Practitioners

NHS Education for Scotland, the Scottish Medical Royal Colleges, NHS Boards and other partners to:

- consider the evidence around standards of care in remote and rural areas by December 2006
- consider operational issues associated with the delivery of health care in remote and rural areas, including how staffing can be assured and clinicians' skills maintained in low-volume procedures, and report in December 2006
- develop appropriate training for remote and rural practitioners and report by June 2007
- consider how this training can best be incorporated into posts in these areas and report by June 2007.

f) Virtual School of Rural Health Care

Proposal for development to be ready by the end of 2006. Aims to develop world-class approaches to the development and training of the rural workforce.

g) Scottish Centre for Telehealth

To be established to help NHS Boards realise the potential of telehealth;

5. Mental Health Services

“Of older adults who have physical illness such as heart disease, stroke, cancer and arthritis, about 25% may also be depressed.”

- a) **National Delivery Plan** to be published by the end of 2006.
- b) **Implement the report on Children and Young People’s Mental Health: A Framework for Promotion, Prevention and Care.** Interim targets to be identified to allow tracking of progress by 2008 and 2010.
- c) **Produced evidence-based practice guide on depression** for primary care (2006) with proposals for how the approach can be rolled out across Scotland.
- d) **To learn from the crisis services pilots and out-of-hours services** to develop a national standard for such services in 2006.
- e) **National standards for Integrated Care Pathways (ICPs)** for the main diagnoses (schizophrenia, bi-polar disorder, dementia, depression and personality disorder) to be developed by late 2007.
- f) **National and regional analysis of specialist service needs** and the action required to meet those needs – to be completed by end of 2006.
- g) **Forensic Managed Care Network** development to be supported.
- h) **New medium secure units, in the West and North-East of Scotland,** with redevelopment at the State Hospital by 2009.

6. Child health services

a) General Services

Children and Young People's Health Support Group produced a draft *Action Framework for Children and Young People's Health Services*. Final framework to be published early 2007.

RCSLT response to Delivering a Healthy Future; Action Framework for Children and Young People's Health Services available on request from RCSLT Scotland Officer.

b) Children and Young People's Mental Health Services

National project for children and young people's mental health, *HeadsUpScotland*, to develop a framework that will help local agencies deliver the strategy for children and young people's mental health.

Committed to the strategic direction set by the Scottish Needs Assessment Programme (SNAP) report on children and young people's mental health published in 2003.

"We must ensure that services and approaches are in place to promote children's mental health, prevent mental illness, and support those children and young people with mental health problems more effectively."

"We want to develop and increase capacity within mainstream children's services for mental health promotion and identification of potential mental health problems."

"We also want to ensure that specialist services are available and accessible for those children and young people who need them."

c) Specialised acute care for children

Focus to be on implementation of the recommendations from review of specialist children's services (cancer services, complex respiratory conditions, gastroenterology and neurology) in 2003.

Main recommendations from these reviews included:

- development of MCNs at regional and national level
- redesign of services using a four-level model of care describing how services could be provided and organised at local, district general hospital, regional and national levels
- an increase in specialist staff to meet Working Time Regulations and service gaps
- development of specialist/consultant roles for nursing and AHP staff
- development of regional and national planning and commissioning of services.

Continuation of Paediatric Intensive Care (PIC) units in both Edinburgh and Glasgow

To carry out two-year audit of high dependency unit (HDU) care to provide information on the future need for dedicated HDUs and how these will relate to the PIC units in Edinburgh and Glasgow.

7. Neurosurgery and neurosciences

As indicated in National Framework Review services to move from current configuration of four neurosurgical centres to a model of a single, nationally organised service on three levels;

Level 1 - Focused through CHPs, Minor Injury Services and GP practices, this level will promote access to neurological teams supported by nurse-led clinics and rehabilitation facilities. It will be able to refer to Level N2 and directly to Level N3. It will provide simple tests, referrals, decision support, pre-admission clinics, local neurology

Level 2 - Focused through District General Hospitals, this would be supported by neurologically trained A&E resuscitation staff and specialist outreach and follow-up clinics with rapid access to deal with urgent neurological emergencies. It will provide: all Level N1 services, CT/MRI, with image transfer, rehabilitation, stroke medicine, general neurology, neurophysiology (linked to Level N3 centre), local orthopaedic service, outpatient neurosurgery, post-operative care for neurosurgery (supported by education and training from Level N3 centre) and general intensive care

Level 3 - The specialist neurosurgical centre co-located with all neurosciences specialties and the major specialties of a teaching hospital. To provide a comprehensive range of sub-specialty expertise and national sub-specialties. It will provide all Level N1 and N2 services, complex medical and surgical management, CT/MRI/CTA/MRA/angiography, interventional neuroradiology, neuro critical care, inpatient neurosurgery, emergency surgery and paediatric neurosurgery.

The SEHD will establish a national implementation team to take forward this work. This programme will be completed by December 2007.

8. Workforce planning

- **NHS Board Workforce Plans** to be produced by April 2006 and **each April thereafter**; these will be part of local health planning processes and will provide assessments of the workforce.
- **Regional Workforce Plans** to be produced by January 2006 and **each September thereafter**.
- **National Workforce Plan** to be produced in December 2006 and **each December thereafter**; to be informed by the bottom-up evidence obtained from regional and NHS Board workforce plans on their future demands for staff, and allow decisions to be made on training numbers, which will effectively align supply with projected demand.
- **To build on frameworks for role development in nursing and the AHPs**, focusing on the development of key clinical roles that will support the delivery of actions on unscheduled care, long-term conditions, out-of-hours and emergency services, orthopaedic services and diagnostic waiting times.

9. Pay Modernisation

Future pay modernisation aims to deliver new pay systems which directly support the achievement of priorities for improving services to patients, e.g. attaining waiting time targets, better managing chronic disease, or pursuing our health improvement objectives.

NHS Boards to implement **Pay Modernisation Benefits Delivery Plans** outlining how they will achieve benefits to services from the new contracts through working in partnership with staff to support redesign and improvements in services. These plans to be updated regularly.

10. Performance Management of Delivering for Health

- **SEHD Delivery Group** to monitor and where necessary take more “assertive role in supporting and intervening” in
- **NHS Board level Local Delivery Plans.**
- **CHPs** to work in partnership with local authorities on shared measurable outcomes using community-planning framework.
- **SEHD Primary and Community Care Group** responsible for service development and partnerships with social services.

11. Paying for Delivering for Health

- To be implemented within current spending plans.
- Pace of change will depend on amount of resources that can be allocated to actions.

**Brief compiled by
Kim Hartley
RCSLT Scotland Officer
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