



A NATIONAL CLINICAL STRATEGY FOR SCOTLAND - A SUMMARY FOR VOLUNTARY HEALTH ORGANISATIONS

Introduction

1. The Scottish Government published A National Clinical Strategy for Scotland in February 2016.
2. VHS has summarised the Strategy to give voluntary health audiences an overview of the key changes proposed for health services in Scotland over the next 15 years.
3. The needs and challenges set out include those of Scotland's ageing population and Scotland's unacceptable degree of health inequalities.

Overview

4. The strategy makes the case for:
 - a. Planning and delivery of primary care services around individuals/communities.
 - b. Planning hospital networks based on population needs not geographic boundaries.
 - c. Providing high value, proportionate, effective and sustainable healthcare.
 - d. Transformational change supported by investment in e-health/technology.

What the Strategy is for

5. It is the Scottish Government's framework for the development of health services across Scotland for the next 15 years.
6. It provides a unifying direction to the range of service reviews currently underway.
7. It provides an outline of how the NHS in Scotland will change.

What it addresses

8. It is confined to the delivery of healthcare services to meet assessed needs.
9. It does not address socio-economic, educational, employment or environmental issues that contribute to poor health. It does not deal with strategies to support healthier lifestyle choices or mental wellbeing.
10. Effective healthcare services, particularly in primary and community care, can significantly reduce the impact of inequalities.
11. The increased demand from an older population will require more staff and/or more innovative technological solutions.

A new clinical paradigm

12. The continuous drive to deliver services of the highest quality and value are the best way to manage resources.
13. Medical practice can result in overdiagnosis, overtreatment and waste but also undertreatment.
14. A new clinical paradigm is needed to ensure healthcare delivery is proportionate and relevant to individual patients' needs.
15. The emphasis is on maximising patient value from the available resources.

Primary care is key

16. Stronger primary care will be delivered by increasingly multi-disciplinary teams, with stronger integration (and where possible, co-location) with local authority social services, independent and third sector providers.

Expanded health and social care teams

17. The expanded health and social care team will:
 - a. Support patient self-management, independence, prevention and rehabilitation.
 - b. Provide patient-focused not condition-focused care, based on long-term relationships between patients and clinical teams.
 - c. Understand the role of social interventions to address complex needs (not default to medical solutions).
 - d. Provide evidence-based interventions to reduce risk of hospital admission.
 - e. Provide more community-based services.
 - f. Provide sensitive end of life care in the setting a patient wishes.
18. Transformation of primary/community care will be supported by the move to integrated health and social care (April 2016) and by the new GP contract (April 2017).
19. Primary care capacity will be built, with enhanced recruitment of GPs and newer, enhanced roles in primary care, e.g. Advanced Nurse Practitioners, Pharmacists, Allied Health Professionals.
20. GPs will increasingly take on a role in dealing with complex cases and providing expert assessments of new cases.

Dental care

21. The outdated and complex dental system will be transformed, to meet the needs of younger people in particular.

Prevention using technology

22. The potential for prevention through extended vaccination programmes and evolving IT solutions.

Secondary care

23. Necessary changes to secondary care processes are discussed.
24. Hospital discharge and return home must be timely and supported by responsive health and care services.
25. Patient recalls to review outpatients appointments will be reduced if possible, e.g. by alternative arrangements using modern technology.

Specialist settings and hospital networks

26. Overwhelming evidence that some complex and many less complex operations are best performed in specialist settings.
27. Some services should be planned at a national, regional or local level on a *population* rather than *geographical boundary* basis. Networks of hospital services will be developed.
28. Most hospitals will continue to deliver outpatient, diagnostic and day care.
29. £200 million for elective diagnostic and treatment centres to provide increased capacity for surgical procedures especially age-related (cataracts, knee/hip replacements etc).
30. Planning and delivery services for and across populations, regardless of locality, will be key. Collaborative working must be increased.

Technology and data

31. Technology will be harnessed, including to enable specialist input for remote communities to augment local care via telecommunications.
32. The NHS will make much greater use of information and big data to make more informed decisions, provide better coordinated and more personalised care, prevent risks, assess outcomes, predict future needs, drive continuous service improvement, etc.

Skilled workforce

33. Development of an increasingly skilled staff working effectively in multi-disciplinary and multi-organisational teams.

Leadership

34. The new clinical paradigm will mean long-term cultural and clinical change with strong national clinical leadership.
35. The new paradigm will support an approach that uses lifestyle medication first before more significant intervention. It will support self-management and resilience rather than dependency, where appropriate. It will reduce use of interventions of limited use/that cause harm.
36. Technology will be key. It hopes genomics will help stratify patients into low and high risk, to enable reduction of treatment for some and more effective focusing of treatment for others.



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