National Clinical Strategy – the regional implications

NoSPG is asked to:

• Discuss the content of this paper
• Provide guidance on any specific implementation requirements

Synopsis of Paper:

This paper explores the potential regional implications of the National Clinical Strategy for the north of Scotland.

Elements of the National Strategy relevant to our regional agenda are identified and considered as either enablers or supporters of future changes to the regional strategic direction.

The paper concludes by linking this thinking into high level next steps for the North of Scotland Regional Planning Group.

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4th March 2016
Scotland’s National Clinical Strategy was published in February 2016. Developed by Dr Angus Cameron, Elizabeth Porterfield and Karen McNee, it is presented by Professor Jason Leitch (National Clinical Director), Dr Catherine Calderwood (Chief Medical Officer) and Professor Fiona McQueen (Chief Nursing Officer).

It provides a strategic continuation from the 2020 Vision document and takes the planning view through to 2025-30. It sets out ‘a broad direction for change to help the NHS in Scotland meet the challenges ahead’.

The twenty point Executive Summary concludes by stating that the document sets out the case for:

- Planning and delivery of primary care services around individuals and their communities.
- Planning hospital networks at a national, regional or local level based on a population paradigm.
- Providing high value, proportionate, effective and sustainable healthcare.
- Transformational change supported by investment in eHealth and technological advances

Naturally not all of the National Clinical Strategy relates to regional working. However this paper explores some of the areas where the national strategic agenda is likely to impact on the regional planning agenda in the North of Scotland.

Some of these areas/elements will have a more indirect impact on the regional agenda and act as a support for change, while others are likely to have a more direct impact as drivers of change that will need to be carefully interfaced with the existing regional planning programme of work.

The table below explores some thinking around potential regional implications of these elements of the National Clinical Strategy.

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<thead>
<tr>
<th>Elements that will support the north of Scotland Regional Planning agenda</th>
<th>Potential North of Scotland implications</th>
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<tbody>
<tr>
<td>Practise ‘realistic medicine’</td>
<td>This may modify the effect of the demographic changes</td>
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that are expected. As the population ages their healthcare needs, if this model is widely adopted, may move away from requiring acute based specialist care, and sit within the locally planned and delivered primary and social care services.

| **Increase the health literacy in the population** | We will need to make sure that any messages pertinent to regional planning at a population level are included in any national work to increase health literacy e.g. expectations of local care, and information to support decisions about travelling for care. |
| **Improve workforce planning** | Ways to better deliver both workforce planning and implementing workforce changes based on those plans do need to be improved. Regional elements of this are likely to include region-wide workforce planning, particularly where there are shared services or the opportunity for collaborative planning, and moving towards common processes that increase the number of meaningful regional workforce data sets. |
| **Sort the technology needed to support change** | Technology is a key enabler of many innovations in health care. Many of these will involve care at a distance, which may be expected to have a disproportionate effect in the large scale geography of the north of Scotland. We need to ensure that the regional process for delivering technology supported care and innovation is a robust as it can be. This is likely to require changes in the way eHealth support is prioritised, as it is currently orientated more towards Board and national level planning. |
| **Transform professional roles and collaboration** | These changes are likely to be driven nationally. However we will need to ensure that professional roles that are being developed as innovations in remote and rural areas are being actively considered as part of any national changes. Development of both skills and processes to support effective collaboration need to be core to regional working. |
| **Identify services needing to be planned regionally/plan more services regionally and nationally** | Identifying an agreed list of services that should be planned regionally will require both national and Board level input. The strategic intent to increase the services planned at regional and national level needs to be clearly captured in the Regional Clinical Strategy and a robust mechanism to ensure that north of Scotland challenges and priorities are clearly described in the process needs to be ensured. There will also be a |

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The North of Scotland Planning Group is a collaboration between NHS Grampian, NHS Highland, NHS Orkney, NHS Shetland, NHS Tayside and NHS Western Isles. This group has a requirement to ensure that close links with the Shared Services agenda are maintained and functioning well.

Increasing the primary care resource

This will have a two-fold effect on regional planning. One is likely to change the requirement for specialist and acute services (relating to the Realistic Medicine element above) as more services are made available at a locality level, and the second will be that, if the primary care resource increases, then the secondary and tertiary care resource is likely to decrease. This may mean altering pressures on these services and a changing shape of healthcare planning as a result.

Elements that will drive the North of Scotland Regional Planning agenda

<table>
<thead>
<tr>
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<th>Potential North of Scotland implications</th>
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<tr>
<td>Decrease the number of sites where specialist inpatient care is delivered</td>
<td>Scoping work for this in the north of Scotland is already well underway in surgical services. Key next steps include agreeing a framework for decision making, and developing robust ways to identify both intended and unintended consequences of rationalising the number of specialist centres for some procedures.</td>
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<tr>
<td>Network specialist care across groups of hospitals</td>
<td>This model appears to differ in some ways from both the Managed Clinical Network and the Managed Service Network, and potentially combines strengths of both. The national model describes a network of four or five hospitals where all deliver most of the service (e.g. outpatients, step down care and diagnostics) but only one hospital delivers the acute inpatient care. One of the regional implications of this will be that in the north of Scotland there may be limited configurations of this arrangement which may make any balanced redistribution more challenging. However the other side of this may be that this constraint drives more innovative solutions than in envisioned central belt models, and would lead to increased activity and sustainability in smaller Rural General Hospitals.</td>
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<td>Better clinical leadership at a regional and national level</td>
<td>This is implied rather than stated in the National Clinical Strategy as the clinical leadership comments appear more directed toward board level services. However if more services are planned and delivered at regional and national level then inevitably clinical leadership at those levels must also be strengthened, both in terms of the governance structures and the support for staff undertaking those roles.</td>
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<th>Support rural practices and Rural General Hospitals</th>
<th>This is likely to be a key driver of the Regional Clinical Strategy and it is helpful to have a mandate for this from the National Clinical Strategy</th>
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<td>Increase remote access to health advice and care</td>
<td>This element may signal a move away from traditional outpatient based models of care. There are wide ranging opportunities in current communication technology to transform both the location and the timing of interactions with all layers of health services, and it is essential that this challenge is embedded in regional planning. This is also likely to be a key driver of the Regional Clinical Strategy and it is helpful to have a mandate for this from the National Clinical Strategy. Projects such as Transforming Care After Treatment (TCAT) will be particularly close to this agenda.</td>
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<td>Increase decision support provision</td>
<td>This is already involved as driver in north of Scotland regional planning work to date. A national strategic framework for this will be helpful, provided that regional constraints and priorities are clearly included in the future plans for this work or a regional framework may need to be considered, or a blended model of both for different tiers of need.</td>
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**The whole picture**

Describing the elements and potential implications as separate items is perhaps over simplifying the challenge facing the teams planning services at a regional level. Other papers to this meeting describe the challenges and rate limiting effects when one or more of these elements are not in place.

Securing our regional strategic vision, closely linking it to the national vision, will be a priority for the Regional Planning Team in the coming months and years.

Planning structures at national, regional and Board level may need to evolve to deliver this complex programme efficiently.

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4th March 2016