Clinical Strategy

2022 - 27

NHS
Orkney

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Acknowledgements

We would like to thank members of the Orkney community who took part in the survey and patients who gave up time to talk to us. We would also like to thank staff for their time and enthusiasm in contributing to this document and Orkney Health and Care for allowing us to use selected material from the Joint Strategic Needs Assessment.

FORWARD

This Clinical Strategy sets out our ambition of how our clinical teams and services will develop and grow to meet the needs of the people of Orkney over the next five years. It has been developed in consultation with our community and staff and with extensive input from our clinicians.

It describes the approach we will take to shaping our clinical services, which will be driven by evidence, best practice, safety and transparency. In order to achieve the ambitions of the clinical strategy we will ensure that we support and develop our workforce, harness the power of technology and innovation, and undertake continuous quality improvement.

Everything we do within NHS Orkney and as part of the wider health and care sector, aims to keep people healthy and well. However, good health and wellbeing are not just about NHS and care services, and not just about treating illness and accidents. Good health and wellbeing come from every aspect of our lives, environment and society. The quality of our education, employment, housing, neighbourhoods, relationships, families, jobs, safety, food and environment are among the many things that influence our health, happiness and wellbeing, for better or worse.

The health and care we provide is designed to reflect local needs and make a positive difference to many of the challenges to health and wellbeing that local people face. However, as an anchor institution at the heart of the community we serve, we also aim to make a wider contribution to the community in Orkney, beyond the healthcare that we provide. Through such things as providing access to quality employment, purchasing locally as far as possible, reducing environmental impact and working closely with local partners.

We need to ensure we make a real difference to the health of our local population throughout their lives. We will do everything possible to maintain health, prevent illness and provide the best available care. We will do this in partnership with individual patients and their communities. We will deliver care seamlessly across hospital and community services and in collaboration with other services that meet the needs of our population. Including third sector organisations and public sector partners such as Orkney Islands Council, NHS Grampian and Scottish Ambulance Service.

The Clinical Strategy will help our services evolve to meet the changing health needs associated with the changing demographics of the population in Orkney. In particular, the needs of increasing numbers of older people in our communities who are living with long-term conditions and frailty. It will also focus on reducing unwarranted variation and addressing health inequalities. This focus is needed now more than ever because many pre-existing health inequalities have been made worse by the Covid-19 pandemic. This is a result of both the direct health consequences of Covid-19 and the impact of measures required to control the pandemic, including changes in access to education, increased social isolation, reduced physical activity, and changes to employment and income. The Clinical Strategy will also help achieve our commitment to delivering greener healthcare, including reducing waste, which will enable us to make our services more environmentally and financially sustainable.

This Clinical Strategy sets out our commitment to enable people to remain as healthy and independent as possible throughout their lives. It describes the key role of prevention and early intervention in realising this ambition and explains how these principles will be further developed throughout our services, in order to help improve the health and well-being of our population. It also sets out how we will improve care and support independence by strengthening our delivery of personalised and coordinated care.

We will focus on what matters to our patients, not just in terms of their medical care, but also as individuals and members of their families and communities. We will give people the information and support they need to make informed decisions and to be empowered to manage their own care, as far as possible. This will in turn allow more effective and efficient use of resources, help ensure timely treatment, and reduce harm and waste from over or under treatment.

The Clinical Strategy explains the Model of Care which is central to our vision, how we have used this to develop a strategy focused on four key clinical areas and how specific key services will develop to support this. The areas of focus are:

- Improving health and well being of people in Orkney
- Children and young people
- Mental health
- Supporting independence for people living with long-term conditions.

In order to improve the health and wellbeing of people in Orkney we will prioritise keeping people healthy and ensure that we make the most of every opportunity to reduce health inequalities. We will focus on improving health through concerted action in the key areas of stopping smoking, reducing alcohol use, managing bodyweight and improving physical activity.

To improve the health of children and young people we will build on the Children's Services Inspection improvement work, through further integration of services and development of opportunities to create effective multi-disciplinary teams. The service redesign will involve all stakeholders including young people and their parents and will consider Royal College of Paediatrics and Child Health guidance, as well as best practice models from elsewhere.

We will improve mental health by focusing upon the implementation of the Orkney Health and Care Mental Health Strategy and Dementia Strategy, both recently published. There will be a focus upon enabling people to access their own strengths and supports where possible; preventing onset of mental health conditions and providing early intervention and support for recovery; developing personal and community resilience. We will work in close partnership with individuals, carers, communities, statutory and voluntary sector providers to build upon existing services and make most effective use of all resources available. This will enable us to be responsive and adaptable to changing mental health needs of our population, including those resulting from the pandemic.

We will reduce the risk of people developing long-term conditions by supporting people to live healthier lives and we will support people who do develop long-term conditions to remain healthy and independent for as long as possible. We will do this by focusing on early diagnosis and management of long term conditions; helping people to understand and manage their conditions; and providing coordinated care that is in line with latest evidence and best practice, whilst at the same time recognises peoples' individual needs and choices.

We recognise that people who are living with multiple long-term conditions often need different support to those who are living with a single long-term condition and we will tailor their care accordingly. We also recognise that people with multiple long-term conditions are more likely to develop frailty in older age. Care and support for people with multiple long term conditions and frailty will be provided by a multi-disciplinary team, working together to make sure that people understand the overall impact of their conditions, have the support that they need to make decisions about their care and are able to retain control of their care.

Michael Dickson
Interim Chief Executive
NHS Orkney

THE COMMUNITY WE SERVE

NHS Orkney is the smallest territorial health board in Scotland and is responsible for the health care of the population of Orkney. We employ around 620 staff and provide a comprehensive range of primary, community-based, and hospital services. As a large, non-profit, public sector organisation whose long-term sustainability is tied to the wellbeing of the population it serves, NHS Orkney can be seen as an anchor institution. Anchors are unlikely to relocate given their connection to the local population and have a significant influence on the health and wellbeing of communities. In addition to providing quality health and care services the NHS can make a difference to local people by:

- Widening access to quality employment
- Purchasing more locally
- Using buildings and spaces to support communities
- Reducing environmental impact
- Working closely with local partners

The majority (69%) of people living in Orkney live in a remote and rural setting. In 2019, the population was estimated as 22,270, with equal numbers of males and females. About one fifth (18%) of the population were under the age of 18, over half (58%) between 18 and 64 years and about a quarter (24%) aged 65 and over. For more information on demographic changes see 'Why we need to work differently' later in this document.

National Records of Scotland estimates that the population will decrease slightly (0.7%) between now and 2035. There were 182 births in Orkney in 2019, a drop of 15% from 2005. People moving into and away from Orkney also play an important role in shaping the population. Net migration into Orkney is expected to decrease by 6% between 2019 and 2030.

Employment plays an important role in people's lives in many ways. It provides a sense of purpose, financial stability, and continuity, as well as future security. It can also be a source of stress due to underemployment, seasonal or temporary contracts leading to uncertainty and anxiety, as well as the physical impact of demanding and/or repetitive tasks. However, the employment situation in Orkney is relatively good compared to Scotland as a whole.

There are well-established links between health (physical and mental), and personal financial circumstances. Recent results from the Scottish Household Survey suggest that only 66% of Orkney households manage well or very well in terms of their household finances. This has shown general improvement over the 20 years from 1999.

Fuel poverty means that a household spends more than 10% of its income on fuel costs and does not have enough left over to maintain an acceptable standard of living. Extreme fuel poverty means that this spend is more that 20% of household income. Fuel poverty is one of the major challenges for many households in Orkney and often affects people's health. For example, cold and damp homes can cause worsening of a number of long-term conditions, such as respiratory disease, heart disease, circulatory disease, and poor mental health. In Orkney 31% of the population were estimated to be living in fuel poverty between 2017 and 2019. Older people were mostly affected, with 34% living in extreme fuel poverty.

Food insecurity is another important risk to health and wellbeing. The Trussell Trust is a charity which supports food banks nationwide and in Orkney the number of food parcels provided by the Trust increased by 46% in 2020/21.

Child poverty is also a significant risk factor. As well as causing problems directly during childhood, child poverty can cause health problems that last throughout a person's life. In Orkney the number of children living in poverty increased to 703 in 2019/20.

A sense of community plays an important role in health and wellbeing outcomes. A healthy, inclusive community provides a sense of identity as well as being a source of resilience in times of difficulty at both individual and community level. Results from Scottish Household Survey suggest that people in Orkney have a strong sense of belonging: 88% of people felt a very strong or fairly strong sense of belonging during 2017-2019 and 80% of people said they met socially at least once a week. During the Covid-19 pandemic, this support and resilience came to the fore with community initiatives, the work of the coronavirus community support hub, and the NHS Covid-19 centre.

HOW OUR SERVICES ARE PROVIDED

NHS Orkney provides a wide range of healthcare in Orkney, from urgent and emergency care to GPs and dentistry. Some of these services are based in The Balfour, our hospital and healthcare facility, and many are provided in the community across the mainland and our isles. Patient safety is our highest priority and sometimes difficult decisions have to be made regarding whether care can safely be delivered in Orkney and within our isles with the resources available to us, or whether it needs to be delivered outside Orkney. Some specialist services such as Consultant Paediatric and Oncology services as well as interpretation of CT scans and MRI scans are provided by NHS Grampian in Aberdeen. Ophthalmology services are provided by NHS Highland. These longstanding arrangements with NHS Grampian and NHS Highland which support specialisms that would not be feasible within NHS Orkney have worked successfully for decades and it is not anticipated that this will change. NHS Orkney belongs to the NHS North Region which supports collaboration and innovation across the north of Scotland.

We work in close partnership with Orkney Islands Council to improve and develop social care, community health and wellbeing. This partnership is called Orkney Health and Care and provides social work for adults and older people, mental health services, child protection and many other services. We also work in partnership with the Community Planning Partnership and Local Outcomes Improvement Plan.

We recognise the need to invest in our skilled workforce and ensure the correct staffing levels as set out in the Health & Care (Staffing) Bill. We will work in partnership and innovatively with the Third Sector and those using our services. Wherever possible we work closely with patients and carers to design our services to best meet their needs. We will further develop this approach and therefore better support people to maintain, improve or manage their own health. We also aim to maximize the opportunities for improvement in care provided by basing different services at the same location.

HOW THIS STRATEGY WAS DEVELOPED

This Clinical Strategy has been developed in line with a number of national strategies which can be found here. The principles and approach advocated through Realistic Medicine have informed this strategy.

Work on the Clinical Strategy started in 2019 but was paused early in 2020 due to the Covid-19 pandemic. Work began again in summer 2021 with community and staff surveys, interviews and focus groups with clinical and operational staff from both NHS Orkney and Orkney Health and Care. An advisory group with a broad clinical representation was formed to review progress and discuss content.

Members of Orkney Health and Care also contributed to this document and provided population statistics for the area.

A broad group of clinical staff contributed text for their specialist areas, and the advisory group and reviewers from a range of clinical backgrounds gave comments on the strategy before it was finalised.

WHAT WE HEARD FROM OUR COMMUNITY

A small group of patient representatives met to discuss their priorities for the clinical strategy. They highlighted the need to focus on mental health and children's services as well as intermediate care and returning home from treatment. The need for good communication both between clinicians and the patient, family and carers was stressed, along with the need to engage regularly with patient representatives.

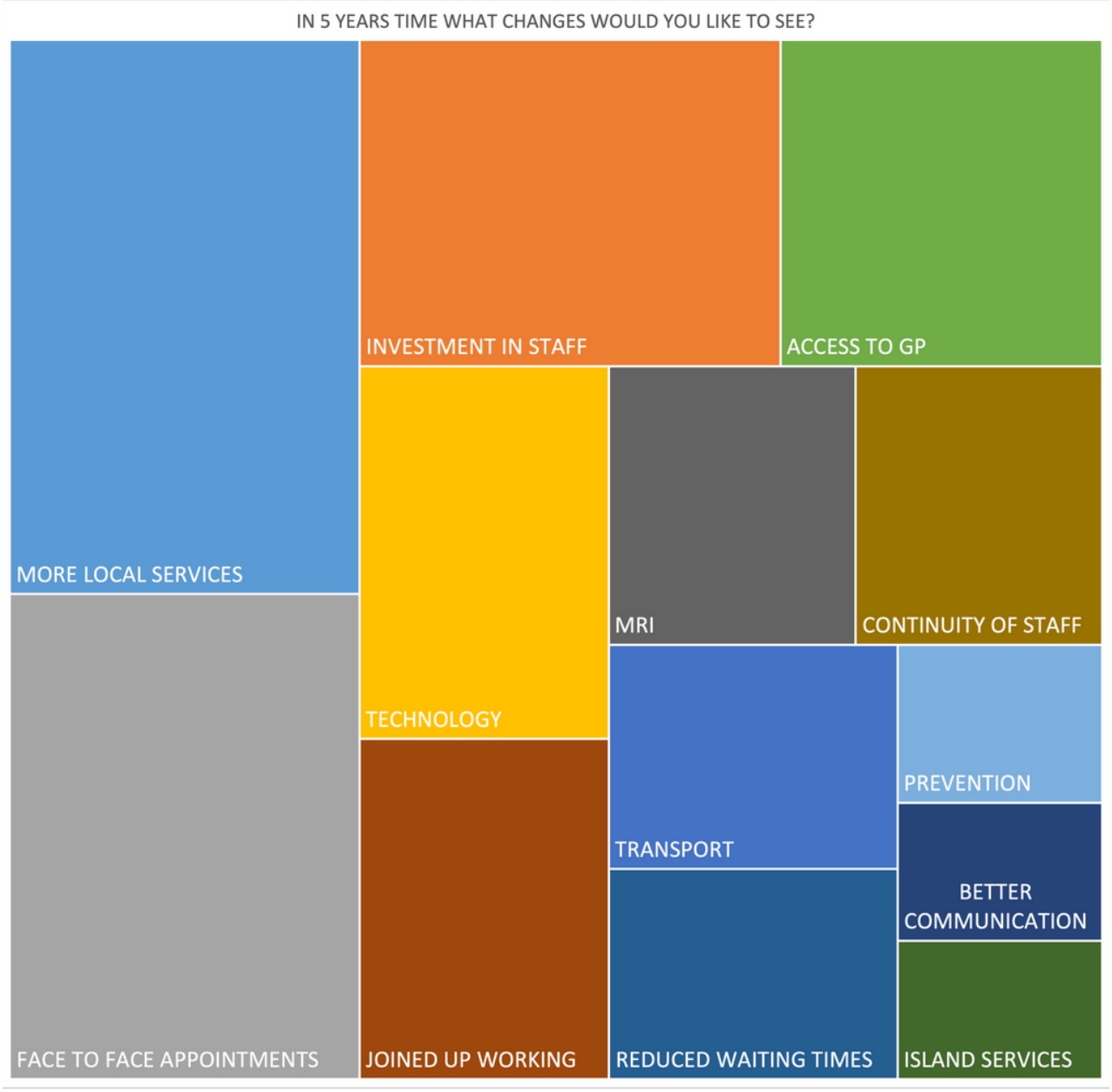
A community survey was widely promoted through local media and social media. The survey was easy to access in a digital format, but paper copies were also available. More than 330 members of our community took part, spending an average of 23 minutes completing it. The results have made a very important contribution to the strategy. You can take a look at the full report here.

Residents of all areas of Orkney across both mainland and the isles were well represented in the survey responses, as were people from all adult age groups. The survey was also discussed at the Youth Forum where it was felt that the NHS had done an excellent job of coping with the Covid-19 pandemic. Those present hoped to see a reduction in waiting times for seeing a specialist and receiving treatment. The need for financial support and a personalised approach for equipment such as wheelchairs was noted together with the need for a local paediatric unit to alleviate financial and emotional stresses on families.

We asked participants of the survey what they felt was going well in the service. 299 respondents gave us feedback with the largest number highlighting the vaccination rollout and Covid-19 response.

> The staff at my GP Practice are always polite and helpful. The Covid vaccination effort was phenomenal. The OHAC team deserve a pat on the back!

We asked participants what changes they would like to see in health and care services in 5 years time. We received responses on both how you would like to see the service delivered and specific clinical areas. The diagram below represents the changes in the ways of working that people have asked for with the size of the block representing how often it was mentioned.



17% of the responses mentioned that they would like to see more services delivered locally, avoiding travel to Aberdeen. Some participants also highlighted increased services on the inner and outer isles to avoid travel to mainland Orkney. 15% of the responses asked for a return to face-to-face, reflecting the necessary move to phone appointments during the Covid-19 pandemic.

Investment in all frontline staff including GPs was mentioned in 12% of the responses. Increased staff numbers and investment in training the current staff were both areas which were highlighted.

Services have adapted and become more flexible in their approach due to Covid-19, and have been doing a grand job. However a return to more face to face consultation for those that prefer it would be good.

More investment in front line staff for all services and a continuation of services running as they currently do.

More joined up communication between the many parts of NHS Orkney and its partners.

When we asked about the changes you would like to see in health and care services in 5 years the responses mentioned a number of specific clinical areas.

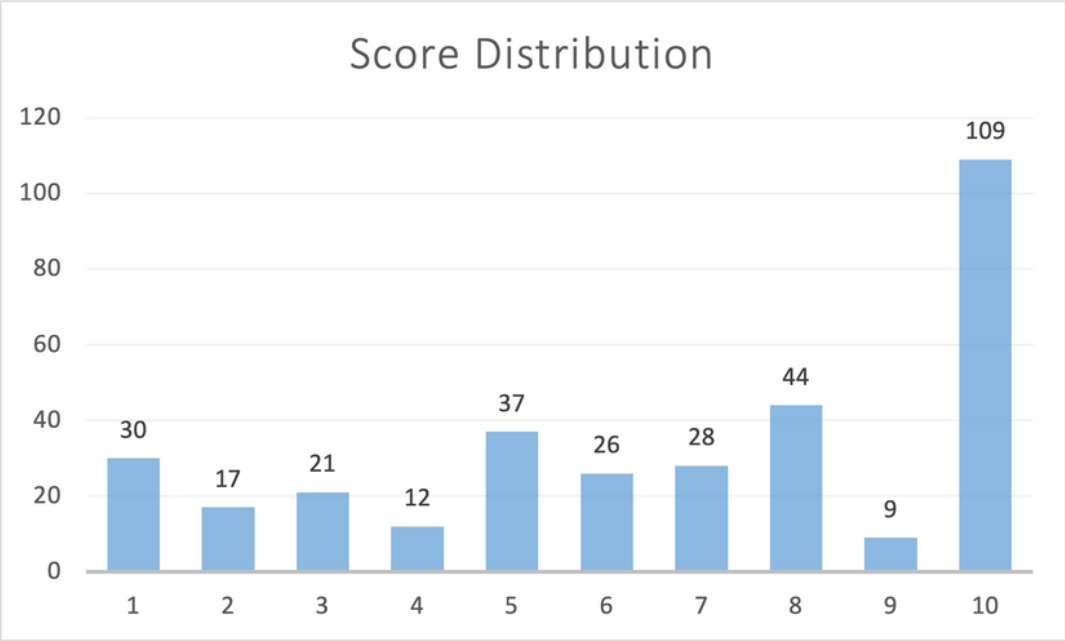
33% of the responses highlighted the need for faster access to mental health services and for those services to be improved and invested in. Mental health in children and young people was mentioned in a number of responses.

Care was mentioned in 17% of the responses with easier access, care tailored to the individuals' needs, improved care in the home and the need to involve and value family and friends who take on care responsibilities more. The need for more sheltered housing and care staff was also highlighted.

Significant improvement to mental health services. Easier access to clinics and support, for those with both severe mental health conditions, and those who are perhaps just going through a hard time and need short term support...

More investment in community based services to allow staff the time to adopt a more proactive approach to helping support people to manage their conditions.

We asked participants how willing they would be to have a phone call or video call with a health care professional instead of a face-to-face appointment (if they and their health care professional felt it would be appropriate).
The diagram below describes the response we received where 1 is "not willing at all" and 10 is "extremely willing".



Having young children, a phone call can be easier than trying to take them to an appointment or find childcare, however there are some cases where it's easier to discuss certain things, for example mental health issues, face-to-face.

An appointment at Aberdeen Royal Infirmary means three days away from home. We don't all have time for that. Not to mention the cost.

I am willing. But I know many folk who just don't like speaking on the phone and others would not open up to discuss their worries. It's about equal access for all whatever their mental or physical capacity.

WHAT WE HEARD FROM OUR STAFF

We carried out a staff survey in September and October and over 80 members of staff took part. We asked staff to identify an innovation they would like to highlight. These included hospital at home, discharge to assess, health care partnerships in the GP surgeries, chronic pain pathways and many more.

We asked which factors we should consider that are specific to our board. Three broad categories were described in the responses:

- Staff (small clinical teams and the need to be generalists and specialists)
- Isolation
- Relationship with NHS Grampian, and NHS Shetland

> Local services deliver comprehensive clinical services but often with very small teams which adds significant complexity to clinical delivery, the ability to juggle clinical, managerial, and leadership roles, developing and maintaining clinical competencies, and team resilience.

> Resilience - eg lack of beds is a major issue when we are an island location with no neighbouring hospital.

> Access to healthcare by patients living on the isles or those who find travel to the Balfour difficult or prohibitively expensive so we can address the remote and rural health inequalities more.

When asked which clinical areas the clinical strategy should focus on the response was that mental health should be the top priority followed by children and young people and those with long term conditions.

These priorities are reflected in this strategy.

WHY WE NEED TO WORK DIFFERENTLY OVER THE NEXT 5 YEARS

The opening of The Balfour in 2019 brought state of the art facilities and equipment and was the first important step towards making our services 'fit for the future'.

In order to provide good care for the people of Orkney in the years ahead we need to continue to develop our understanding of the make-up of our population, the health needs they are experiencing and how these things are likely to change in the future. We must make sure that we recognise those people within our community with the greatest health needs, particularly as they are often also the people who find it the most difficult to access services.

We need to use this knowledge and understanding to develop and support a workforce able to design and deliver services that address these inequalities and meet changing needs throughout Orkney. We need to enable our teams to work together to make best use not only of the resources available at the Balfour, but also those in other local settings across the county; further developing the care that is already delivered in peoples' homes and communities.

We also need to support our workforce to embrace the adaptability and innovation needed to make best use of new treatments and technologies as they arise, as well as to meet the challenges of environmental and financial sustainability.

Many of these challenges are Scotland wide and are addressed in the National Clinical Strategy for Scotland, and this national strategy has helped inform our Clinical Strategy for Orkney. However our Clinical Strategy addresses specific needs and circumstances which are at times unique. The following changes and challenges have been identified through our engagement process as the most important issues for Orkney.

THE HEALTH OF OUR POPULATION

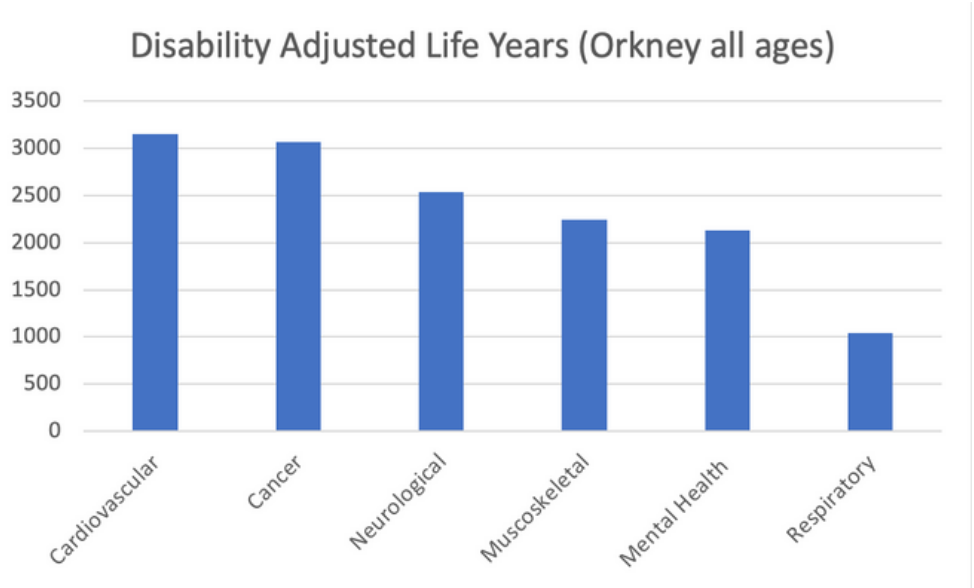
Our aim is that people in Orkney will have the chance to live longer and healthier lives. In order to do this, we need to understand the diseases and conditions that affect people throughout their lives. Some conditions shorten peoples' lives, some conditions cause disabilities, and many conditions do both.

We need to understand the impact of these conditions on individuals, so that we can plan personal care and treatment. However, we also need to understand the overall impact of these conditions on our population, so that we can plan how to best organise our services to deliver this personal care and treatment.

One way of describing the overall impact of specific diseases and conditions on the health of people in Orkney is to use a measure called 'Disability Adjusted Life Years' (DALY), described **here**. The higher the 'DALY', the bigger the impact of that disease or condition on the health of the population.

Different conditions have different degrees of impact at different stages in our lives. Older age groups for example are most affected by cardiovascular diseases and cancer, while younger people are most affected by mental health disorders and musculoskeletal conditions.

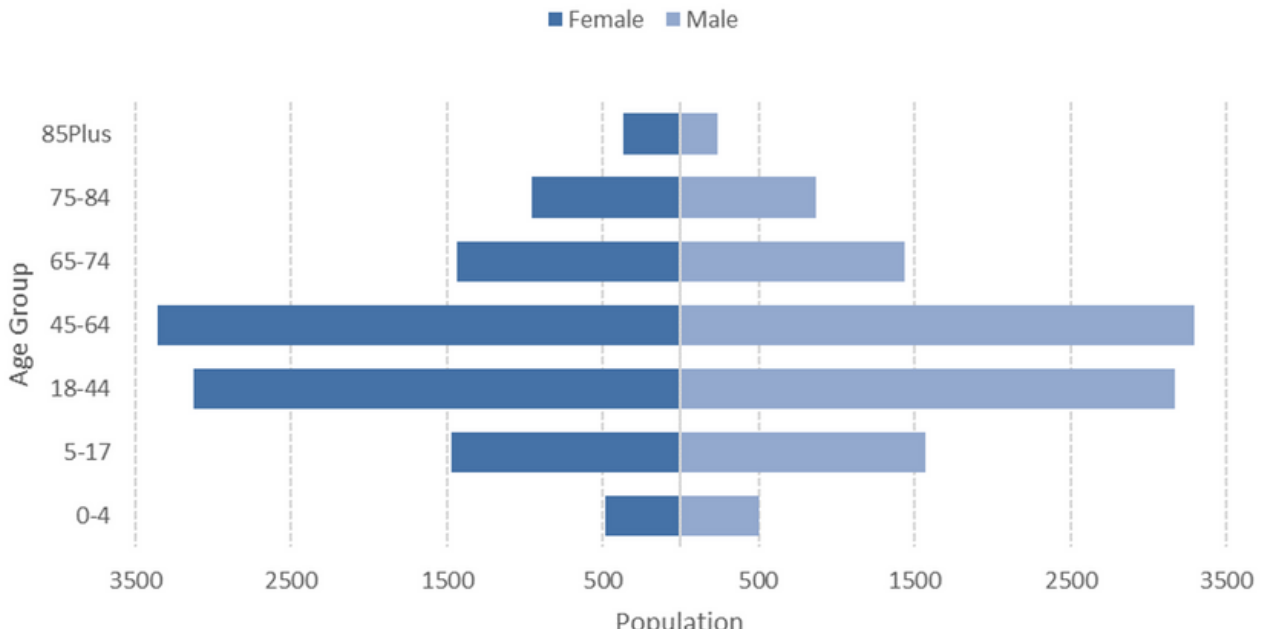
The diagram below shows the most common conditions in our community and their overall impact upon healthy lives in Orkney.



A more detailed description of the impact of different conditions upon different age groups in Orkney, along with more information about the risk factors for these conditions can be found on page 37.

DEMOGRAPHIC CHANGES IN OUR POPULATION

The demographics of an area shape the nature of community needs in many ways and are crucial when considering the nature of health and social needs. The chart below shows the population distribution of the Orkney Islands (source National Records of Scotland).



The age profile in Orkney is changing, resulting in fewer younger and more older people. National Records Scotland has estimated that there will be 618 fewer children and young people in 2035 than in 2020, a drop of 15%. The number of people aged between 18 and 64 is expected to fall by 1,255, a drop of 10%. However, there is expected to be an increase of 1,716 people aged 65+, which is a 30% increase in this age group overall.

Within this population aged over 65, the biggest rate of increase will be in the numbers of people aged 85+, which are expected to double by 2035.

CHANGING PATTERNS OF ILLNESS AND DISABILITY

The changing age profile of the population is accompanied by a change in patterns of illness and disability. This is largely because a number of important health conditions develop over a period of time and then last for the rest of a person's life. Conditions which last for more than 12 months are called Long-Term Conditions. Due to the way these long term conditions develop and progress, they are more common in older people than in younger people. Therefore, the older we get the more likely we are living with one or more of these conditions. For example, about half of people in their early 50s will have one long term condition and around quarter of them will have two. This increases with age and 25% of people in their early 70s have four conditions.

As the number of older people increases, there is an increasing care need for people living with one or more long term conditions. Our services need to understand and adapt to this. We have explained how we will do this in the improving care and supporting independence for people who are living with long term conditions section of this document.

WORSENING HEALTH INEQUALITIES DUE TO THE COVID-19 PANDEMIC

The Covid-19 pandemic has had wide ranging impacts on health and wellbeing for our entire population. The health impacts include both the direct effects of Covid-19 infection and the indirect effects of delayed diagnosis or treatment of other conditions during the pandemic. There have also been much wider impacts on our society and the economy as a result of the measures needed to control the pandemic. These include disruption to education, relationships and family lives; increased stress, anxiety, isolation and loneliness; negative impacts on employment and the economy resulting in financial hardship. Many of these factors will also have negative effects on people's health and wellbeing, now and in the future.

The impacts of the Covid-19 pandemic are therefore very great. However, there is also evidence that these impacts have not been equal and that the negative effects of the pandemic have been felt most by people who were already worse off and experiencing poorer health.

The wider social and economic environment can have a very big impact on the health and social care needs of communities. Prior to the pandemic, there were already marked inequalities across many areas of society, including income, wealth, living standards, employment opportunities, health, education and life choices. Covid-19 has made many of these pre-existing inequalities worse. As we begin to recover from the pandemic, we therefore need to make addressing health inequalities in our society a high priority and put a renewed focus on supporting the most vulnerable and disadvantaged groups in our communities.

GREEN AND SUSTAINABLE HEALTHCARE

Climate change threatens health directly from impacts due to weather, and indirectly through disruption to natural systems and to our society. However, at the same time as needing to meet health problems resulting from climate change, the healthcare sector is also contributing to it. If the global health care sector were a country, it would be the fifth-largest emitter of greenhouse gases on the planet. The NHS is a significant contributor to the climate emergency because it emits a large amount of greenhouse gases, consumes huge amounts of resources and produces vast amounts of waste.

NHS Scotland has committed to being a 'net-zero' greenhouse gas emissions organisation by 2040 and aims to be a world-leading sustainable healthcare provider. Responsibility for achieving this rests with us all and will require unprecedented changes in how we work.

The Organisation for Economic Co-operation and Development estimates that up to one fifth of healthcare spending across member countries, which includes the UK, is wasted. Many aspects of healthcare have the potential to cause harm – e.g., exposure to radiation from imaging, risks from procedures, and side effects from medication. Furthermore, over investigation and overtreatment wastes healthcare resources, consumes natural resources and contribute to environmental degradation.

Including the measurement of environmental and social costs in the evaluation of healthcare practices and outcomes will help us become a more sustainable healthcare system, by identifying opportunities for improvement which might otherwise be missed and helping us to develop sustainable ways of working.
To become a sustainable and greener healthcare provider, we must deliver safe, effective, personalised care, and reduce harm and waste through improvement and innovation. We must also take responsibility, individually and collectively, for better management of our healthcare resources.

The Balfour was the first hospital and healthcare facility in Scotland to be built to a net-zero standard. We will build on this by using current knowledge, and new evidence as it emerges, to reduce the environmental impact of the care we deliver. We will fulfil our role as an anchor institution in our community and do this by:

- Doing what we can to practice greener and more sustainable healthcare
- Becoming more mindful of the NHS resources we use and using them more wisely
- Consider how we can empower staff, patients and communities to practice climate positive behaviours, that also have a positive impact on physical and mental health

The following will be our initial priorities:

- Focus on prevention and early intervention to reduce need for high resource interventions at later stages of disease progression
- Reducing travel through remote consultation where clinically appropriate
- Reducing travel through delivery of local care where clinically appropriate
- Adopt changes in use of anaesthetic gasses towards those with lower CO2 emissions
- Move to prescribing inhalers with a lower carbon footprint (see case study)
- Consider the 100 actions in Green Impact for Health Toolkit

Case study: Inhaler Prescribing

Inhaler devices are extensively prescribed for patients with asthma and COPD. The options are a Dry Powder Inhaler (DPI), which delivers medication in a dry powder form, or a Metered Dose Inhaler (MDI) which delivers the medication as an aerosol. The propellants used in MDIs are potent greenhouse gases and have a substantial adverse environmental impact. It is estimated that approximately 4% of the carbon footprint of the NHS results from the use of MDI inhalers. In 2017, 13% of inhalers in use in Sweden were MDIs, in comparison to 70% in the UK. Changing our prescribing practice will significantly reduce the environmental impact of inhaled medication.

Dr Iain Cromarty has calculated that the impact on greenhouse emissions from inhalers prescribed by Orcades Practice amounts to more than a quarter of a million car miles a year or approximately 70 tonnes of CO2 equivalent.

HOW WE NEED TO CHANGE

Reduce health inequalities

Prevention and early intervention

Improving care and supporting independence

Each of these approaches have been informed by Realistic Medicine which states that:

"It is more important than ever to have an honest and open dialogue with people about their needs and support them in a way that is helpful to them and their families. We want people working in health and social care and people who use services to think about the values and the behaviours that underpin good experience. Drawing on these values to have meaningful conversations with people to plan and agree care will support all staff and patients to base care around what matters most to people, with a shared understanding of what healthcare might realistically contribute to this. This is the ethos of Realistic Medicine."

REDUCING HEALTH INEQUALITIES

We will work to reduce health inequalities by:

- Tackling health inequalities in our everyday practice
- Ensuring equitable access as far as possible to the services we provide
- Supporting disadvantaged people to access to the services they need, whether delivered by NHS Orkney or by partner organisations
- Recognising and considering health inequalities at every level from interactions with front-line staff to policy approval

Inequalities in health remain widespread and prevent people from living longer, healthier lives. For example, people at the margins of our society, such as those who are, or at risk of, homelessness and those involved in the justice system, often experience greater inequalities and lower life expectancy. The wider social determinants of health, such as sustainable employment, access to education, nutritious food, and good quality housing have a large impact on these health inequalities.

The geography in Orkney presents particular challenges in enabling equal access to services. Partnership working plays a key role in efforts to overcome these challenges.

Although these inequalities cannot be resolved by providing good healthcare alone, and as health and care professionals our ability to influence these determinants can sometimes feel limited, we still have a vital role to play. As healthcare professionals we need to understand the challenges the people we care for are facing and continue to seek out new ways of delivering personalised care. We can help people to regain control by placing them at the centre of their care, through shared decision-making and adopting a rights-based approach to care. Furthermore, as advocates for those whose needs are often unrecognised and unmet, we can support and enable them to make their voices heard. We also need to consider how our workforce can be made more diverse, and how we can use our position as an anchor institution to influence and deliver change in our community, ensuring that for individuals in need of support, no door is the wrong door.

PREVENTION AND EARLY INTERVENTION

Prevention and early intervention are key principles of our Clinical Strategy. These principles already play an important part in the care we deliver. However, they will be further developed throughout our approach to care, in order to help improve the health and wellbeing of our population.

One example of how we will do this is through our approach to national screening programmes. People from disadvantaged groups often experience difficulties in accessing health screening services for specific conditions, e.g. breast cancer and bowel cancer. This unequal access to screening can result in worse health outcomes for these conditions in these disadvantaged groups. We will review our delivery of national screening programmes to ensure that all people eligible for screening have equal access to these services. This will enable prevention and early intervention for all and therefore help reduce avoidable differences in health outcomes that result from current inequalities in access to these services.

Prevention can take place at different stages of disease progression, including before a disease has developed, when it is in its early stages, or when it is more established. At every stage, prevention can improve health outcomes by slowing down or stopping further development or complications of the condition.
Primary prevention aims to prevent illness from developing before the disease process has begun. Factors such as stopping smoking, maintaining a healthy weight, maintaining good oral health, taking regular exercise, or avoiding harmful drinking are all examples of primary prevention. Immunisation is another example.

Secondary prevention does not prevent conditions from occurring but focuses instead on diagnosing conditions as soon as possible once they have developed. This early diagnosis in turn allows ‘early intervention’, which means treating conditions as soon as possible in order to prevent more serious problems later on. Screening for conditions such as breast cancer and bowel cancer are examples of secondary prevention, because this screening allows these conditions to be diagnosed early, at a point when they can be treated, and sometimes even cured, by less aggressive treatments than those required if the conditions are diagnosed at a later stage. Early diagnosis and treatment of long-term conditions such as high blood pressure and diabetes are further examples.

Tertiary prevention helps recovery and rehabilitation and reduces the impact of an established condition. Cardiac rehabilitation after a ‘heart attack’ is an example of tertiary prevention.

IMPROVING CARE AND SUPPORTING INDEPENDENCE

We will personalise our approach to care by finding out what matters to our patients, not just in terms of their medical care, but also as individuals and members of their families and communities. Shared decision-making and informed consent are fundamental to good practice. We must give people the information and support they need to make informed decisions about their care, recognising that such decisions are not always clear cut. It is important that the people we care for are equal partners in decisions about their care, and we provide them with balanced information on benefits and risks which enables them to make an informed choice. We need to be honest about the limitations of many of our treatments and the side effects that may come with them.

We must also support people to have the knowledge, confidence, and skills to cope with the complex demands of our modern health and care system. We will provide information and advice that is easily understood so that people feel empowered to manage their own care, as far as possible. We will do all that we can to make health information and services more accessible to the people we care for.

We will take time to understand what is going on in people's lives, empower them to be active partners in their care and be mindful of the impact our practice has on the people we care for. By practising this shared decision-making and delivering a more personalised approach to care, we can assist people to make informed choices about the care that is right for them. In turn, this will allow us to utilise our services more effectively and efficiently, help ensure timely treatment, and reduce harm and waste from over or under treatment. We will also continue to embrace technology and innovation to build services that meet people's needs.

In summary, we will:

- Strengthen our delivery of personalised care through shared and informed decision making
- Work more collaboratively across professional and organisational boundaries to provide better care and support independence - especially for people living with complex conditions
- Learn from patient and staff feedback, local and national data and internal learning systems to inform ongoing improvements to ensure people receive the right care at the right time
- Reduce harm and waste by considering for each individual whether an investigation or treatment is going to add value to the care we provide

Case Study: Home First

The Home First initiative was identified as part of winter bed planning in 2020 and started in February 2021. Capacity issues within health and social care services and the current in-patient assessment process led to prolonged hospital stays for those waiting for assessment and packages of care to be in place. With Home First, individuals who require a new or increased care package when they have been discharged (to the mainland) are supported by this reablement team. This pilot has reduced strain on acute and social services, and has demonstrated that patients of all abilities can progress in their own environments given the opportunity. Patient experience surveys have also been positive. You can find out more about the pilot here.

OUR MODEL OF CARE

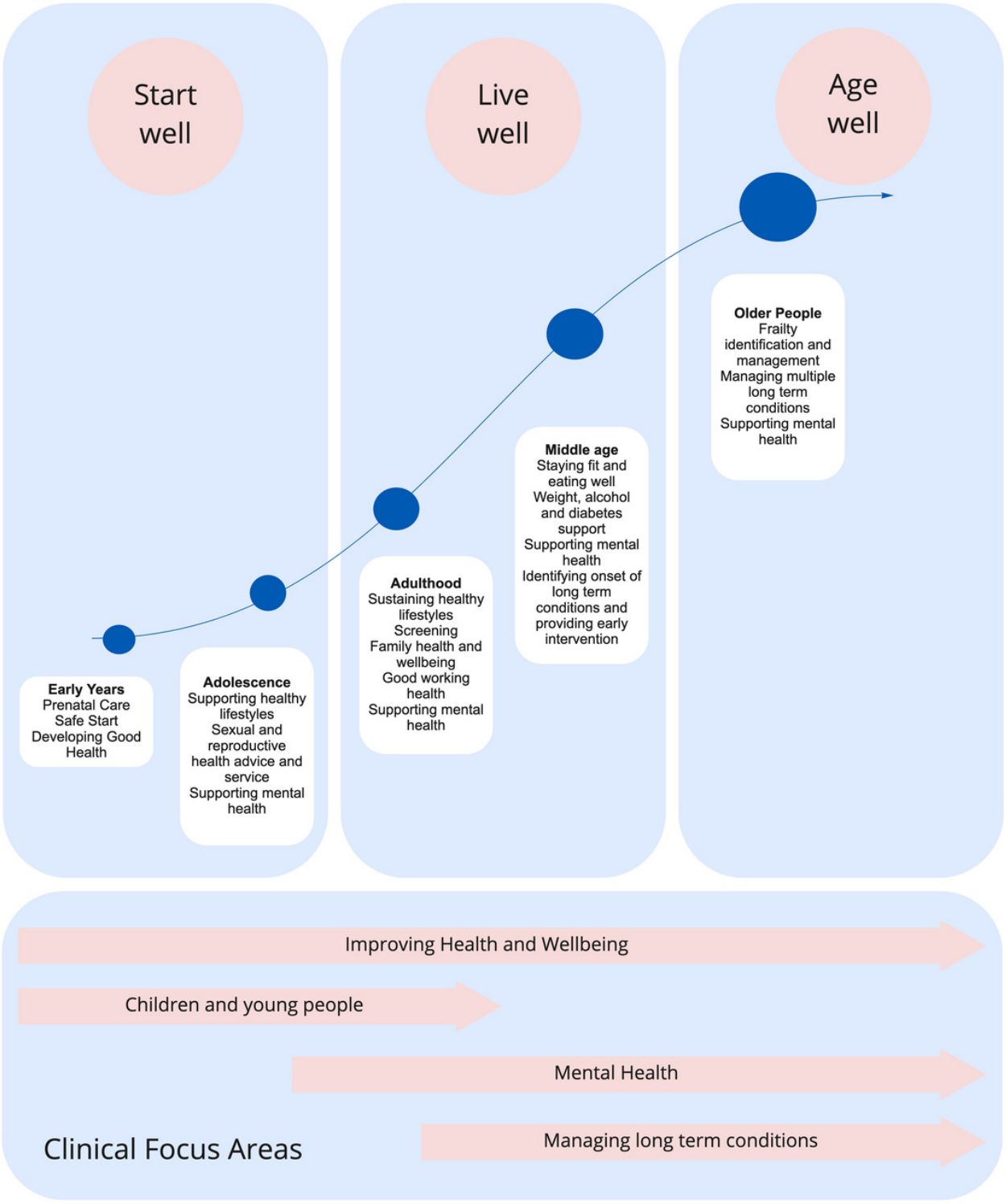
At the core of the Clinical Strategy is our model of care. This will ensure the care we provide is delivered seamlessly across hospital and community services and integrates with other services that meet the needs of our population, including, for example, those provided by Orkney Islands Council and NHS Grampian. We will provide care as close to people's homes as possible and in partnership with communities. We will focus on keeping people healthy and ensure we take every opportunity to reduce health inequalities by focusing on key improvements such as stopping smoking, reducing alcohol use and obesity.

We aim to give everyone healthy opportunities throughout life. We will support babies and children from their earliest moments to develop good health. Through adolescence and adulthood we will aim to keep people healthy and support their wellbeing. As people get older, we will focus on early identification of long-term conditions and frailty, so that support can be offered at the earliest opportunity, when conditions are easiest to manage.

Where possible we want to help everyone avoid the need for clinical services. However, when they are needed, we will make sure that diagnosis, treatment and care are safe, effective and tailored to every person's needs and circumstances. At all times we want to enable people to be independent, in good health and supported to live well with any conditions that develop. When that is not possible, we will be there for people with the full range of clinical services at the right time and in the right setting. We will also ensure that people receive the care they need at the end of their lives, and that they are treated with dignity and respect.

Traditional approaches to care have often focused on the route a patient takes through NHS services, built around rigid processes and locations. This can make it feel like healthcare is all about being at a clinic appointment or in the hospital. Our Clinical Strategy aims to turn this around and provide truly patient-centred care, built around individuals, when and where they need it. Our approach is not about summoning people to appointments or pointing them down rigid paths of care. Instead it is focused on ensuring that we offer the best care that we can to support a person's health and wellbeing, wherever they need it and at the time that it will make the most difference.

A person's good health is not just based on the response we offer at moments of crisis - although of course we will always provide that too. It also relies upon the wide range of services that contribute to keeping people healthy and reducing avoidable ill health being relevant, convenient and effective. Our overall approach is not a fixed pathway to be followed, but an adaptable system through which we will support people in a healthy partnership throughout their lives.



This approach is essential to fulfilling our vision and commitment to our communities to enable people to live well and independently, for longer. We want to keep people well and healthy, but be ready to support them when they need our care.

CLINICAL AREAS OF FOCUS

In line with our Model of Care and the feedback we received from both the community and staff surveys we have developed our Clinical Strategy to focus on four key clinical areas:

- Improving the health and wellbeing of people in Orkney
- Children and young people
- Mental health
- Supporting independence for people living with long-term conditions.

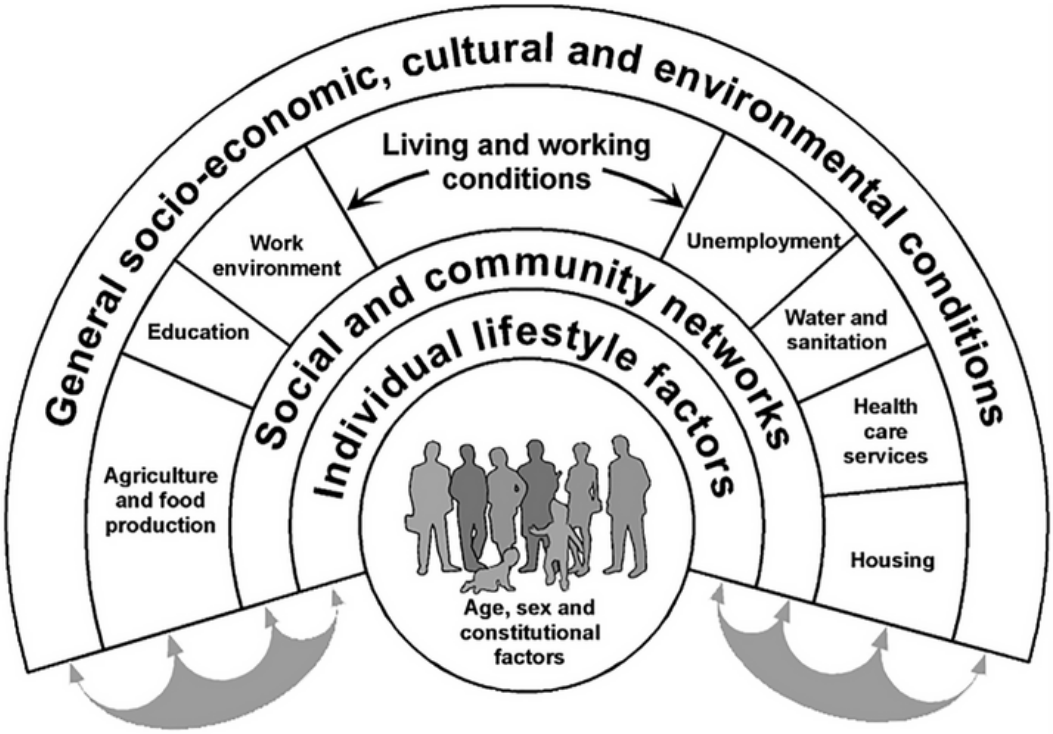
IMPROVING THE HEALTH AND WELLBEING OF THE POPULATION OF ORKNEY

The Scottish Government has identified a number of public health priorities for Scotland:

- A Scotland where we live in vibrant, healthy and safe places and communities
- A Scotland where we flourish in our early years
- A Scotland where we have good mental wellbeing
- A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
- A Scotland where we have a sustainable inclusive economy with equality of outcomes for all
- A Scotland where we eat well and have a healthy weight and are physically active

We will engage with people across Orkney to understand what these national priorities mean to local communities and collaborate with them to design and deliver services that will empower people and communities to make the changes needed to achieve them. We will work in partnership with other organisations across Orkney to reduce inequalities and ensure fairness and equity of access to services.

In particular, we will focus on prevention of illness and injury, and on early intervention to stop established conditions from further progressing. We recognise that health and wellbeing is influenced by many factors, and good healthcare plays a small but significant part as shown below in the determinants of health diagram.



Determinants of health Source: Dahlgren and Whitehead 1991

We will take a human rights based approach to health, helping create a fairer, healthier Orkney. This approach means the right of everyone to the highest possible standard of physical and mental health and for this to happen services should be accessible, available, appropriate and of high quality.

The Scottish Health Survey is carried out each year by the Scottish Government. It gives detailed information for all areas of Scotland and the results are an important way of assessing progress against the public health priorities above. The results can therefore help us to understand and monitor the health and wellbeing of the population in Orkney, both over time and in comparison to other areas in Scotland. The most recent results, as below, were published in September 2020.

General Health:
In Orkney 79% of people (77% of females and 82% of males) reported their own health as good or very good. This is significantly higher than the number of people in this group for Scotland as a whole (72%).

However, this is no cause for complacency -many people still suffer harm to their health through broader societal factors as well as individual risk factors such as smoking, inactivity, poor diet, excess weight, poor oral health or harmful drinking. These risks are more common amongst people who are experiencing deprivation and often occur together, which further increases the risks they pose to health. We will work in partnership across our communities to reduce inequalities and ensure fairness and equity, so that everyone in Orkney has a better chance of achieving their best possible level of health and wellbeing.

Support services, including online resources for mental health and domestic abuse services have been advertised through 'Caring for people'. The Grampian psychological hub has offered a telephone support service for anyone affected by Covid-19

Smoking:
In Orkney 12% of people (9% of females and 15% of males) are regular smokers. These numbers for Orkney have improved since the last published results and are now lower than the number of regular smokers for Scotland as a whole (19%). In line with the Scottish Government's tobacco free generation action plan, we will continue to work toward a smoking prevalence of 5% or lower by 2034.

There is currently an additional focus on supporting pregnant women to stop smoking.

Alcohol Consumption:
In Orkney 23% of people (14% of females and 32% of males) consume hazardous or harmful amounts of alcohol, compared to 24% for Scotland as a whole.
Orkney Alcohol and Drugs Partnership (Orkney ADP) is a multi-agency partnership established to achieve the priorities set both locally and nationally to improve the outcomes for individuals, families, and the wider community of Orkney in relation to the reduction of alcohol and drug related harm. Orkney ADP's Strategy 2021-26 sets out the vision, outcomes and approach to delivery, whilst considering the local and national priorities for Orkney ADP.

NHS Orkney's Drug and Alcohol Team are a small team integrated within the Community Mental Health Team, responsible for providing high intensity treatments for people with moderate or severe addiction difficulties, alongside mental health problems. The service provides community and in-patient alcohol detox, therapeutic treatments, substitute prescribing and Take-Home Naloxone. It also plays a critical role in implementing the Medication Assisted Treatment Standards introduced by the Scottish Government and the Scottish Drug Deaths Taskforce to ensure that this treatment is safe, effective, acceptable, accessible and person centred.

Bodyweight:
In Orkney 75% of people (72% of females and 79% of males) are overweight or obese. These numbers have worsened since the last published results and there are now significantly higher numbers of people in Orkney who are overweight compared to Scotland as a whole (65%).

Being overweight or obese is a severe risk to health. Obesity is the second-biggest preventable cause of cancer behind smoking, and is the most significant risk factor for developing type 2 diabetes. It also increases the risk of other conditions including high blood pressure, heart disease and stroke. We will work in partnership and guided by '**A healthier future: Scotland's diet and health weight plan'** to address this priority. There are child and adult healthy weight standards and a diabetes framework which are currently being implemented locally.

Physical Activity:
In Orkney 61% of people (55% of females and 67% of males) meet current physical activity guidelines, compared to 65% for Scotland as a whole.
Being physically active helps to prevent heart disease, strokes, diabetes, and several cancers; it plays an important part in helping maintain a healthy weight; and reduces the risk of developing depression. It can also help prevent isolation, strengthen communities, and help develop confidence. In line with the **'Active Scotland Delivery Plan'** we will work in partnership across Orkney to encourage and enable people who are inactive to become more active, and those who are active to stay active throughout life. A multiagency local physical activity strategy is being developed.

New approaches are being considered such as the 'Let's Prevent' app which is offered to anyone with a new diagnosis of pre-diabetes and promotes physical activity.

CHILDREN AND YOUNG PEOPLE

When considering the future needs of children and young people in Orkney we need to be open to developing a new and very different model of care to meet the needs of children and young people during this recovery phase from the pandemic. It is anticipated that there is a 'hidden' waiting list for a number of children's health services.

The Nuffield Trust report 'The future of child health services: new models of care' states:

'An ideal child health system is one: that understands children, young people and their families' specific needs (including the broader determinants of health) and is designed to address them; where there is access to high-quality paediatric and child health expertise and multidisciplinary teams in the community; that has linked-up timely information, communication, data and care (different forms of integration) to allow for continuous quality improvement; and where health literacy and education for children, young people and their families, as well as professionals, is prioritised'.

Ensuring there is a strong and resilient link maintained with partners such as NHS Grampian is essential particularly as we expect demand to increase in fields such as Children and Adolescent Mental Health (CAMHS), paediatric and neurodevelopment together with support for child protection provision.

To deliver this we intend to compare what we currently provide against options for a new model and explore what we may be able to deliver sustainably in Orkney in a way that meets the needs of children and young people. Options include further integration of services, creation of regional multi-disciplinary teams, shared information systems and the development of flexible roles underpinned by good quality data.

It is important that we consider how best to deliver change acknowledging that current capacity and capability in this area is limited.

As a principal any scoping and subsequent change in the service will be undertaken in partnership with the young people and their parents.

Therefore, we will explore:

The development of shared protocols that support patients in Orkney receiving the right care in the right place.

- How access and capacity from specialist services such as Neurodevelopmental can be maximised
- Supporting the development of specialist and advanced practitioners to widen access to pathways and treatments in support of lifelong conditions
- How expanded children and young people's services can continue to be delivered within Orkney sustainably

Additionally, targeted funding from the Scottish Government in support of Child and Adolescent Mental Health Services will enable us to address the following:

- Expanded and strengthened mental health provision for children and young people
- On-island services with an aim of expanding the specialist assessments and treatments for complex conditions
- Ensuring care experienced users of the service can continue to receive support up to their 26th birthday

MENTAL HEALTH

Mental illness is one of the major public health challenges in Scotland. Around one in three people are estimated to be affected by mental illness in any one year (source Scottish Government).

Mental health conditions include severe and enduring mental health conditions such as schizophrenia, psychosis and bi-polar disorders, as well as depression, anxiety and dementia. There were 198 people in Orkney diagnosed with severe and enduring mental health conditions in 2018/19. This number has remained broadly stable between 2008/09 and 2018/19. Depression and anxiety are by far the most common mental health conditions in Orkney, and the numbers of people with these conditions are increasing. The number of patients diagnosed with depression has doubled since 2012/13. Just over three people per 100 were diagnosed with depression in 2018/19.

The Covid-19 pandemic has had a significant impact on mental health and wellbeing of our population. The immediate impact includes the direct effects of the stress and trauma of the pandemic in causing or worsening mental health conditions, as well as indirect effects such as making it more difficult for people to access the services or support that they need to live well with mental health conditions. There is evidence of growing demand for mental health services in Orkney, with increasing numbers of people requiring support and often with more complex or urgent needs. In addition to the immediate effects, it is also likely that the Covid-19 pandemic will have longer term impact upon the mental health of our population.

People with mental health needs in Orkney access support from a wide range of sources, including informal carers, communities, voluntary sector organisations, NHS and OIC services. Health service provision ranges from general practice and other primary and community healthcare services, through local, and sometimes regional, specialist psychiatric services. Our focus is on working together to find new ways of delivering the right care in the right place and at the right time, in order to best meet both the individual and collective needs of people with mental health difficulties in Orkney.

One example of new ways of working is the successful development of new roles for mental health nurses working directly in GP practices in Orkney. This is part of a national initiative to develop multi-disciplinary teams in General Practice, with specialist nurses and allied health professionals working alongside GPs and practice nurses to enable greater prevention, early intervention and more proactive management of a range of health problems.

Orkney Health and Care have recently published the Orkney Islands Mental Health Strategy 2020 – 2025 which provides a framework for the improvement and development of mental health and wellbeing supports across all our communities. This document reflects the vision, objectives and priorities within Planning for our Future: Orkney strategic plan 2019/22. It recognises the complexities of providing a wide range of services to individuals, from birth to end of life, focusing on: enabling people to access their own strengths and supports where possible; preventing onset of ill-health and providing early intervention and support for recovery; and developing personal and community resilience.

The strategy states that by working in close partnership with individuals, carers, communities, statutory and voluntary sector providers we are seeking to build upon existing services, to improve upon these and to develop additional supports through effective use of all resources available. This will enable us to better meet the current mental health needs of people in Orkney and to be responsive and adaptable to changing needs, including those resulting from the pandemic. Over the coming five years we will:

- Improve quality of life for individuals experiencing mental health problems, through a strength based, prevention, early intervention and recovery orientated mental health service provision
- Support a professional workforce, including robust training and strong multi-disciplinary culture
- Provide a range of community-based support services, which promote prevention, self-management, self-reliance and resilience from birth to old age
- Decrease mental health inequality, stigma and discrimination through greater community awareness
- Improve access to information and communication.
- Develop opportunities for more effective use of resources accessible through all stakeholder groups and across all communities, to enhance support services to individuals and carers
- Improve access to a range of support for carers

Key steps towards achieving the ambitions set out in this Strategy will include:

1. Recruitment, training, and retention of key clinical staff
2. Review local community service provision taking account of demand
3. Review current operational constraints, including those impacting upon care delivery overnight and at weekends
4. Consideration of the balance between services that can be delivered in Orkney and those that need to be delivered elsewhere and review the management of patient transfers when required.
5. Enable third sector partners to increase ability to achieve earlier intervention and reduce the volume of patients requiring referral to the service

NHS Orkney, Orkney Health and Care and Orkney Islands Council have jointly produced an Orkney Dementia Strategy 2020-25. This Strategy highlights the importance of risk reduction, early diagnosis and access to high quality post diagnostic support which is dynamic to needs, strengths and identified personal outcomes for people with dementia. It recognises the positive contribution and need to support carers, volunteers and staff and has been developed from a grass roots perspective. It supports Community Led Support and the need for integrated systems, which promote enablement and uphold rights for people with dementia, the building of dementia friendly communities and increasing community capacity to enable people with dementia to live well, without stigma as a valued part of their community and in their own homes when possible.

There is recognition of the need to do things differently, both in relation to people's experiences and to ensure a sustainable model of support. We need to work together with all relevant people and groups to design and deliver the best care and support we can. This provides us with an opportunity to make changes which support the appropriate level of priority and investment needed for dementia in Orkney.

We must recognise that we will face challenges in a time where statutory services are being asked to make savings, these challenges are not insurmountable barriers. We must use them as a catalyst for positive change through innovative ways of working, engaging with those at the heart of services to support continued grass roots feedback, evaluation, prioritisation and consultation. This is not about trying to do more with less; it is about a collaborative response, which will involve a change in culture and thinking.

We need to consider this in context of the wider health and social care system, shifting the emphasis of investment towards proactive, person centred approaches which will not only improve outcomes for people, but will also reduce costs in other parts of the service. This preventative approach is closely aligned with national policy and drivers. It must also be acknowledged that if the status quo remains the model of delivery, significant increased statutory services funding will be required to deal with an increasing number of people reaching crisis without having had the proactive support to delay or prevent crisis.

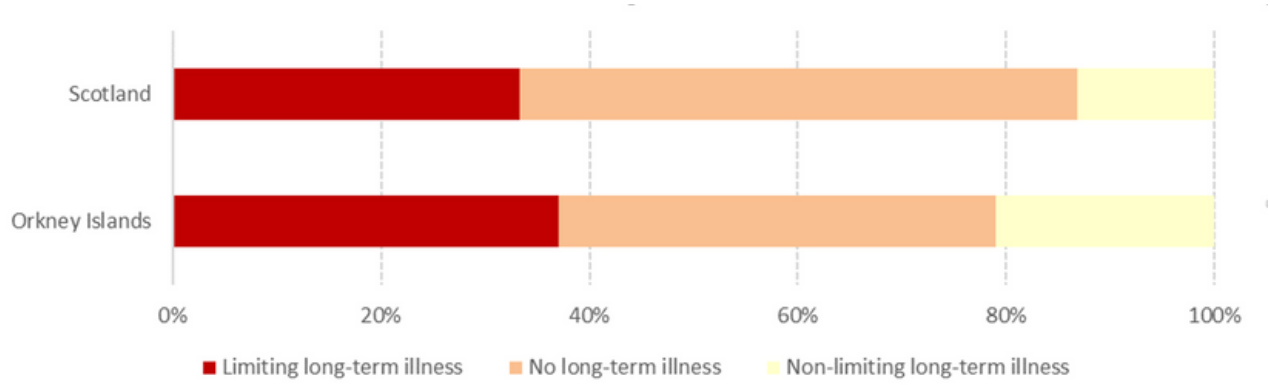
Interagency collaboration and a single point of access for support and services will be key to improvements. The Hub at Age Scotland Orkney is already reported as one of the most valuable resources with feedback stating "I'd be lost without it" and "it is the best part of our experience".

SUPPORTING INDEPENDENCE FOR PEOPLE LIVING WITH LONG-TERM CONDITIONS

Many people in our community are living with long-term physical or mental health conditions. These include depression, asthma, diabetes, heart disease, multiple sclerosis, and dementia. These long-term conditions affect people's health and the quality of their daily lives. They are more likely to experience psychological problems, to need help with day to day tasks and activities, and to be disadvantaged in areas such as employment, education and income.

People living with a long-term condition will not live as long, be more likely to attend hospital and to stay in hospital longer than people without a long-term condition. These problems usually increase with the number of long-term conditions and are greatest for people who are living with several long-term conditions. Living with long-term conditions in younger and middle age also increases the chance of a person developing frailty in older age.

The Scottish Health Survey reported that 37% of Orkney residents surveyed between 2016 and 2019 were living with a limiting long-term illness. The figures illustrated below are from 2016 to 2019.



We will work to improve the lives of individuals by supporting them in reducing their risk of developing long-term conditions, and helping those who are living with long term conditions to remain healthy and independent for as long as possible.

We will do this by:

Supporting people to live healthier lives. The risk of developing many long-term conditions can be reduced by living healthier lives. Following a good diet, taking regular exercise, keeping to a healthy bodyweight, **maintaining good oral health**, avoiding smoking, and not drinking too much alcohol can all help to prevent the development of long-term conditions. Prevention is a key focus of our Clinical Strategy, and you can find out more about this and about how we will support people to live healthier lives in the Health and Wellbeing section of this document.

Focusing on early diagnosis and intervention. We promote early diagnosis by working to encourage uptake of routine health checks and national screening programmes, particularly focusing on people who find it difficult to access these programmes. Following diagnosis, we will ensure consistent follow up and monitoring so that people living with long-term conditions can be offered the right support and treatment as soon as it is required.

Providing care that is in line with latest evidence and best practice. We will make sure that our approach to care for individual long-term conditions is driven by current evidence and in line with best practice for each clinical condition.

Helping people to understand and manage their condition. We will help people to increase their knowledge, skills, and confidence in managing their own health and care, by providing interventions such as health coaching, education on how to manage the condition, and the opportunity to gain support from other people with similar conditions.

Providing care that recognises peoples' individual needs and choices. We will take a personalised approach to care, making sure that people have choice and control over their care, and are supported to make decisions about their care.

Delivering coordinated care. Different teams and professionals in NHS Orkney will work closely with each other and with other organisations across Orkney to identify peoples' needs and to offer coordinated care and support.

Meeting the needs of people with multiple long-term conditions. We recognise that people who are living with two or more long-term conditions often need different support to those who are living with a single long-term condition, and we will tailor their care accordingly.

Meeting the needs of people living with frailty in older age. People with long-term conditions are more likely to develop frailty in older age. In turn, people with frailty often need a different approach to the management of their long-term conditions. We will improve the care provided for this group of people.

We will apply these principles to the prevention and management of all long-term conditions.

If you would like to see some examples of the work that we are doing for individual long-term conditions in Orkney, please follow the links below:

Diabetes
Cancer
Musculoskeletal disorders
Coronary Heart Disease
Neurological disorders
Respiratory conditions
Chronic Pain

Multiple long-term conditions

Supporting people with two or more (usually referred to as 'multiple') long-term conditions is more complicated: the different conditions and their treatment can interact in many different ways. Despite this, care for people with multiple long-term conditions has traditionally been focused on managing each individual condition, rather than on caring for the person as a whole. This can all too easily result in care that is disjointed and does not fully consider the overall impact of the different conditions and their various treatments on a person's wellbeing and quality of life.

As a result, people living with multiple long-term conditions often not only experience problems caused directly by the conditions themselves, but may sometimes find the treatment they receive, or the way they receive it, a burden in itself. For example, they may experience side effects from taking many different medications or find it exhausting to attend their different clinic appointments. This can worsen the physical and psychological impact of living with multiple long-term conditions.

We will address this problem by using a tailored approach to care for people with multiple long-term conditions, which is based on the principles of Realistic Medicine. This focuses on what is most important to each individual, puts people at the centre of decisions about their care and supports them to be as independent as possible in managing their care.

We will identify the people who are likely to benefit most from this tailored approach to care, focusing on those who:

- Have both long-term physical and mental health conditions
- Have multiple long-term conditions in younger or middle age, due to deprivation
- Are prescribed multiple regular medicines
- Have difficulty managing their treatments or day-to-day activities
- Are receiving care and support from multiple services
- Are living with frailty or having falls
- Have cognitive impairment
- Frequently require urgent or emergency care

Care will focus on identifying what is most important to each individual, and helping them to plan and manage their care. This may include, for example, starting, stopping, or changing medicines and treatments, or deciding whether to undergo further investigations. It will also focus on helping people to understand and anticipate how their condition might change over time and thus enable them to plan for their future care.

Informal carers, friends and family often provide considerable support to people with multiple long-term conditions. Carers who are themselves living with one or more long-term conditions, or frailty, may find it more difficult to manage their own conditions and provide the care needed. We will take an integrated approach (as advocated by the Feeley Report) and identify carers, assessing their needs and supporting their health and wellbeing.

Frailty in Older Age

As life expectancy is increasing, many more people are enjoying active and healthy lives in older age. However, some older people need greater support to do the things that are important to them. These older people may also find that the things they would have been able to cope with quite easily in the past tend now to cause bigger problems. One way of describing this experience is to say that they are 'living with frailty'.

Frailty is important because people living with frailty are less able to manage with and recover from accidents, illnesses, or other stressful events. This can result in a larger than expected deterioration in a person's health, wellbeing, and ability to live independently. People living with frailty are also likely to take longer to recover from illness or injury, and do not always get back to their previous level of independence.

Frailty becomes more common as age increases. Evidence suggests that up to 50% of the population aged over 65 years are living with some degree of frailty. 2019 population data shows around 5,300 people aged over 65 years in Orkney, giving an estimated 2,650 people living with frailty. People with long-term physical and mental health conditions are more likely to develop frailty in older age. People who experience loneliness and social isolation are also at increased risk of frailty.

Frailty usually develops slowly but there are a number of things that can help to prevent the development and progression of frailty, such as maintaining physical activity, following a healthy diet, maintaining good oral health and avoiding smoking. Supporting people to maintain social contacts and prevent loneliness can also help tackle frailty.

We will work together with our partners across the health, care, and voluntary sector to help people access activities and services that will reduce frailty. We will also work together to identify people who are living with frailty in Orkney. This will give us important opportunities to offer proactive care and support to reduce its impact. We will ensure that people living with frailty are able to access well planned and well coordinated services which are tailored to their individual needs and support their health, wellbeing, and independence at every stage of their condition.

Case Study: Frailty

In the summer of 2021 the NHS Orkney Area Clinical Forum worked with a wide range of people from health, care, community and voluntary organisations to look at how care for people living with frailty in Orkney could be improved. It was agreed that we need to improve awareness, understanding and recognition of frailty in Orkney. This will then enable us to help older people access services and support to help prevent frailty, reduce the impact of living with frailty and maintain their independence. Health Improvement Scotland have recognised the importance of the work we want to do and have awarded funding to support it over the next 2 years.

WHAT WE NEED TO HELP US CHANGE

QUALITY IMPROVEMENT

There is increasing evidence that suggests the impact of quality improvement work is most significant when it forms part of a long term, structured, organisation wide approach focusing on culture as illustrated by the quote below from the Kings Fund (2017).

> Key enablers for embedding a culture of quality improvement included: developing and maintaining a new approach to leadership; allocating adequate time and resources; ensuring there is effective patient engagement and co-production; maintaining staff engagement. Fidelity to a chosen approach is critical to sustaining and embedding quality improvement in an organisation's culture.

In light of this, our Clinical Strategy is underpinned by a commitment to a long term approach of continuous improvement which will take account of evolving national and local priorities. Through the development of a supporting Quality Framework we will focus on improving how we measure and evaluate the effectiveness of improvement interventions as well as ensuring we build organisational capacity and capability for improvement across our workforce to equip staff for fully engaging in delivering measurable improvement outcomes for patients and service users.

WORKFORCE

In line with Orkney's population, the age profile of the workforce is also changing. More than 20% of staff who currently work for NHS Orkney are aged over 56, meaning that we are likely to see many of our highly experienced staff retiring over the next few years. Many staff working in Orkney face the challenge of needing both generalist and specialist skills to deliver their roles, and maintain services within small clinical teams. This has important implications for how we recruit and train our workforce.

In addition to these underlying issues, we recognise that the demands of the pandemic have resulted in acute workforce pressures, including increased workload and staff shortages. Just as our staff have been central to supporting our communities through the pandemic, they are vital to the future of all our services, and through them to the health and wellbeing of our population. We need to increase our support for the health and wellbeing of our staff in order for them to stay well and to enable them to continue to deliver compassionate and high quality care. We will do this through:

- Increased focus on the health, safety and wellbeing of our staff
- Creating and fostering a positive and inclusive workplace culture that builds strong relationships, based on respect, kindness and trust
- Supporting training and encouraging development opportunities
- A focus on recruitment, retention and succession planning
- Ensuring that we have multidisciplinary clinical leadership
- Alignment of our planning and performance processes to understand both the skills needed for current staff and to help define the pipeline of staff we need

Three areas were identified at the Area Partnership Forum. These included staff recruitment, retention and staffing models.

Recruitment

- Improved hiring process
- The hiring manager to involve the team hiring in the content of the job specification and to keep them informed of progress
- Good engagement with applicants from the initial contact
- Drafting a clear job role including the challenge that NHS Orkney staff may have many hats
- Good onboarding, including all kit and desk ready for the first day

It was noted that progress has been made in promoting NHS Orkney to prospective applicants with the release of a video which you can access **here**.

Retention

The following factors were noted as being important:

- Ensuring flexible work life balance
- Training to be prioritised in order to develop comprehensive coverage of local skills and ensure backup for services which are provided by small teams or individuals
- The expansion of staff training and development including support to move into management and more senior roles identified within the succession planning

Staffing Models

There were a number of factors which were noted as being important in the development of new staffing models, these included:

- Planning of services and pathways to encourage better integration and backup for staff, facilitating working and support across boundaries
- Avoiding silo working and actively supporting staff to pursue options for collaboration

Innovative models were suggested allowing for swapping staff within the service and with partners, for example an Advanced Nurse Practitioner working in the Emergency Department in order to learn and maintain less commonly used skills. Scenario training could also be further developed.

It was also suggested regular collective reviews of patient and clinical pathways so that improvements can be identified, and new and temporary staff can be clear about how local services work given that interdependencies may work slightly differently.

Case Study: Adult Speech and Language Therapy Service

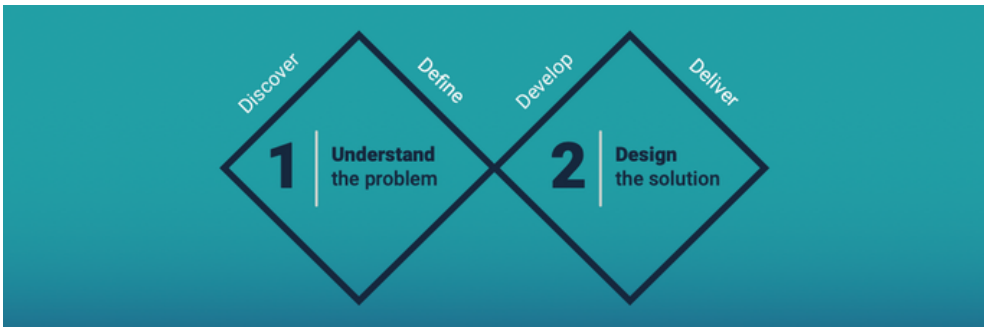
Hosted alongside the Paediatric Speech and Language Therapy Service in Children's Services, the Adult Speech and Language Therapy (SLT) Service includes 1.7 WTE therapists who provide assessment, treatment, support and care for adults who have difficulties with Speech, Language and Communication (SLC) and/or with Eating, Drinking and Swallowing (EDS). This includes adults who have developmental conditions such as learning disabilities, Autism and Down Syndrome, and adults with communication and/or swallowing difficulties as a result of medical conditions, such as stroke, head and neck cancer, Parkinson's Disease and Dementia.

Supporting individuals with SLC and/or EDS difficulties involves liaising with a wide range of people involved in their care across a number of settings, including; hospital, day centres, care homes and within people's own homes. The Adult SLT team would like to develop their service by offering more formal/robust programmes of training for staff and families who support those with SLC and/or EDS difficulties. Up-skilling and enabling others would allow for a more consistent, informed approach to be implemented across services/ settings, would enable direct SLT interventions to be more effective, and would result in better support and outcomes for those with SLC and/or EDS needs.

While the team recognise the importance of this work and the benefits it could bring, they do not currently have capacity to develop and regularly offer robust training programmes while responding to often urgent requests which require direct input. It is acknowledged that this is a challenge that is also likely to exist in other boards/departments. However, it is brought more sharply into focus in a small fragile team where changes in staff and any staff absence have a disproportionately large effect.

EMBRACING INNOVATION

New treatments, new ways of working and uses for technology can bring new opportunities for both health and care. New ways of working are supported by the Scottish Approach to Service Design which supports and empowers the people of Scotland to actively participate in the definition, design and delivery of their public services (from policy making to live service improvement).



We live in an era where the use of technology in our everyday lives is increasing and it is important that we are poised as an organisation to benefit from technological opportunities, indeed we have seen innovations which have provided support during the Covid-19 pandemic.

Embracing technology has allowed the delivery of care where patients could not be seen in person. As part of our response to the Covid-19 pandemic, Near Me, a video consultation service, has been made available in almost every hospital and GP practice in Scotland. It is transforming the way people are accessing health and care services. Prior to March 2020, there were around 300 Near Me consultations a week across Scotland. By June, it was nearly 17,000 a week, and by January 2021, over 22,000 a week were taking place. There may have been some early hesitancy to make the change to video consultations, but the pandemic has brought home its full potential.

Near Me has supported physical distancing by reducing the number of people attending services in person. It supports personalised care by enabling people to attend appointments from their own home and allows someone to join the video call with them, even from abroad. Moreover, Near Me reduces the need for time off work or study, and contributes to a significant reduction in miles travelled, delivering greener healthcare.

The range of services now provided by Near Me is extensive. The continuous improvement of the service is underpinned by comprehensive national public engagement. When the community in Orkney were asked how willing they were to use a phone call or video call (if they or their health care professional felt it was appropriate) they said:

On a scale of 1 (No) and 10 (Yes) an average response of 6.71 showed that the majority of people were willing. The most common reasons for supporting a phone call or video call were:

- Reduction in travel
- Savings in time
- Easier and more convenient

The top reasons which were given for preferring face-to-face appointments included:

- Difficulty in diagnosing
- Rapport and picking up on body language
- Hearing difficulties
- Technology barrier

Although virtual consultations do not suit everyone, there will be a greater use of Near Me for supported self-management; to involve the wider healthcare team in multidisciplinary discussions about patient care; to facilitate patient support groups; and for continued professional development of health and care professionals.

Together with partners, further consideration will be given to expanded use of technologies to bring care closer to home, such as devices for remote monitoring. This could also include increased use of systems to support staff. This would present an opportunity for a reduction in duplication, the use of paper and data collection as well as supporting improved data sharing and communication. It is noted that new systems will require the provision of training for those using them.

WORKING TOGETHER AND NEXT STEPS

Our aim is that people in Orkney will have the chance to live longer and healthier lives. In order to support this aim we will:

- Prioritise keeping people healthy
- Ensure that we make the most of every opportunity to reduce health inequalities
- Provide people with the information and support they need to make informed decisions and to be empowered to manage their own care
- Work closely with patients and carers to design our services to best meet their needs
- Develop systems which deliver care seamlessly across hospital and community services

In order to improve the health and wellbeing of people in Orkney we will:

- Focus on improving health through concerted action in the key areas of stopping smoking, reducing alcohol use, managing bodyweight and improving physical activity

To improve the health of children and young people we will:

- Build on the Children's Services Inspection improvement work
- Further integrate services and continue to develop effective multi-disciplinary teams
- Redesign services. involving young people and their parents in this process
- Consider Royal College of Paediatrics and Child Health guidance, as well as best practice models from elsewhere

We will improve mental health for the population of Orkney by focusing on:

- Implementation of the Orkney Health and Care Mental Health and Dementia Strategies
- Enabling people to access their own strengths and supports where possible
- Working to prevent the onset of mental health conditions and providing early intervention and support for recovery
- Working in close partnership with individuals, carers, communities, statutory and voluntary sector providers to build upon existing services and make most effective use of all resources available
- Being responsive and adaptable to changing mental health needs of our population, including those resulting from the pandemic

In addressing the increasing number of people living with long-term conditions, we will:

- Reduce the risk of developing long-term conditions by supporting people to live healthier lives
- Support people who develop long-term conditions to remain healthy and independent for as long as possible
- Focus on early diagnosis and management of long-term conditions
- Help people to understand and manage their conditions
- Provide coordinated care that is in line with latest evidence and best practice
- Recognise peoples' individual needs and choices
- Recognise that people with multiple long-term conditions are more likely to develop frailty in older age
- Provide support for people with multiple long-term conditions and frailty through a multidisciplinary team approach
- Ensure people have the support that they need to make decisions about their care and are able to retain control of their care

NHS Orkney's Clinical Strategy has not been developed in isolation. Achieving the aims set out throughout this document will only be achieved through support and linkages with other strategies, plans and processes. These include:

The NHS Orkney Healthcare Governance and Assurance Quality Improvement Framework. This is currently being developed with the aim that it is published in early 2023.

The NHS Orkney Workforce Plan. Underpinning the delivery of any clinical strategy is our health and care workforce. They are employed in many different roles and in different settings with a diversity of skills and experiences that will deliver our patient centred care. Our Workforce Plan will describe the composition of our staff not only for the present but for the short and medium term future.

The Clinical Strategy, in combination with the Financial Recovery Plan, will also help achieve our commitment to delivering greener healthcare, including reducing waste, which will enable us to make our services more environmentally and financially sustainable.