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| **INTERNAL USE ONLY** (Initial once complete) | | |
| Logged on database | Saved onto eRDM | Confirmation email sent |
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**Value Improvement Fund - Project Proposal**

**Application Form**

*Note: guidance notes to help you complete this form are included below.*

|  |  |
| --- | --- |
| **1. Project title:** |  |

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| --- | --- |
| **2. Project Lead** | [*Also add details of contact person if relevant*] |
| Title and Full Name |  |
| NHS Board/HSCP |  |
| Address  (including post code) |  |
| Telephone Number |  |
| E-mail |  |

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| **3. Funding Required** | |
| **Year 1 (2022/23)** | **Year 2 (2023/24)** |
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| **4. Project Description** |
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| **5. Value Based Healthcare** |
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| **6. Measuring success** |
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| **7. Sustainability and Spread** |
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| **8. Evaluation** |
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| **9. Date submitted** |  |

**Applying for Value Improvement Fund 2022/23 & 2023/24**

**Guidance on completing the Form**

The application should be on no more than two sides of A4. Include supporting papers where necessary.

**1. Project title**

Please use a short, descriptive title.

**2. Project Lead**

The lead for the project and the person able to provide additional information if required during the assessment process. Also include details of contact person for additional information if this is someone other than the Project Lead.

**3. Funding Required**

A detailed breakdown of the costs must be submitted with the application – how much are you spending and how will it be spent? See also ‘Financial Monitoring’ below.

The maximum award per year is £40,000, and £80,000 in total over two years.

**4. Project Description**

Describe the rationale, aims, objectives, milestones/deliverables and timetable. i.e. What are you trying to do and by when. The project should:

* contribute towards achieving our shared vision, that ‘by 2025 every health and social care professional in Scotland will be practising Realistic Medicine’
* have the potential to improve patient care/outcomes in Scotland
* demonstrate value for money
* be feasible
* demonstrate evidence of innovation
* have an agreed host
* be underpinned by quality improvement methodology

**5. Value Based Healthcare**

What is the anticipated benefit of your project? How will your project provide value based healthcare? How will it add value (Personal, Technical, and Population)?

* **Population value:** allocate resources to different groups equitably and in a way that maximises benefit, defined as improved health outcomes, for the whole population.
* **Technical value:** improve the quality and safety in the delivery of healthcare to increase the benefit derived from resources allocated to particular services.
* **Personal value:** base decisions on the relevant scientific evidence, careful assessment and judgement of an individual's clinical condition and an individual's values and preferences.

Examples of ways in which teams are delivering Population, Technical and Personal value are provided in Annex C.

Examples of projects that have been successful in securing an award from the Value Improvement Fund are included in Annex B.

**Quality improvement by itself although important is not sufficient justification for bidding for this fund.**

The following aspects should be taken into account when demonstrating the project value:

Costs

What are the current costs of care in this area, and are there better ways resources could be deployed? Consider costs to the service, social care and the patient.

* % of health and/or social care budget spent on procedure
* High cost/ low volume
* High volume/ low cost

Population benefits

* Number of people who would potentially benefit
* Size of the benefit to individuals/ service
* Potential of harm avoidance
* Uncertainty of outcome from interventions
* Choice of interventions

Health Inequality

* Interventions which will reduce health inequalities

Greener Healthcare

* How your project may deliver [greener or more sustainable care](https://cmoannualreport.theapsgroup.scot/52/).
* How your project may influence and empower people to practice climate positive behaviours.

Feasibility

* High probability of positive benefits being realised
* Evidence of previous work with proven value.
* Topics/ areas which already have work programs in place
* Available workforce/ acceptability/ process complexity
* Operational feasibility (including consideration of high priority areas)
* Potential to shift resource i.e., dis-invest and re- invest to add value.

**7. Measuring Success**

What is the baseline position/data? What measures will be used to gauge improvement? What data are available and/or needed to be captured in order to assess progress? What will be the impact of this project? What outcomes / benefits will be measured and reported?

**9. Sustainability and Spread**

Describe the ‘must haves’ for successful implementation, whether these are resource dependent and if so, how the resources will be secured once Value Improvement funding has come to an end? How will the activity outlined in the proposal be sustained once the funding has ended? What is the exit strategy?

How will the outcomes/deliverables from the project be spread?

**Please note,** funding will be contingent on confirmation from your Health Board’s Medical Director, that there will be local support and funding made available for projects which evaluate well once they have been completed.

**10. Evaluation**

How will the project be evaluated? Please confirm that you will complete and return the evaluation form once the project ends. Please also provide any other evidence of similar projects within your board which have evaluated positively.

Please also confirm that you will complete and return Scottish Government project progress reports on a six monthly basis – these will be sent to you for completion at 6 monthly intervals.

**11. Date submitted**

Application forms for NHS Board projects MUST be returned to your NHS Board’s Realistic Medicine Clinical Lead ([alastair.ireland@ggc.scot.nhs.uk](mailto:alastair.ireland@ggc.scot.nhs.uk)) and your Deputy Medical Director (Corporate) ([chris.deighan@ggc.scot.nhs.uk](mailto:chris.deighan@ggc.scot.nhs.uk)) by **17 January 2022.**

Application forms for social care projects, should be submitted to [RealisticMedicine@gov.scot](mailto:RealisticMedicine@gov.scot) by **17 January 2022.**

Late applications will not be considered.

**12. What happens next?**

Your Realistic Medicine Clinical Lead will assess all of the applications they receive against our agreed national scoring criteria and will then submit the top 3 scoring applications from your NHS Board area to Scottish Government for consideration. Medical Directors will submit all applications directly to Scottish Government, as will social care applicants.

Scottish Government will then score all of the bids submitted. Those bids which best meet the agreed Value Improvement Fund assessment criteria will then be awarded up to 2 years of funding. The assessment criteria are set out in Annex A.

Once you have received notice that your application for funding has been successful, you will then be required to complete and sign a project charter. The project charter will set out your project’s key objectives, against which your project will be evaluated. This document is your contract with us, to be completed and returned before funding is issued.

**13. Realistic Medicine Leads**

You should submit your top 3 bids to RealisticMedicine@gov.scot by **31 January 2022**. Late applications will not be considered.

You should also provide feedback to successful and unsuccessful applicants. As a minimum you should share your assessment of their bid using the agreed scoring criteria.

**Notes:**

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| **Financial Monitoring** | If successful in securing Value Improvement Fund support, the funding must be used for the project for which it was intended. The grant must be used for revenue funding, and not for capital funding.  The financial information provided will be subject to scrutiny to ensure value for money, so all costs must be clearly explained. The absence of detailed breakdown of costs, may result in the application being rejected.  Recipients of funds should be able to demonstrate sound arrangements for financial management and have a good track record in compliance with audit requirements. They will be expected to provide financial monitoring information to the Scottish Government on request.  Failure to submit these reports:   * may render the grant recipient ineligible for future grant awards, and * represents a violation of the terms of agreement, which could result in withholding of grant funds or require that grant funds to be returned to the Scottish Government. |
| **Other conditions attached to the award of funds** | The Scottish Government reserves the right to demand the return of unused grant money if:   * it becomes clear that any information provided in the application form is inaccurate or untrue. * the project is not completed by the agreed deadline.   The Scottish Government may request references or proof to support statements in the application form at any time during the period of the grant. Failure to comply with requests will result in withdrawal of the grant. |
| **Rights & acknowledgement of support** | The Scottish Government attaches great importance to the publication and dissemination of any projects undertaken with its grant support. Recipients of funds must acknowledge ‘Realistic Medicine’ support in all material originating from the project even when the contribution to individual projects may be small. |

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| **Key Documents**  Realistic Medicine:  <https://www.gov.scot/Resource/0049/00492520.pdf>  Realising Realistic Medicine:  <https://www.gov.scot/Resource/0051/00514513.pdf>  Practising Realistic Medicine:  <https://www.gov.scot/Publications/2018/04/6385/downloads>  Personalising Realistic Medicine:  <https://www.gov.scot/publications/personalising-realistic-medicine-chief-medical-officer-scotland-annual-report-2017-2018/>  Recover, Restore, Renew:  [Chief Medical Officer - annual report: 2020 to 2021 - gov.scot (www.gov.scot)](https://www.gov.scot/publications/cmo-annual-report-2020-21/) |

**Annex A - Value Improvement Fund Assessment Criteria**

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| **Quality Assessment** | **Weighting (%)** | **Marking**  **(0-4)** |
| Project description:   * There is a clear rationale, aims, objectives, milestones/deliverables and timetable. * The proposal is feasible and underpinned by a quality improvement methodology. * The project demonstrates a clear link to the RM drivers * There is a clear indication that local support is in place to help the project achieve its objectives. | 20 |  |
| Value based healthcare:   * The proposal sets out how it will provide value based health care and add value (personal, technical and allocative). * Consideration is given to the costs and benefits to the service, social care and the patient. | 30 |  |
| Measuring success:   * There is a clear indication of how success will be measured including the data requirements and intended outcomes and benefits. | 20 |  |
| Sustainability and spread:   * There is an exit strategy covering implementation and resourcing plans following the conclusion of Value Improvement funding. | 15 |  |
| Project costs:   * The proposal demonstrates the ability to deliver the proposal to a high standard based on the requested funding * The proposal provides a clear breakdown of costs against activities which on balance appears proportionate and good value * The proposal states the quality assurance standards * **Please ensure that your bids do not exceed £40,000 per year.** Bids over this value will not be able to be supported through this fund. | 15 |  |

Discretionary bonus points may be awarded to projects that meet the criteria below, in the event of equal quality assessment scores being achieved across the applications we receive:

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| **Added value and innovation** | **Weighting (%)** | **Marking**  **(0-4)** |
| * There is evidence of an innovative approach to person centered care and/or tackling unwarranted variation | N/A |  |
| * The proposal makes clear how the project will encourage healthcare to be greener and more sustainable | N/A |  |

Please see marking scale and additional considerations on page 2

**Marking scale**

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| 0  unacceptable | Nil or inadequate response. Fails to demonstrate an ability to meet the requirement. |
| 1  Poor | Response is partially relevant but generally poor. The response addresses some elements of the requirement but contains insufficient/limited detail or explanation to demonstrate how the requirement will be fulfilled. |
| 2  Acceptable | Response is relevant and acceptable. The response addresses a broad understanding of the requirement but may lack details on how the requirement will be fulfilled in certain areas. |
| 3  Good | Response is relevant and good. The response is sufficiently detailed to demonstrate a good understanding and provides details on how the requirements will be fulfilled. |
| 4  Excellent | Response is completely relevant and excellent overall. The response is comprehensive, unambiguous and demonstrates a thorough understanding of the requirement and provides details of how the requirement will be met in full. |

**Additional considerations**

Prior to award of any funding the strategic alignment of shortlisted bids will confirmed with Scottish Government policy leads.

Funding will also be contingent on confirmation from Medical Directors that there will be support to embed projects which evaluate well on the basis of the VIF project funding.

**Annex B**

**Examples of Successful Bids**

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| **Project title:** | **PAVES – Psychology Adding Value: Epilepsy Screening** |

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| **Project Description** |
| **Rationale**:  Children and young people with epilepsy (CYPwE) have an increased risk of developing social, emotional, behavioural and learning difficulties. These difficulties are often not identified and addressed in a timely manner, leading to increased moribidity and impacting adversely on quality of life, treatment outcomes and educational attainment. With earlier identification of difficulties and a stepped care approach to prevention and early intervention, impact on services may be reduced over time and long term outcomes improved for these patients.  **Aims / Objectives**:  On behalf of the Scottish Paediatric Epilepsy Network (SPEN), the PAVES (Psychology Adding Value: Epilepsy Screening) pilot at the Royal Hospital for Sick Children (RHSC) in Edinburgh developed an innovative mental health screening methodology and early intervention pathway for CYPwE within routine neurology appointments. Based on the validated Strengths and Difficulties Questionnaire (SDQ), the traffic light system developed in the pilot is used to indicate level of need and signpost to appropriate stepped care interventions. (Please see attached sheet for more detailed information.) The **aim of this project** is to **further develop the PAVES** approach to:   * allow mental health screening to be carried out electronically in routine epilepsy clinics, without a requirement for psychology staff input; and * develop capacity in Scotland to identify ‘at risk’ CYPwE, develop and deliver effective and locally sustainable intervention pathways and support materials to meet their needs. Providing a similar stepped care approach across the country would improve equity of care, reduce waste, and provide an efficient way to identify and manage risk, in line with the aims of ‘Realistic Medicine’.   **Deliverables**:   * An electronic tool (based on the SDQ and the PAVES traffic light system) to provide an automated and easy to deliver mechanism for mental health screening * A manual that describes the sceening method and early intervention pathways to facilitate the development of local capacity for appropriately tiered interventions to meet the mental health support needs of CYPwE. * Specialist psychology advice to develop local pathways and support infrastructure as a first step towards national roll out (further funding likely to be required to complete roll out beyond year 2)   **Duration**:  2 years, November 2018 – October 2020. |

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| **How will your project add value?** |
| The project will add value by:  **Allocative**   * Maximising use of existing resources in each locality (e.g. specialist epilepsy nursing, third sector services) by targeting them efficiently (see attachment for evidence from NHS Lothian pilot). * Allowing mental health issues to be identified and addressed earlier, minimising the future impact on Child and Adolescent Mental Health Services (CAMHS), which are already very stretched.   **Personal**   * Providing access to appropriate early interventions for CYPwE with previously unknown/unmet need. * Improving long term outcomes for CYPwE by reducing social, emotional, behavioural and learning difficulties due to earlier identification of difficulties and early intervention and prevention.   **Technical**   * Providing a novel mechanism for risk assessing and stratifying the currently unmet mental health needs of an estimated 3,500 CYPwE in Scotland. * Enabling paediatric epilepsy services to routinely screen for mental health needs in their clinic population without costly investment in the psychology workforce. This approach also offers better accessibility and reduced need for patient travel / additional clinic appointments. |

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| **How will you measure success?** |
| **Year 1**:  **Allocative:** Increase in numbers of CYPwE accessing ratified 3rd sector resources (reflecting increase in local capacity); Reduction in numbers of CAMHS referrals for CYPwE (relative to historic rates obtained retrospectively)  **Personal**: Qualitative measures of patient experience (of screening and intervention) e.g. increase in self esteem; coping; self-management; learning; engagement in social/leisure activities  **Technical:** Increase in percentage of eligible CYPwE screened and accessing pathway; clinician experience measures – e.g. increased confidence in recognising psychosocial difficulties and knowledge of appropriate intervention/referral pathways  **Year 2**: Similar measures to year 1 to be used in first phase of a national roll out.  Longer term, we would hope to measure a reduction in demand on epilepsy nursing and CAMHS. Qualtitative measures and direct measures of individual functioning e.g. engagement in social activities, increased independence, are likely to be most effective in evaluating personal value. Quantitative measures are less likely to capture change over a two year period and across such a diverse range of difficulties. Longer term, it may be possible to measure improvement in schools’ understanding of difficulties associated with epilepsy. |

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| **National Applicability** |
| Through the coordination provided by SPEN, paediatric epilepsy services in Scotland deliver highly standardised care across the country. The PAVES approach could thus be rolled out nation-wide with minimal local adjustments being required, mainly in relation to local pathways for providing stepped care support to CYPwE. Moreover, the PAVES approach is built on the SDQ, which is a widely used non epilepsy specific validated questionnaire. Although some interventions used in PAVES are epilepsy specific, the approach as a whole is transferrable to other populations. |

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| **Sustainability and Spread** |
| At the end of the funded project, PAVES will have developed an electronic mechanism for screening CYPwE in routine epilepsy clinics without additional psychology staff time being required. It will also have created a manual for developing local interventions, with an expectation of sharing resources and learning across different health board areas. Specialist psychologist advice to support the development of local capacity in areas not covered during the project would need to be funded from other sources to complete a full national roll out beyond year 2. Longer term, this small upfront investment would be offset by better use being made of epilepsy nursing and CAMHS if CYPwE have better support at an early stage. As mentioned above the PAVES approach also has applicability in other clinical areas. It is anticipated that any potential for crossover into such areas would be explored during the 2 year project. |

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| **Evaluation** |
| We will complete and return the project evaluation form. The project will be evaluated to assess its cost and benefit for both services and CYPwE in terms of population impact (size of population that benefitted and improvements in patient measures), efficiency gains through better use of paediatric epilepsy and mental health services, as well as the cost of the screening and interventions. This will look at the percentage of eligible CYPwE/their families reached by the screening, numbers of CAMHS referrals for CYPwE, and qualitative data from patients and professionals e.g. outcomes from specific interventions, experience of the process, feasibility and usefulness of the project for clinicians but also costs associated with the PAVES approach.  We plan to disseminate results via presentations to relevant groups, reports to SPEN and peer reviewed journal articles. |

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| **Project title:** | **Improving patient engagement and activation** |

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| **Project Description** |
| **Project Aim** – **to improve the percentage of patients in the practice who attend for an annual chronic disease review from 45% to 65% by October 2019 and to improve measured levels of patient activation.**  Tranent Medical Practice has a population of 14,300. Tranent sits within the 15% most deprived areas in East Lothian. In 2012, 9.6% of the population sat within the most deprived quintile, compared to East Lothian’s overall average of 5.1%. (SIMD)  We are aware that the “did not attend” rate for booked practice nurse appointments in our practice is currently 10%. We have calculated that in the last calendar year 55% of our patients with long term conditions such as diabetes, COPD, asthma and coronary heart disease did not attend for annual review appointments of their condition.  We would like to understand reasons for patient non-attendance, to improve attendance, improve levels of patient activation and ability of patients to self-manage.  In Tranent we have developed the use of the House of Care model for our patients with Type 2 diabetes. We are now moving to multi-morbidity annual reviews. We have a Community Links Worker attached to the practice.  A number of us in the practice have received Quality Improvement training and we are well supported by the NHS Lothian Primary Care Quality Improvement team and the Local Intelligence Support Team.  Lothian’s House of Care Collaboration has acquired 1000 licenses for use of the Patient Activation Measure through Insignia Health with the option to buy more licenses. This is a validated tool which assesses a patient’s confidence, skills and knowledge in managing their own health. We will measure Patient Activation Measures at baseline and following intervention and tailor interventions to patients based on patient levels of activation.  Interventions we would like to test are further roll out of the House of Care model, development of the Links Worker role, introduction of health coaching, development of a personal care navigator or coordinator role within the practice, development of local patient support groups or use of group consultations. We will collect information from patients to try to understand reasons for non attendance and involve patients via our Patient Participation Group in co-producing a service which works for them. We will work with STRiVE, the third sector interface for East Lothian, to develop innovative ways of working.  Relevant references are listed on the attached sheet and Lothian’s House of Care Collaboration report (March 2018) is attached. |

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| **How will your project add value?** |
| Allocative value – The project will improve balance of resources to patients with a known need who are not currently accessing care.  Techinical value – Reduction in inequity. Reduction in wasted clinician time. Planned regular contact according to personal need will lead to improved patient safety, better coordinated care.  Personal Value – Through use of a House of Care model we aim to provide a framework which puts the patient at the centre, asks the patient “what matters to you?” and fosters good conversations between a prepared patient and professional. |

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| **How will you measure success?** |
| Data will be collected at baseline and following intervention.  Quantitative data – measurement of biomedical markers such as HbA1c, blood pressure, spirometry data. Percentage of patients who attend for a chronic disease review in the practice. Number of secondary care and out of hours contacts per patient. Use of the Patient Activation Measure as a patient reported process and outcome measure and WEMWBS as a patient reported outcome measure.  Qualitative data –patient interviews, staff interviews.  We will use the Life QI website to record our project. We will use an outcome chains approach as developed for use in the Lothian House of Care evaluation. |

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| **National Applicability** |
| Patients living with a long term condition are in our “rising risk” or “at risk” population for future use of health care. Around 40% of the Scottish population have at least one long term condition. People living with long term conditions are twice as likely to be admitted to hospital and account for over 60% of hospital bed days used. There is evidence showing an association between increased patient activation levels and reduced use of unscheduled care in primary and secondary care settings. If patient activation levels are increased by this project, we might expect there to be a reduction in use of unplanned primary and secondary care. |

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| **Sustainability and Spread** |
| Sustainability – This work will lead to development of skills and roles in the practice. Ongoing funding for Links Workers is available via the Primary Care Improvement Fund.  Spread – This will be through the Primary Care Cluster Quality network in Lothian, Diabetes and Respiratory Managed Clinical Networks, third sector organisations, Lothian House of Care Collaboration.  Exit Strategy – Once systems are established there will be no ongoing upfront costs. Costs will be paid through existing primary care funding streams. |

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| **Evaluation** |
| We will complete the accompanying evaluation form.  The Lothian House of Care Collaboration work to date has evaluated positively. |

**Annex C**

**Examples of Triple Value**

Example of Population Value

1. Population value is determined by how well the assets are distributed across a programme of healthcare, or to different groups in the population. A good example of seeking to deliver allocative value is work on reducing exacerbations of Chronic Obstructive Pulmonary Disease (COPD), Pulmonary rehabilitation (PR) has been shown to be highly effective in reducing exacerbations of COPD, as well as occupied bed days attributable to the condition.
2. However access to PR is dependent on local provision of the service and varies considerably across NHS Boards. Over many years, there have been high levels of prescribing of high dose inhaled corticosteroids (ICS) across Scotland, with variation between NHS Boards, despite the poor evidence of long term benefit to patients. Work has been carried out to look at prescribing rates for these drugs to assess whether lack of PR availability correlates with an increase in drug usage. The aim is where provision of PR is low and prescribing of high-dose ICS is high, we can demonstrate the case for further investment in PR, re-allocating the spend to areas of programme that are known to have greater benefit. This will provide better value care - the optimal intervention for COPD patients, a reduction in prescribing costs for the service and fewer emergency bed days.

Example of Technical Value

1. Healthcare professionals must continue to pursue technical value by improving the quality, safety and efficiency of their services. A good example of delivering technical value is the approach taken with work on orthopaedics which focuses on delivering:

* **Cost Avoidance** – for example, a reduction in hip/knee infection rate by 1% point. Evidence shows how much infection costs (up to £50,000 to £100,000 per case). You can then calculate the cost avoided by delivering a 1% reduction in hip/knee infection rates by multiplying the cost of infection by the reduced number of cases.
* **Cost Efficiency** – for example, reduced bed nights per patient (shorter length of stay), reduced need for appointments per patient (redesigned pathway with straight to test or virtual options or less steps), fewer operations (reduced rate per head of population) etc.  The ‘saved’ beds/appointments/theatre capacity is used for other, more appropriate care.
* **Cost Saving** – Actual cost taken out of system, for example hip and knee implants are cheaper as better deals have been driven with the suppliers through improved procurement. This demonstrates “value” is not solely a consideration for clinical staff, but everyone working within health and social care.

1. Improving services while delivering cost avoidance, cost efficiency and/ or cost savings is very much about delivering technical value. An example of how the Atlas of Healthcare Variation might help deliver technical value comes from the tonsillectomy maps:

An early example of how the Atlas could reduce waste...
Atlas maps on elective tonsillectomies released in February 2019 highlight that some areas have very low rates of same day surgery for this procedure. This is despite clinical guidelines recommending that most tonsillectomy patients (~90%) should be discharged on the same day as their surgery. 
At Scotland level, of the 1,823 patients having tonsillectomies in 2017/18 only 800 (44%) were same day procedures.  If the aspirational goal of 90% same day procedures had been met, this could have potentially saved approximately £1m in that year alone. 
Source: Scottish Health Service Costs 2017/18 https://www.isdscotland.org/Health-Topics/Finance/Costs/
Average cost per ENT day case: £1,496
Average cost per ENT inpatient: £2,764
Difference in cost per case: £1,268


Example of Personal Value

1. A multidisciplinary approach to delivering personalised care (personal value) can be very effective. The Silver City project in Aberdeen City Health and Social Care Partnership uses a community multidisciplinary team (MDT) model to build resilience for people living with frailty and who experienced frequent admisions to hospital. The MDT includes a GP, Community Geriatrician, Care Manager, Allied Health Professionals, District Nurses, and a Community Geriatric Nurse, Practice Pharmacist, Community Link Practitioner and third sector representatives. They meet regularly in participating GP surgeries. For each patient, the team tries to establish the person’s life goals through deep interviewing and tailor their interventions to achieve them. The collaboration across the multi-disciplinary team enables expertise to be shared on the patient’s illness and their life situation and priorities.
2. The MDT also identifies opportunities to improve wellbeing (including polypharmacy reviews and signposting to activities) and shares their suggestions with the patient. Although every meeting has these features in common, the MDT approach at each GP surgery is different, drawing on local assets and reflecting community and individual need. Qualitative feedback from staff and patients has been overwhelmingly positive. For many people, their pattern of interaction with both hospital and community services has been converted from reactive and disordered to planned and proactive with a reduction in the volume of admissions to hospital. Crucially, the focus of their care is now on achieving what matters most to them.

Conclusion

1. In order to achieve our goal of sustainable universal provision within a high quality, high value, health and social care system, we must enable a better understanding of Value Based Healthcare and support professionals to practise it. We must also support more effective multi-disciplinary working using all the skills across the teams to contribute to improved outcomes, patient satisfaction and reductions in harm or unwarranted variation. This shared commitment, properly understood, across Scotland’s health and care professions will provide better value care and foster the culture of stewardship that will deliver a sustainable NHSScotland.