NHS Forth Valley

SHAPING THE FUTURE

NHS Forth Valley Healthcare Strategy 2016-2021

SUMMARY

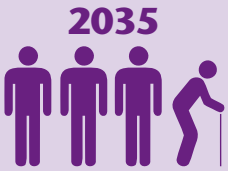
Introduction

Major changes have been made to health services across Forth Valley over the last few years. However, services need to continue to develop to ensure we keep pace with rising demand and meet the future needs of local patients and their families.

This summary explains the need for change, describes how the new Healthcare Strategy was developed and outlines the ten key priorities which will shape the way local health services are designed and delivered over the next five years.

The need for change

The population served by NHS Forth Valley is growing and more people are living longer. Whilst this is good news, it means healthcare needs are becoming more complex as many people are now living for long periods of time with several different illnesses.



The proportion of Forth Valley residents **aged 65 and over** is expected to grow from 1 in 6 of the population in 2010 to **one in four** of the population by 2035.

As a result, demand for health services is increasing year-on-year with more people attending hospital for treatment, often as emergency admissions. Many people are making multiple trips to hospital to see different specialists and some frail, older people are re-admitted to hospital on a regular basis. Once admitted, older people tend to stay in hospital for longer and are less likely to return to living independently in their own home.

Healthcare advances have reduced deaths from many of the traditional life–threatening illnesses such as heart attacks, cancer and stroke. While these are still major health issues, the focus of healthcare is shifting towards delivering care to people with long term conditions like dementia, arthritis and diabetes which require ongoing support.

Despite many improvements, there are still major health inequalities across our local communities which need to be addressed. Growing numbers of people are also developing preventable health conditions linked to alcohol, smoking and being overweight. All of this presents a huge challenge to the NHS and our healthcare services need to adapt to meet these challenges.

We therefore need to find ways to help people stay healthy and provide support at an early stage before problems become more serious. We also need to work with partners, community organisations and the voluntary sector to deliver more care and support in people's homes, GP practices and health centres to help reduce emergency hospital admissions. We know that funding will continue to be tight so we must also identify ways of working which make the best use of our existing staff, facilities and resources. This includes supporting our workforce to take on extended roles, develop new skills and work in a more integrated way across hospital and community based services.

Rising demand for long term care

Long term conditions are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support. Around two million people (40% of the Scottish population) have at least one long term condition and one in four adults report some form of long term illness, health problem or disability.

By the age of 65, nearly two-thirds of people will have developed a long term condition and, as people age, they are more likely to develop several different health conditions.

The impact

The human costs and the economic burden for health and social care are profound as 60% of all deaths are attributable to long term conditions and they account for 80% of all GP consultations. People living with long term conditions are twice as likely to be admitted to hospital, tend to stay in hospital for longer and are more likely to require long term residential care. They are also more likely to experience psychological problems and have difficultly accessing employment and educational opportunities. The following examples highlight the scale of the challenges faced by health boards across Scotland.

CANCER

New cancer cases are expected to increase by approximately 8% every five years until 2020, mainly due to the ageing population. Around 200,000 people in Scotland are living with a cancer diagnosis – this is expected to double by 2030. In Forth Valley, more than 6,000 people currently have cancer.

DEMENTIA

In 2016, 90,000 people in Scotland were diagnosed with dementia and more than 4,900 live in the Forth Valley area. This figure is set to double in the next 25 years and it is estimated that, at any one time, up to one in four patients occupying a hospital bed are suffering from some form of dementia.

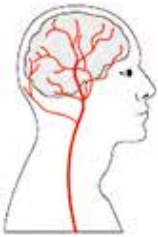
HEART DISEASE

Heart disease is the main cause of death in Scotland. It accounts for more than 18,500 deaths every year (approx one-third of all deaths). It is also the major cause of premature death in people under the age of 75 in Scotland. Around 14,000 patients in Forth Valley have coronary heart disease and more than 2,000 have heart failure.

DIABETES

There are 19,000 new cases of diabetes each year in Scotland and numbers are set to increase year-on-year with rising levels of obesity. In Forth Valley more than 14,500 people have diabetes.

STROKE



Stroke is the third commonest cause of death in Scotland and the most common cause of severe physical disability amongst adults. It is estimated that about 15,000 people in Scotland have a stroke each year.

ASTHMA

In Scotland, 368,000 people (1 in 14) are currently receiving treatment for asthma with more than 18,000 in the Forth Valley area.

OBESITY

Almost two-thirds of adults are now overweight with more than a quarter of these classed as obese. Almost a third of Scots children are at risk of being overweight or becoming obese. Being overweight is closely linked to rising rates of type 2 diabetes, high blood pressure and heart disease.

ARTHRITIS

In Scotland, 800,000 people live with osteoarthritis, the most common form of arthritis. Most people over 65 have at least one worn joint and one in ten show symptoms. There are many more living with other types of arthritis and musculoskeletal conditions, including lupus, rheumatoid arthritis and gout.

Developing the Strategy

In October 2014, eight working groups, led by senior clinicians and healthcare managers, were set up to carry out a major review of the following clinical services across Forth Valley:

- Cancer care
- Emergency and out-of-hours care
- Planned care (non-emergency appointments, operations and treatment)
- Frail, older people and end of life care
- Women and children's services
- Mental health and learning disability services
- Long term conditions
- Clinical support and infrastructure

The working groups looked at best practice and innovative ways of working across the UK and beyond. They also took account of key policies and plans such as the Scottish Government's 2020 Vision for healthcare, strategic plans developed by the two local Health and Social Care Partnerships and a number of national strategies, including the National Clinical Strategy for Scotland.

What you told us

A key part of the Clinical Services Review involved gathering feedback, ideas and suggestions from local staff, patients, community groups and voluntary organisations.

More than 50 events, workshops and meetings were arranged and hundreds of people completed an online questionnaire to tell us what they thought of existing services and how they would like to see them developed in the future. A special edition Community Health News was widely distributed, setting out the need for change, and the Review was widely promoted via local media and social media.

We would like to thank everyone who took part in the Clinical Services Review as the feedback we received has been invaluable in identifying a number of common issues and themes.

How we are responding

We have reviewed the recommendations from each of the eight working groups and all of the feedback gathered from local staff, patients and members of the public throughout the Clinical Services Review. This has helped us to identify ten key priorities which describe how we are going to do things differently in future. These priorities are illustrated in the following Vision:-

Our Vision is of a future where:-

Prevention keeps people well whilst early treatment and support stops conditions from getting worse.

Health and social care services are **Person Centred** recognising that people have differing needs, circumstances and expectations of care.

Health **Inequalities** are reduced and people are encouraged and supported to take **Personal Responsibility** for managing their own health and health conditions.

Care is provided **Closer to Home**, and fewer people need to go to hospital.

Planning Ahead and working in **Partnership** with staff, patients, local councils and community organisations avoids emergency hospital admissions and reduces A&E attendances.

Unnecessary **Delays** and **Variations** in services are minimised and our **Workforce** is fully supported to deliver high quality, safe and effective care.

Reducing variations

While there will always be a need to adapt services to meet the needs and preferences of individual patients, it is important to ensure that care is delivered in a consistent way.

Reducing variations in the way services are delivered across Forth Valley will ensure that everyone receives high quality, safe, effective care. Standardising the way patients are assessed, treated and discharged also helps reduce delays, improve outcomes and save resources.

Referral and investigation rates also vary across different areas and individual clinicians. There is a need to avoid overtreatment in some situations and improve access to services in others. Working with healthcare staff who make referrals and giving patients more information about the risks and benefits of the different treatment options and tests available will help address this.

The increase in the number of people taking lots of different medications is also an issue as it is estimated that around 20% of the population is taking five or more prescribed medicines on a regular basis. Many elderly patients take considerably more than that, and it is not uncommon for patients who are admitted to hospital to be on over ten different types of medication. The volume of medicines prescribed is also increasing steadily year-on-year which provides a huge financial challenge for all health boards.

Key actions will include:

- Providing clear, consistent guidelines for accessing tests and treatment to avoid unnecessary outpatient appointments and investigations
- Supporting pharmacy services to work more closely with local GP practices and patients to review and, where appropriate, alter or reduce medication
- Ensuring patients are not admitted to hospital if they can be treated successfully as outpatient or day cases

Preventing illness and disease

We all know prevention is better than cure so it is vital that we do everything we can to help people remain healthy for as long as possible. Many health problems, including those linked to diabetes and obesity, can be prevented if people are supported to make changes to their diet, drink less alcohol, give up smoking and become a bit more active. We therefore need to encourage and support people to make lifestyle changes and take more responsibility for improving their own health.

Detecting diseases like cancer and hepatitis C at an early stage means treatment is far more likely to be successful and many other health conditions can be prevented from getting worse if they are identified early on.

Key actions will include:

- Identifying and treating conditions at an earlier stage to prevent illnesses from developing or getting worse in later life
- Looking at ways to increase participation in screening programmes which encourage people to get tested for conditions like breast and bowel cancer
- Identifying new opportunities to offer health information, advice and support to people when they come into contact with local health services

Children from St Ninian's Primary School running their daily mile.

Julie's Story

Just after her 50th birthday Julie was invited for a mammogram at her local clinic. Fit and healthy, she had no family history of breast cancer so wasn't worried, but thought it would be a good idea to get checked.

Julie had her mammogram and was called back for a biopsy. This is not uncommon after the first visit as there are no previous results for comparison.

The biopsy showed Julie had early stage breast cancer and she had lumpectomy surgery two weeks later. She was allowed home the same night.

Julie was told she'd had a small, deeply-rooted tumour which was why it couldn't be felt. There was no spread to her lymph nodes. She needed radiotherapy for a fortnight coupled with hormonal treatment for the next five years.

Without the mammogram, Julie's lump could have remained undetected and grown and spread. She was grateful to have been invited for breast screening as this ensured her condition was detected early, treated quickly and enabled her to return to a normal life.

Identifying changes before diseases take hold, for example through bowel or cervical screening or identifying disease at its earliest stage as in breast screening, increases the likelihood of successful treatment. By encouraging people to attend for screening we can enable them to keep well and identify disease at an early stage.

Providing person centred care

Person centred care is care that takes account of a person's individual circumstances, needs, preferences and goals and ensures they are involved in decisions about their care.

Patients who are well informed and involved feel more in control and are better at monitoring and managing their own health, with appropriate support from health and care professionals. This can help delay illnesses from progressing and help people remain independent for as long as possible.

In addition, bringing health and social care staff, patients and carers together to plan what they should do and what they would like to happen if a person's condition changes or begins to worsen, can help people feel better prepared and more in control. Developing what is known as an anticipatory care plan can also help prevent a person's condition from deteriorating, set out a plan of early action if it does and avoid the need for them to be admitted to hospital for more intensive treatment.

Person centred care relies on hospital staff, GPs and other health and care professionals working more closely together to ensure care is co-ordinated and seamless. We will therefore introduce a new care framework to enhance the relationship between patients, carers and staff and work more closely with volunteers and community organisations to improve access to local services and support.

Throughout the review of clinical services, many people and staff highlighted the importance of good end of life care and bereavement support. Although most people, when asked, say they would prefer to die peacefully at home, we know that many patients end up being admitted to hospital as an emergency in their last few days, or hours of life. We therefore need to change the way we work to reflect people's wishes. One way of doing this is to enhance 'Hospice at Home' services and look at other ways of increasing the time people spend at home in the last six months of life. Listening to patients is also vital, and finding ways to give patients more time to discuss treatment options and address any concerns will also be explored.

Key actions will include:

- Developing anticipatory care plans for patients with complex health needs to ensure they remain well and are able to live independently for as long as possible
- Creating more multi-disciplinary teams which bring together GPs, practice nurses, pharmacists, community nurses and hospital specialists to provide better co-ordinated care for people living with multiple illnesses or diseases
- Ensuring local people have access to a wider range of care options at the end of their lives to enable and support a dignified death

Liz's Story

28 year old Liz has been admitted to hospital repeatedly due to poor healing of her wounds and infection. Liz used to train twice a week with the football club and meet friends regularly but lately she has not gone to training and has cancelled most of her social activities, preferring to stay at home.

Liz is admitted to hospital for the fourth time in two months due to poor healing of her wounds. The nurse suspects a mental health problem so refers Liz to the Liaison Psychiatry Service who work with patients across the hospital.

During a psychiatry assessment, Liz discloses that she harmed herself intentionally. An underlying severe depression was also identified.

After the assessment, contacts were made with mental health services to address Liz's needs and help prevent her having to be readmitted to hospital.

After a few months of appropriate care, Liz began football training once a week and started to see her friends again.

This story illustrates the importance of access to expert mental health services as Liz felt she couldn't disclose the underlying reason she was frequently in hospital to the staff who treated her. Mental health problems can often be unrecognised in patients with a physical illness. Appropriate management of mental illness can significantly improve a person's life and help prevent them having to go back into hospital.

Tackling health inequalities

The main causes of health inequalities are complex and closely associated with social factors such as where people are born, go to school and live. Lifestyle factors such as smoking and alcohol also play an important part. We recognise the need to work with local councils, voluntary organisations and community groups to tackle some of the underlying causes of poor health such as poverty and high unemployment.

The key to success is empowering people to take greater responsibility for their own health and wellbeing and make them feel more confident about themselves. We know it is the poorest and most vulnerable in our society who are at greater risk of becoming unwell and our aim is to reduce health inequalities so they can enjoy the same level of good health as those living in more affluent areas.

Key actions will include:

- Identifying and helping the most vulnerable people and working with the community to tackle poor lifestyle choices and help improve living standards
- Improving access to services in areas where there are high levels of poverty and unemployment to achieve better health outcomes
- Listening to and learning from the public, patients, carers and community groups to develop services which are flexible and responsive to local needs

The Hawkhill Story

Hawkhill is a small, self-contained community in Alloa. It experiences high levels of unemployment, largely due to the decline of the glassworks and textile industry, and faces challenges around poverty, health and education. The key to improvement is getting people involved, building esteem and self-confidence and empowering them to take more control of their lives.

NHS Forth Valley and local partners met with local residents who said they wanted a self-help group for various stress and mental health issues.

A facilitator was appointed and has been working with the group weekly.

The emphasis has been on mindfulness, reducing anxiety and improving self confidence.

Other interventions have included a group organised by local men where members can receive health checks.

Weekly walking groups have been established together with a community garden.

We know that life and health outcomes for many of our communities are far worse than others. We realise that if people can take forward their own ideas for improvement, and be supported by local agencies, it helps build a more resilient and healthier community.

Taking more personal responsibility

Although things are improving, people in Scotland still smoke and drink too much, are overweight and take little exercise. The consequences are high levels of diabetes, obesity and cancer and the NHS is increasingly stretched by treating growing numbers of people with largely preventable illnesses.

Persuading people to take better care of themselves would not only improve their own health and wellbeing, but also generate savings which could be reinvested to improve local healthcare services and facilities. In addition, it would free capacity, reduce delays and lead to shorter waiting times for treatment.

A clear and consistent message throughout our review of local clinical services, as well as the national discussions on the future of healthcare across Scotland, was that we all need to take more personal responsibility for our own health. A key priority is to move away from people being passive recipients of care to a partnership approach where patients are actively involved in decisions. In addition, there is a need to ensure everyone accesses health services appropriately and makes the best use of the information and support available.

Key actions will include:

- Encouraging patients to become more independent and supporting them to take a greater role in looking after themselves
- Directing people at higher risk of becoming unwell to local services which can support them to make the lifestyle changes necessary to improve their health
- Supporting people with long-term illnesses to effectively manage their conditions at each key stage from diagnosis to end of life care

Ali's Story

Ali is 57, overweight and suffering from heart disease and diabetes. His GP thought he would benefit from some healthy lifestyle changes and that exercise would help his weight and other health problems.

Ali's GP referred him to Braveheart but Ali wasn't convinced he would be able to do any walking because of his weight. However he gave them a call.

Helpful volunteers encouraged him to give it a try. Ali started walking with his local group and soon found it a good way to meet people whilst getting some exercise. He really enjoyed it.

After a few months his weight reduced significantly and he looked forward to his walks. Friends and neighbours noticed the difference and asked if they could tag along.

Around the same time, Braveheart volunteers asked Ali if he would train up to take a group out himself. He now leads his own group twice a week, enjoys meeting new people and is able to manage his health conditions much better.

This story illustrates the difference small changes can make to a person's health and fitness. It also highlights the benefits of working with voluntary and community organisations to improve health and reduce loneliness. We must ensure these opportunities are promoted as widely as possible to encourage participation.

Providing care closer to home

Most people prefer to be cared for in their own home or in their local area. This means more services need to be delivered in the community and these services need to be better co-ordinated with good communication between health and social care teams and improved access to a wide range of specialist advice and care. To help deliver this, community staff will be supported to extend their roles and make better use of their skills and experience. For example, community nursing staff could become more involved in planning and supervising the care provided by professional carers. Pharmacists are already working more closely with GPs to review medication taken by older people and those requiring end of life care.

Being admitted to hospital should be a last resort and any inpatient stays required should be as short as possible to allow people to return home quickly. Hospital admission should no longer be seen as the main route to residential care or a nursing home and no-one should be left to live out their lives in a ward if they no longer require hospital care.

Health and social care assessments should be carried out in people's own homes and people should have access to a flexible range of services and support to allow them to live independently for as long as possible.

In some other areas, providing a single point of contact for healthcare professionals to access services has been shown to improve care for patients with complex needs and ensure people can rapidly access the care, treatment and equipment they require, delivered in the most suitable location. Extending this access to social care professionals, care home staff and ambulance crews has also helped to prevent unnecessary hospital admissions and enable more people to be cared for at home.

Key actions will include:

- Making NHS Forth Valley a dementia friendly organisation and providing a wider range of enhanced dementia services with our partners
- Exploring opportunities to develop a single point of contact for health and care professionals, based on successful systems operating in other parts of the UK
- Extending outreach and tele-health services in the community to improve access to specialist assessment, advice and decision making closer to home

Jane's Story

Jane was an elderly lady, suffering from confusion, reduced mobility and incontinence, possibly due to a urinary tract infection. Following a house call, her GP prescribed antibiotics but noticed that Jane's disabled husband was struggling to cope. He called the local Closer to Home team who were able to assess Jane and her family circumstances.

The Closer to Home enhanced care team undertook a holistic nursing assessment, which looked at Jane's social, emotional and health needs.

Initially, they arranged for urgent support from carers and a mobility assessment from the rehabilitation team. Jane was also referred to a community psychiatric nurse and to local services for continence advice.

Extra equipment was provided quickly and Jane had regular visits from a variety of carers and nursing staff, including an evening visit to help her go to bed. Her confusion improved, along with her mobility and appetite.

She stayed at home and was discharged by day four.

The Closer to Home team felt they had been able to reduce the anxiety experienced by Jane and her husband. Measures were put in place to support Jane to stay at home and the Team felt the process was much more satisfying and rewarding.

This experience highlights the importance of speedy access to direct and personalised support at home. The Closer to Home team were able to join different elements of care together, arrange ongoing support and see the difference this made to Jane.

Working in partnership

The health service cannot work in isolation as many other organisations have an important role to play in helping to improve the physical and mental health of local people. These include patients and their families as well as local councils, the Scottish Ambulance Service, volunteers, community groups and voluntary organisations.

Many people now use the internet to research common health conditions and the NHS needs to welcome and embrace this change and work with well-informed patients to discuss and agree which treatments are right for them.

Two Health and Social Care Partnerships have been created in the Forth Valley area (one covering Falkirk and the other covering Clackmannanshire and Stirling) which bring health and council staff together with local carers, community and voluntary organisations to oversee the development of a wide range of local health and care services for adults. These Partnerships provide an opportunity to strengthen relationships between local health and social work staff and ensure services are better co-ordinated and more joined-up in the future. NHS Forth Valley also has a strong track record of working with other NHS Boards and we will explore opportunities to develop additional joint initiatives locally, regionally and nationally over the next five years.

Key actions will include:

- Establishing a number of local community 'hubs' which will provide a range of health and social care services
- Working with the Scottish Ambulance Service to manage and support people who fall at home
- Strengthening relationships between GP practices and care homes to support residents by developing individual care plans and carrying out regular health reviews

Joan's Story

Joan (73) was diagnosed a few years ago with motor neurone disease which soon affected her ability to walk, swallow and speak. She had always enjoyed listening to The Archers and visibly relaxed when this was on the radio. Towards the end of her life she was supported by her GP, district nurse, a neurologist, allied healthcare professionals (AHPs) and a specialist palliative care nurse from Strathcarron Hospice.

Using a communication aid, Joan developed an Advance Care Plan. She highlighted being able to stay at home, being pain free and living to celebrate her Golden Wedding anniversary later that year.

Soon Joan developed an infection and it was clear she was approaching the last weeks of her life and would be unable to celebrate her Golden Wedding anniversary.

Together with her palliative care nurse, Joan re-evaluated her goals and with the help of carers and the palliative care team, a party was held to celebrate the 50th anniversary of her engagement instead.

Joan died two weeks later. Her doctors and nurses had been open with her, which empowered her to meet her minister early in her diagnosis and plan her funeral. She chose her favourite readings and hymns and was carried out of church to The Archers theme.

Joan's story illustrates the importance of good, honest communication and advanced planning. The flexibility of the community team helped Joan to achieve her goals despite the limitations of her illness.

Planning ahead

Many people are taken to hospital as an emergency because their health has worsened or because carers or relatives are unsure of what to do or who to contact for advice. Research also shows that a small number of patients account for a large proportion of emergency attendances and many end up being regularly re-admitted to hospital. This is disruptive for patients and their families and places a strain on hospital services. Effective care planning by health and social care professionals has been shown to reduce unplanned admissions to hospital and visits to A&E. This involves discussing with the patient and their family what do if they have any queries or concerns and agreeing a plan for what they would like to happen if their heath changes or worsens. This plan can then be shared with relevant staff to ensure everyone is aware of what has been agreed and what matters most to this individual and their family. In many cases, providing advice on who to contact can help avoid an unnecessary visit to A&E. For example, if a person has any questions or concerns about their medication then a local pharmacist can provide advice and support and patients and families can also call ALFY (a round the clock advice line for older people which is staffed by experienced community nurses).

Patients will also have access to multi-disciplinary teams who will provide more follow-up and aftercare in the community. This will improve care for patients who have undergone hospital treatment but still require ongoing support once they have been discharged. For example, patients who have been treated for cancer, experienced a stroke or are suffering from mental illness may require physiotherapy, counselling and other therapeutic services.

Key actions will include:

- Ensuring that patients with complex needs, including those with mental illness, have a care plan in place which is regularly reviewed and shared with everyone involved in their care to help reduce hospital admissions
- Providing more ongoing support in the community with wider access to follow-up and after care for patients who have been discharged from hospital
- Exploring ways to offer a wider range of care options between hospital and home (also known as intermediate care)

Alice's Story

Alice (75) is a retired teacher with long term conditions including arthritis, high blood pressure and a heart condition. Her husband Bill, five years older, has recently had a heart attack and is less mobile and more breathless than before. Their daughter Mary visits daily.

Alice may have early dementia so her GP refers her to the Memory Clinic and asks a community psychiatric nurse to see her at home with her daughter Mary. Alzheimer's Scotland help Mary apply for Power of Attorney. Alice is diagnosed with Alzheimers disease. Her consultant liaises with her GP about medication and arranges a dementia link worker to support her.

The GP records details about Alice's circumstances and her new diagnosis on a care plan and gives her a copy. He also puts key health information onto an electronic system (also known as KIS) which can be accessed in an emergency.

Bill is offered help but only needs support so he can go to his bowling club. Alice is referred to a local day centre but Bill suddenly becomes ill and dies. Mary is concerned her Mum can't cope.

Alzheimer's Scotland put Mary in touch with Crossroads who provide Alice with company whilst Mary is at work. Safety aids are installed and visits to the day centre increased to twice weekly.

Alice is in hospital for two days with a UTI and returns home. Details are added to her KIS profile and emergency antibiotics arranged. She is given the number for the ALFY advice line. Alice becomes more fragile but is keen to stay at home. Increased support is provided by social care and community nursing enabling her to stay at home until the end of her life.

Alice's story highlights the importance of planning ahead and how a flexible approach is needed in a changing health situation. Her family were involved throughout and supported by 24 hour access to the ALFY advice line. Developing an Anticipatory Care Plan helps staff plan ahead and ensures they are aware of patient's personal wishes and preferences as well as their medical care.

Minimising delays

Some people are concerned that their condition could get worse while they wait for treatment while others experience delays in being discharged from hospital once their treatment has ended. Longer inpatient stays can increase the risk of developing an infection and older people who spend long periods of time in hospital may lose their confidence and mobility and are more likely to be transferred to a care home.

To help people get home from hospital more quickly, we will improve follow-up care in the community and specialist teams will offer advice and support to patients after they are discharged. More minor surgery will be performed as outpatient or day case procedures to reduce the need for people to stay in hospital and we will continue to extend the range of one-stop clinics where patients can undergo a number of different tests and treatment at the same time.

A number of GP practices in Forth Valley already provide an extended range of services delivered by healthcare professionals such as mental health nurses, physiotherapists and pharmacists. We will work with GPs and other primary care staff to explore opportunities to increase the range of services available locally to reduce the number of people who have to wait for an outpatient appointment. Out-of-hours services will also be further developed to ensure people can access a wider range of services overnight and at weekends, depending on their individual needs.

Key actions will include:

- Providing more support to patients in the first few days after they have been discharged from hospital and carry out more follow-up reviews and consultations by telephone or video links to reduce the need for patients to travel back to hospital
- Broadening the range of healthcare staff working in GP practices to reduce delays, introduce more local clinics run by nurses and AHPs and enable GPs to arrange more diagnostic tests without patients having to see a hospital consultant first
- Providing more one-stop clinics and introducing an electronic booking system across healthcare services to make it easier and quicker for staff to arrange tests and book appointments

Michael's Story

Sixty-one year old Michael is married and has two children and a dog. He loves to cycle and watch rugby with his mates. Although fit and healthy, he noticed a mole which worried him so he went to the GP to have it checked.

The mole was on Michael's face. His GP agreed that the mole looked unusual and arranged for Michael to attend a drop-in photography clinic at a nearby Health Centre that week, rather than wait two weeks to see a consultant.

Within 30 minutes of arriving at the clinic the photo was taken and sent to a dermatology consultant.

Within a week Michael received the encouraging news that the mole was nothing to worry about. Because the process was so quick, Michael had less time to worry.

Michael's story demonstrates the benefits of using technology to quickly assess a patient's condition and refer them for treatment as soon as possible, if any issues are identified. The photo-triage service also frees up appointments for other patients to attend the dermatology department and permits patients with suspicious moles to be fast-tracked for surgery or assessment at a clinic.

Developing our workforce

The NHS is dependent on hard working staff and the high quality of care and support they provide. Attracting and retaining a workforce with the skills to deliver the very best services is essential to meet the future needs of patients and their families. We must continue to demonstrate that NHS Forth Valley is a good place to work and ensure our staff are supported to take on new or extended roles and develop new skills. At present many of our specialist healthcare staff work in a hospital setting, however, in the future, we need to support staff to work in a more integrated way across hospital and community based services.

A major challenge is the age profile of our workforce as many of our doctors, nurses and midwives are likely to retire in the next five to ten years. We already have detailed workforce plans in place and these will continue to be reviewed to take account of anticipated future changes and challenges. NHS Forth Valley has a good track record in recruiting and retaining skilled staff and we will continue to work with universities and colleges across the country to train, recruit and develop our current and future workforce.

To support the trend in caring for more people at home and in the community, we need to move away from having separate hospital and community teams. Care in the future will be provided by multidisciplinary teams of staff working across hospital, community and social care services. More staff will have generic skills with additional specialist skills which will enable them to take on extended roles to care and support a wider range of patients in the community. Allied Healthcare Professionals and nursing staff will be able to make decisions to support quicker assessment and discharge, with many more assessments being carried out in the patient's own home.

High quality healthcare requires staff to have excellent skills in listening and communicating, particularly around end of life care. Not only does this prevent inappropriate interventions but it also allows opportunities to explore what is important to people in their last weeks of life and enables care to be planned accordingly.

Key actions will include:

- Supporting staff to take on new or extended roles and work in a more integrated way across community, hospital and social care services and, where appropriate, in partnership with voluntary organisations, community groups and independent providers
- Reviewing our workforce requirements to ensure we continue to have the right staff, with the right skills, working in the right locations
- Adopting more flexible working patterns to enhance community services during evenings and weekends, and move towards more seven day working

Megan's Story

Supporting young people into employment is a key element of NHS Forth Valley's Youth Framework and Workforce Strategy. In Summer 2015, we recruited 14 Business and Administration Modern Apprentices (MAs), working in partnership with Forth Valley College to deliver training.

Megan was NHS Forth Valley's first Modern Apprentice. She joined the Human Resources Department as a Recruitment Assistant, undertaking a full range of administrative and clerical duties.

Megan quickly became part of the HR team, taking on increased responsibilities and developing an excellent working relationship with colleagues.

During her time in the department Megan achieved an SVQ Level 2 qualification in Business and Administration.

Megan successfully gained a permanent, promoted post with NHS Forth Valley as a Quality Improvement Assistant, enabling NHS Forth Valley to retain her skills.

The success of this scheme illustrates the benefits of partnership working with universities, colleges and other educational establishments. It is hoped that the scheme will continue to give young people the opportunity to enjoy a rewarding career in the NHS.

Delivering the strategy

The Healthcare Strategy provides clear direction and a high-level framework which will guide the development and delivery of local health services across Forth Valley over the next five years. The creation of Health and Social Care Partnerships will also provide a great opportunity to work more closely with our council partners and the voluntary sector to provide more effective, better co-ordinated care.

We have listened very carefully to what local people and staff have told us they would like to see happen in the future and work will now be undertaken to identify the short, medium and longer-term actions required to deliver the Strategy over the next five years.

Further information

A copy of the full Healthcare Strategy is available on our website www.nhsforthvalley.com/shapingourfuture or you can telephone 01786 457274 or email shapingourfuture@nhs.net to request a copy.