NHS Forth Valley

SHAPING THE FUTURE

NHS Forth Valley Healthcare Strategy 2016-2021

Foreword

This Strategy sets out a vision for the shape of health care services in Forth Valley over the next five years.

The population are healthier and are living longer than ever before but this success also brings a challenge. As many more people are living into old age, the number of people living with long-term disabilities or health conditions will continue to rise.

We know that for frail elderly patients, emergency admission to hospital can be frightening and disorientating. Elderly patients rapidly lose confidence and independence, as well as experiencing physical deterioration, if they stay more than a few days in a hospital bed.

This Strategy sets out a new direction and focus for health care services in Forth Valley, with the emphasis on doing everything we can to keep people well and to intervene early to stop conditions from becoming worse.

New technology and information systems are removing the need for services to be provided in a small number of high technology facilities and will allow future services to be provided to patients in their local communities or even in their own homes with less need to travel.

Providing care at home, or as close to home as possible, will reduce avoidable hospital admissions or attendances and help people to get back home quickly and safely.

The changing expectations of individuals are recognised. Developments such as social media and the internet have provided rapid access to information, evidence, and advice. There is a move away from the traditional ‘doctor knows best’ approach to medicine as patients can now be informed partners in planning for their own health care needs. With this comes a personal responsibility that individuals manage their own health and health conditions, supported by clear plans for what to do when things change or symptoms deteriorate.

Most of all, we want to ensure that in Forth Valley we are providing the very best healthcare services possible within the resources available. We

are setting out a vision for a service, delivered in partnership with other agencies and the wider community including the Voluntary Sector, that:

- Has low waiting times and easy access when needed
- Uses standard pathways to reduce unnecessary variation and waste
- Has a committed, engaged, and well-trained workforce

Our strategy is captured in our vision statement which we expect all our staff, patients, and partners to understand and adopt as we Shape the Future of Forth Valley.

We would like to thank everyone who contributed during the consultation and engagement that have helped to shape the Healthcare Strategy. The leadership provided by clinical experts to the Clinical Services Review (CSR), along with the contribution of the work stream participants is acknowledged. We also acknowledge the significant input of patients, the public and members of staff, in providing comments, suggestions and views.

Alex Linkston
NHS Board Chairman

Jane Grant
Chief Executive

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1 Executive Summary

In 2014, NHS Forth Valley established a Clinical Services Review (CSR), to plan how we will meet the future healthcare needs in Forth Valley. A "Case for Change" document set the scene and described why our healthcare services needed to undergo transformational change.

The Clinical Services Review sought to identify what changes would better meet the needs of an ageing population, manage increasing demand for health services and help patients to retain their independence, supported by family and friends. We also acknowledged the Scottish Government's 2020 vision and subsequent National Clinical Strategy in informing how care will be transformed.

We engaged extensively with patients, the public and front-line staff, to gain insight into what changes people wanted us to make and what may be possible in practical terms.

Findings from the eight different CSR work streams, along with the views of patients, the public and staff, have informed the NHS Forth Valley Strategic Vision and the priorities described in the NHS Forth Valley Healthcare Strategy 2016-2021.

Eight Work Streams

- Emergency and Out of Hours Care
- Planned Care
- Mental Health and Learning Disability
- Frail Older People and End of Life Care
- Long Term Conditions and Multiple Morbidity
- Cancer Care
- Women and Children Services
- Clinical Support and Infrastructure

These have included Scottish Government legislation to create Health and Social Care Partnerships led by Integration Joint Boards and local Strategic Plans. This strategy has been developed alongside these important changes and provides a mechanism by which to work in partnership to shape our future services.

The Vision sets out ten key priorities which will guide the shape of NHS services between 2016 and 2021. There are also specific recommendations which have emerged from each individual work stream so we have included in this strategy, a summary of the output of each work stream and some of the more specific suggestions.

The NHS Forth Valley 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.

NHS Forth Valley's future vision focuses on the following ten priorities:-

Prevention

Person-Centred

Inequalities

Personal Responsibility

Closer To Home

Partnership Working

Planning Ahead

Minimising Delays

Reducing Variations

Workforce

Delivering the Vision will require coordinated effort sustained over the next five years and delivered in partnership. NHS Forth Valley will set out the detailed steps in our Annual Plans, Local Delivery Plans and Directorate Plans as we move forward.

2 Introduction

Great improvements have been made in Forth Valley health care services over the last 15 years. The world in which we live continues to change and there are new challenges to be addressed and opportunities to be exploited.

People are living longer, often with complex health conditions. There are still health inequalities across our communities and people are developing preventable conditions that often result in ill health. The needs of our local communities are changing. We need to make the most of new technologies and new ways of working to tackle these pressures. Importantly, we need to ensure that people are much more involved in their own health and health care and we need to prioritise prevention and early intervention to promote good health and prevent ill heath across our local communities.

NHS Forth Valley is committed to ensure delivery of safe, effective, person-centred care, to promote population health improvement and to maintain financial balance. However there are a number of important factors which necessitate a change in the way that clinical services are provided in the future.

The Government's healthcare quality strategy has "person centred" as a key quality dimension, providing care that is responsive to personal preferences, needs and values and assuring that people's values guide all clinical decisions.

A confident, flexible, trained workforce, able to work in multi-disciplinary teams providing anticipatory, planned and unplanned care will be required. This Strategy explains why change is needed, our choices, options and the proposed plan for a brighter future, and what this will mean for patients, unpaid carers and communities. The local Clinical Services Review and the subsequent public engagement have helped us to develop a broad agreement on the way forward. We are now keen to engage with patients, the public, our care partners and staff to plan how we can deliver the priorities in the Strategy.

3 National Context

3.1 NHS Scotland 2020 Vision

In 2011, the Scottish Government set out its strategic vision (2020 Vision) for achieving sustainable quality in the delivery of healthcare services across Scotland. In the face of the significant challenges of Scotland's poor population health record, our changing demography and the economic environment, they set out a vision for the future.

The vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

> "We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission."

The 2020 Vision provides the strategic narrative and context for taking forward the implementation of the NHS Scotland Quality Strategy, and the required actions to improve efficiency and achieve financial sustainability.

3.2 Health and Social Care Integration

The Scottish Government has initiated a major programme of reform through the Public Bodies (Joint Working) (Scotland) Act 2014. This has been set up to support the 2020 Vision. NHS Boards and Local Authorities are legally required to establish local Health and Social Care Partnerships, led by an Integration Joint Board. These Partnerships must work in an integrated way to deliver the nine National Health and Wellbeing Outcomes described in Table 1. Adult health and social care services will be planned by the integration partnerships. The Partnerships will work closely with a number of stakeholders, including the voluntary sector and the independent sector.

Table 1: National Health and Wellbeing Outcomes

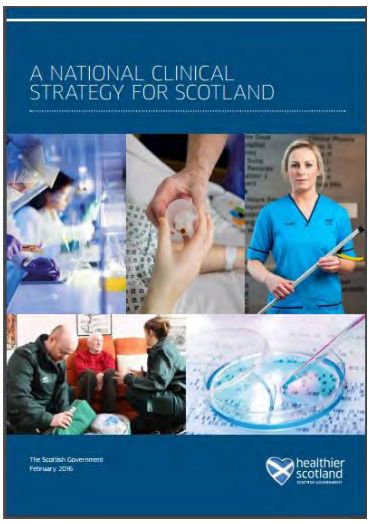
Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer
Outcome 2	People including those with disabilities, long term conditions, or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Outcome 3	People who use health and social care services have positive experiences of those services, and have their dignity respected
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of service users
Outcome 5	Health and social care services contribute to reducing health inequalities
Outcome 6	People who provide unpaid care are supported to reduce the potential impact of their own health and wellbeing
Outcome 7	People who use health and social care services are safe from harm
Outcome 8	People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do
Outcome 9	Resources are used effectively in the provision of health and social care

NHS Forth Valley covers three council areas who have agreed on two health and social care partnerships (Figure 1). One partnership is Clackmannanshire Council and Stirling Council with NHS Forth Valley. The other partnership is Falkirk Council with NHS Forth Valley. For both partnerships an Integration Joint Board has been set up consisting of Council and NHS members, led by a Chief Officer. With effect from 1st April 2016, the two Integration Joint Boards became operational and have responsibility for the planning and delivery of health and social care services for adults within the boundaries of the agreed areas.

Figure 1: Forth Valley's three council areas illustrated as two health and social care partnerships

3.3 National Clinical Strategy for Scotland (2016)

The National Clinical Strategy sets out the direction for change, to help NHS Scotland to meet the challenges ahead. This will be undertaken in partnership with local government and the voluntary and independent sectors, which provide social care, over the next 15 years. The key elements of the Strategy can be summarised as:



- Providing effective healthcare services, with an emphasis on primary and community care, to reduce health inequalities.
- Offering proportionate and appropriate care, to well informed patients.
- Undertaking transformational, patient centred change, rather than condition focussed care.
- Increasing capacity in primary care across a wide range of professions.
- Achieving better outcomes by providing some non-complex and many complex procedures in specialist centres, therefore some services should be planned at a regional or national level.
- Increasing technology and information use to improve decision making and care co-ordination.

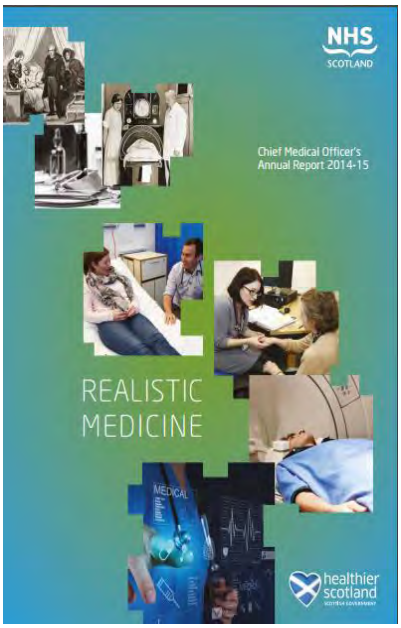
The National Clinical Strategy acknowledges that in order to deliver health care services which are sustainable, NHS Boards require to deliver regional models of care for some specialties which cross traditional Board boundaries. Services should be planned on a local, regional or national basis, depending on the nature of the service and the particular sustainability considerations which require to be addressed.

Finally the National Clinical Strategy notes the difficult economic environment and the need to improve the value delivered by, and from health services, by providing reliable care that is proportionate to need, is safe, effective, person-centred and sustainable.

3.4 Chief Medical Officer's Annual Report 2014-15: *Realistic Medicine*

Realistic Medicine explores the challenges facing doctors today and encourages discussion about how care and treatment are delivered in the future. The key findings in the Annual Report were:

- Over-medicalisation, by treating the condition without taking into account the needs and wishes of the patient, has had the potential to cause unintended harms and is often wasteful.
- Shared decision making includes the patient as a partner in managing and understanding potential risks of treatment options, whilst selecting the best solution for the patient.
- The time lag between the publication of research and the translation of findings into practice needs to be reduced in order to improve access to innovative therapies and advances in patient care.
- Strong clinical leadership is important, linked to providing high quality patient care and the appropriate use of resources as part of a clinical paradigm shift.



3.5 Pulling Together (2016): *Transforming Urgent Care for the People of Scotland*

This national report evaluated the effectiveness of primary care out of hours services in Scotland and provided recommendations for improvement, in the context of Health and Social Care Integration.

The recommendations included a new model for out of hours and urgent care services, which is multi-disciplinary and multi-sectoral, is person centred and outcomes focussed, is underpinned by a robust infrastructure that is fit for purpose and is clinically safe. The model describes urgent care resource hubs, co-ordinating well led and well supported multidisciplinary health and social care teams to deliver urgent care, in the community.

3.6 Creating a Healthier Scotland – *What Matters to You* (2016)

Between August 2015 and March 2016, the Scottish Government invited the public and patients to participate in a national conversation on what a healthier Scotland would look like. The Conversation asked three key questions:

During the conversation, ideas and opinions were provided, reflecting a wide range of priorities and experiences, most of which fell into 6 broad themes.

- Leading healthier lives – prevention, lifestyle and behaviours and education
- Wellbeing and connected communities - prevention, lifestyle and behaviours and education
- Person-centred care – communication, self-management, holistic approach
- Social care and caring – unpaid carers, information and entitlements, support at home and in homely settings
- A responsive and seamless journey of care – access, flexibility and joined up care
- Pressures and priorities – workforce, funding and targets

3.7 Beating Cancer: Ambition and Action (2016)

The revised national cancer plan outlines 53 actions for NHS Scotland, focussing on the areas of:

- Prevention
- Improving survival
- Early detection and diagnosis
- Improving treatment
- Workforce
- Living with and beyond cancer
- Quality improvement
- Research

The actions described in the plan include providing a holistic needs assessment for all cancer patients, which means looking at all of a person's needs, not just their disease and includes assessing their financial situation, their home and social supports and providing access to services and information which support people to make the best care and treatment choices for themselves and their families.

4 Local Context

4.1 NHS Forth Valley's Values

In 2013, staff from across NHS Forth Valley, were involved in creating and defining new organisational values and translating them into behaviours that would contribute to our success as well as identifying behaviours that staff did not want to see. The identified values incorporate those of NHS Scotland. The six values are:

Being **Person Centred**: We will acknowledge and accept that every person is different and we will adapt our approach to meet the needs of others.

Being **Respectful**: We will treat each other, our partners and people who access our services, fairly, as individuals and as equals, with humanity, dignity and respect.

Being **Supportive**: We will be supportive, valuing each other's role and contribution and demonstrating care and compassion in all our actions and communications.

Being **Ambitious**: We will deliver high quality, safe, consistent and effective healthcare.

Having **Integrity**: We will be open and honest in all our actions and communication.

Being a **Committed Team Member**: We will include managers and the wider multidisciplinary team in our communication and decision making.

NHS Forth Valley wants every member of staff to feel supported and confident to role model these values in the way we work and treat each other. Our values will be embedded in our leadership and management competencies, recruitment processes, people policies and procedures, induction, learning, education and training programmes, KSF personal development plan system and our staff recognition scheme.

4.2 NHS Forth Valley Health Strategy (2009 – 2014)

The NHS Forth Valley strategy (2009-2014) noted key priorities on which the new strategy (2016-2021) will build. These key priorities include:

- Prevent ill health
- Improve the experience of people and involve them in their care
- Increase the quality, safety and consistency of care
- Work in partnership
- Increase the effectiveness and efficiency of the services we provide
- Deliver care as close to home as possible

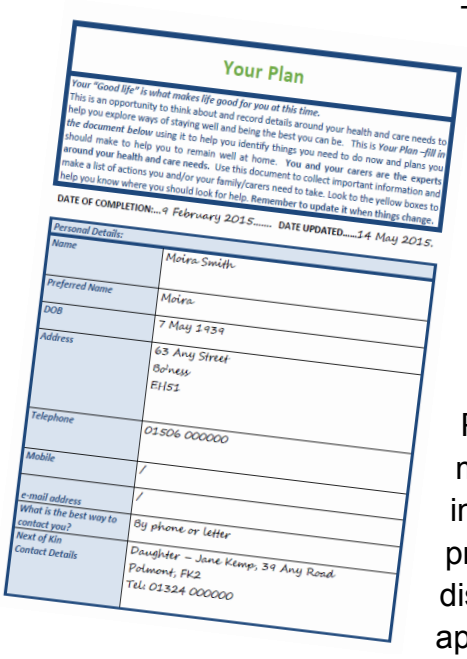
Major structural changes have taken place in Forth Valley, including the building and opening of Forth Valley Royal Hospital, and the creation of community hospitals in Falkirk and Stirling. Forth Valley now has four such community hospitals.

These structural changes support the transformational change of shifting the balance of care from the acute hospital into the community.

4.3 Case for Change

The Forth Valley population is ageing and more people are living longer, leading to a rise in the number of people with multiple illnesses. The population of Forth Valley is also growing in size and, along with the ageing population, this creates an increasing demand for healthcare, which the capacity of the current services may not be able to meet.

Financial balance is a legal requirement, so the NHS can only spend the budget allocated. The NHS is facing areas of significant cost growth including prescribing, staffing costs, technology and changing population demands. NHS Forth Valley requires to deliver annual efficiency savings to meet increasing costs and these must be achieved through real cash savings and using resources more effectively.



Your Plan

Your "Good life" is what makes life good for you at this time.
This is an opportunity to think about and record details around your health and care needs to help you explore ways of staying well and being the best you can be. This is *Your Plan -fill in the document below* using it to help you identify things you need to do now and plans you should make to help you to remain well at home. You and your carers are the experts around your health and care needs. Use this document to collect important information and make a list of actions you and/or your family/carers need to take. Look to the yellow boxes to help you know where you should look for help. Remember to update it when things change.

DATE OF COMPLETION:...9 February 2015..... DATE UPDATED.....14 May 2015.

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The majority of inpatient beds within NHS Forth Valley are used by patients who are admitted to hospital as an emergency and the increase in residents aged 65+ will present a continuing capacity challenge. The estimated potential increase in activity suggests that, if we simply keep doing the same things, 55% more beds would be required by 2035 to meet rising demand, making the current model unsustainable.

People with complex conditions are currently making multiple trips to hospital clinics to see a range of individual specialist services at different times. The preferred future model is a move away from the current disease-based specialist care to more generic approaches, which focus on the needs of the patient not just the disease and manage a range of problems at one clinic.

Risk factors for disease include deprivation, housing, employment and behaviours. We need to take a person centred approach to reducing external risk factors and help motivate people to lead healthier lifestyles.

4.4 NHS Forth Valley Clinical Services Review (2015)

In order to help determine the future shape of services in Forth Valley a Clinical Services Review (CSR) was established to review our current services and to guide our future priorities. The Review comprised of engagement with patients, the public and staff and a detailed review of services led by senior clinical experts. The Clinical Services Review is described in more detail in Section 6 of the Strategy.

4.5 Engagement with the Public and Staff (2015)

Comprehensive public and staff engagement took place as part of the Forth Valley Clinical Services Review. The CSR looked at the clinical services currently in place to ensure the delivery of safe, effective, person-centred care; to promote population health improvement and to maintain financial balance as set out by the 2020 Vision. Engagement was a significant part of the CSR, using a variety of methods, such as questionnaires and group discussions, including patients, front-line staff, unpaid carers, the voluntary sector and the public in general.

A wide range of work was undertaken to raise awareness of the CSR and encourage feedback from staff, service users, local community groups and members of the general public. This included a series of media briefings, public engagement events, meetings, briefing updates and use of social media. A special edition of the Community Health News was circulated widely across Forth Valley and this described the challenges ahead and outlined the case for change. CSR sections were created on the staff intranet and public website to promote the review and to encourage feedback via a short online questionnaire. Leaflets which could be completed and returned to feedback comments, suggestions and ideas, were distributed widely to staff across the organisation. Information on the CSR was also circulated widely to local community groups, voluntary organisations, community representatives, local councils and service user groups across Forth Valley.

Information Source	Number
Team questionnaires returned	115
Public events & arranged meetings with patients, unpaid carers, staff and organisations	55
Questionnaires received from Staff, Public and Voluntary Sector	413

The public and staff have been very helpful in providing comments on the CSR, and submitting suggestions and ideas. These contributions have helped shape our vision and priorities.

The main themes from this are highlighted in Figure 2.

Figure 2: What the Public and Staff Told Us

5 What NHS Forth Valley Will Do Differently – The Priorities

Recommendations from the public and staff engagement, the local CSR work streams and Government priorities were reviewed and considered. Collectively these were used to inform NHS Forth Valley's vision statement which describes how we intend to deliver healthcare services differently in the future.

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.

The priorities in the vision are described in the sections which follow, illustrated by case studies which demonstrate what typical local healthcare services will look like in 2021 as well as how some services are already working at present. It is planned to roll out these service changes and new ways of working consistently across Forth Valley.

It was recognised that there was considerable similarity in the recommendations made by the various CSR work streams, for example, the need to establish a single point of contact for professionals to access services. These generic recommendations have been reflected within the most appropriate priority area, with specific and unique recommendations highlighted within the relevant work stream outputs in section 6.

5.1 Prevention

Prevention featured strongly in the local public engagement work, was a key recommendation of the National Conversation (2016) and was identified as highly important in the clinical work streams.

As our population ages, it is vital that we do all we can to try and keep people well. A significant number of diseases including long term conditions such as obesity and diabetes are largely preventable, or can be improved, with appropriate lifestyle choices. It is essential that people are encouraged and supported to take responsibility for their own health and health outcomes. Early detection and prevention can reduce the severity and impact of ill health.

It is NHS Forth Valley's intention to:

- Continue to deliver ill health prevention and health promotion programmes to reduce the impact of ill health.
- Increase the uptake of self-testing and health screening to identify more conditions at an early stage.
- Treat more conditions at an early stage to prevent illness from developing and to moderate the effects in later life.
- Use every patient contact with health services as a health improvement opportunity, offering advice or short structured interventions to promote healthy living and self awareness.
- Work extensively with our Community Planning partners, with a focus on health improvement.

JULIE'S STORY – DETECTING DISEASE EARLY

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.

DAILY MILE – IMPROVING YOUR HEALTH

After a school volunteer commented on children being unfit, staff at St Ninian's Primary School suggested pupils run round a field a few times. It wasn't good news – many "couldn't run the length of themselves!"

Primary 6 pupils were asked to run a few laps every day for three weeks. Five laps equated to one mile, hence the Daily Mile. Improvement was evident.

The whole school joins in and the Daily Mile becomes part of the curriculum.

Parents report that children are eating and sleeping better. Some parents become involved in leading the running club.

Great results. Of 57 pupils in Primary 1, not one is overweight. Children love the outdoors, are more resilient, have better relationships and improved focus and concentration. They are positive and proud of their achievements.

Daily exercise not only helps improve mood and wellbeing but can also prevent being overweight, one of the problems which can lead to cardiac disease, diabetes, stroke and a variety of cancers in later life. The Daily Mile also shows exercise is easily achievable.

5.2 Person Centred

Person centred care is care that is responsive to individual personal preferences, needs and values, while assuring that patients' values guide all clinical decisions. A person centred culture places the quality of patient care and patients' experiences, at the centre of the healthcare services which are provided to them.

Whilst the population is increasingly healthy and more people are living to an older age, the number of people living with one or more long term conditions is also increasing rapidly. We want to help people focus on positive well-being, preventing disease and complications, anticipating care needs and self-management tailored to their needs.

The changing role of primary care, with an increased emphasis on prevention and self-management and with care planned and delivered by a broader multi-disciplinary health and social care team, will support people to achieve the maximum level they can, whilst encouraging independence. The House of Care is a standard Framework which will facilitate the development of a new and improved relationship between patients, unpaid carers and staff. The framework recognises the importance of well co-ordinated care, planned in partnership with the patient and places the patient and their specific needs at the centre. Well informed patients and carers are supported by health and social care professionals, working collaboratively, with processes and arrangements in place that enable this way of working.

Figure 2: House of Care Framework

Supported self management can delay the progression or exacerbation of illness and aims to maintain people in a state of optimum health and independence for as long as possible. A personalised approach to care, shared decision making and patient empowerment, would, for example, provide the person with a summary of their consultation. It can also support a staged approach to anticipatory care planning. This means that as soon as the condition begins to worsen, the person knows how to take immediate action, preventing avoidable deterioration and the need for more intensive treatment or hospitalisation.

The Cancer Service has introduced treatment summaries, provided to patients and the healthcare professionals involved in their care. These summarise the treatment which was given, outline the patient's follow-up arrangements and give a clear description of the actions to be taken should specified changes happen. This person centred approach should now be extended to patients with other long term conditions.

Integrated primary care and specialist teams, bringing together GPs, practice nurses, pharmacists, community nurses and hospital specialists, will provide shared care. These teams will deliver regular reviews for people with multi-morbidities and support them to create a better understanding about their own condition and how they can manage it.

Good end of life care and bereavement support is a very important aspect of the care that we deliver. Most people when asked to consider their place of death, indicate that they would prefer to die peacefully at home, provided that they are not alone, are pain free and can pass away with dignity. However many patients are rushed to hospital as an emergency in their last few days or hours of life.

Recognising death and dying helps to prevent inappropriate and sometimes costly interventions. This approach is supported by the Chief Medical Officer in her Annual Report: Realistic Medicine. Early identification of people approaching the end of life also allows opportunities to explore what is important to people in the last weeks of life and enable care to be planned accordingly.

It is NHS Forth Valley's intention to:

- Support the development of personal resilience of patients, unpaid carers and family members.
- Adopt the House of Care Framework to guide our improvement programme for care planning and develop services to deliver more complex care closer to home.
- Offer choices around possible future care options, increase autonomy and inclusion in the decision making process.
- Introduce a single Anticipatory Care Plan (ACP) that will work across all of Forth Valley to anticipate people's health care needs in a person-centred way.
- Focus on the overall needs of the person, for example flexible appointments allow people to talk about what really matters to them.
- Ensure that unpaid carers' needs are identified and addressed, by implementation of the carers' assessment, as identified in the Carers Act (2016).
- Engage with voluntary sector partners to support improved self-management.
- Support volunteers to help people live well in their community. This will help people understand and access the services and support available to help them manage their situation.
- Extend treatment summaries, currently provided to patients with cancer, to patients with other long term conditions.

LIZ'S STORY – ACCESSING MENTAL HEALTH SUPPORT

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.

5.3 Health Inequalities

Health inequalities need to be addressed and this requires action across all the social factors which can affect health. These are complex and are associated with the conditions in which people are born, grow, live, work, and age. NHS Forth Valley works with its partners and remains committed to reducing health inequalities and promoting equality, in line with the public sector equality duty of the Equality Act 2010.

NHS Forth Valley will focus on mitigating the effects of social inequalities, for example poor lifestyle choices including smoking and alcohol misuse. It is recognised that working in partnership with Council and voluntary sector organisations will deliver positive outcomes in underlying causes, such as poverty and income.

It is NHS Forth Valley's intention to:

- Listen to and learn from the public, patients, unpaid carers and local communities.
- Work extensively with our Community Planning partners, with a focus on health improvement and health inequalities.
- Identify and focus on the most vulnerable people who are at greater risk of unplanned hospital admissions.
- Deliver services which are person centred, compassionate and flexible.
- Address barriers to healthcare and health inequalities to achieve the same high levels of access, patient satisfaction and outcomes for everyone.
- Support fair employment and good work practices in order to attract, retain and develop the best workforce.
- Create a system that has eliminated wide disparities in health outcomes, that is fair, inclusive and based on our core values.

TACKLING INEQUALITIES – WORKING IN PARTNERSHIP

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.

5.4 Personal Responsibility

Scotland has excellent access to high quality, safe and effective health care services, but we continue to have a disappointing performance when it comes to preventing illness or leading 'healthy lives'. Although things are improving, the Scottish population still smoke too much tobacco, consume too much alcohol, are overweight and take too little exercise. We suffer the consequences with high levels of diabetes, obesity and cancer.

The NHS Scotland Charter of Patient Rights and Responsibilities was laid before parliament (under Section 1(7) (b) of the Patient Rights (Scotland) Act 2011) in September 2012 and sets out the expectation that people "take some personal responsibility for their own health".

BMA Scotland has suggested in its 2016 Manifesto "Securing the Future of Scotland's Health Service" that "Personal responsibility for health should be encouraged and adults and children should be educated on the appropriate and best use of healthcare services".

As a publicly funded system which provides free and universal access to healthcare, the NHS is increasingly stretched by the burden of largely preventable conditions. If people can be persuaded to take better care of their own health then, as well as enjoying much better health and wellbeing, we could achieve the combined benefits of greater economic prosperity, generated by a healthy workforce with low sickness absence and a falling demand on the NHS to treat avoidable conditions like obesity.

From the National Conversation and from local consultation in Forth Valley there is a clear message that we all need to start taking more personal responsibility for our own health. Healthcare services and strategic partners should support and develop the personal resilience of patients and unpaid carers and family members.

Self management describes approaches where people living with long term conditions take control and manage their own health. Information that is up-to-date and personalised is absolutely essential to effective self management.

The Scottish Government Strategy for self management is set out in "Gaun Yersel", which was written by people with long term conditions, who were aided by the Health and Social Care Alliance Scotland. The strategy includes making the person 'the leading partner in management of my health' and identifies five key stages at which people need support; Diagnosis; Living for today; Progression; Transitions; End of life.

ALI'S STORY – MAKING HEALTH CHANGES

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.

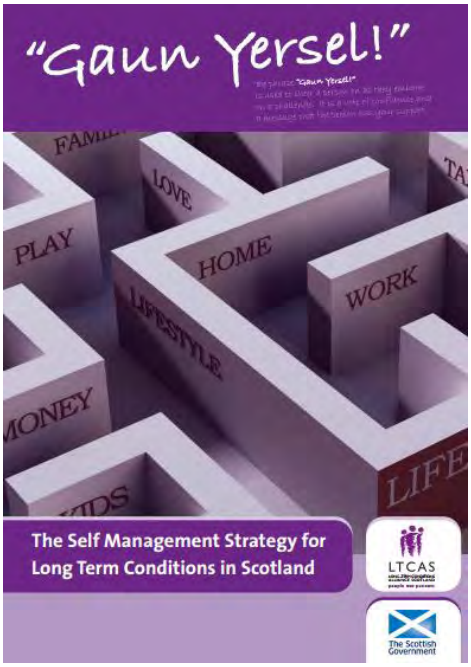
Ali's GP referred him to Braveheart but Ali wasn't convinced he would be able to do any walking because of his weight. However he gave them a call.

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.



Health professionals have a central role in enabling people to manage their own health and in helping them engage with the supports they need in their communities. Self management is also a critical component in the Scottish Government's Quality Strategy, which sets out a 2020 Vision for a safe, effective and person-centred health service.

This promotes a move away from people being passive recipients of care to a model that engages, empowers and supports people in a partnership approach with their healthcare professionals, unpaid carers and community.

It is NHS Forth Valley's intention to:

- Support patients to be more independent and take a greater role in managing their own conditions.
- Develop the personal resilience of patients, unpaid carers, and family members.
- Introduce proactive self management programmes for people with long-term conditions.
- Adopt a model that engages, empowers and supports people in a partnership approach with their healthcare professionals, unpaid carers and community.
- Direct people with the appropriate risk factors to services such as Keep Well clinics.

5.5 Closer to Home

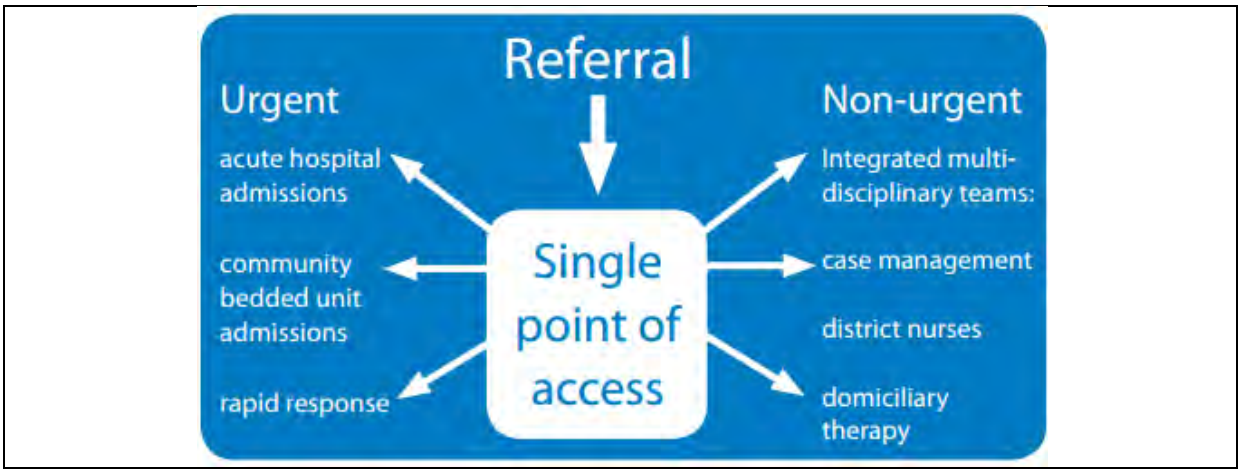
As the population ages more people will be living with chronic conditions such as dementia. People should be supported to stay well at home by providing healthcare services at home or as close to home as possible, which minimise the need for admission to hospital. More services should be community based, with improved access to specialist advice and care in community settings. To support patients at home, locality based care will be delivered with health and social care professionals working in multidisciplinary teams. For example, community pharmacists are working more closely with GP practices to review and rationalise medication in the elderly and those approaching the end of life.

To support individuals to remain in their local area wherever possible, community teams will be developed to meet these needs and deliver care in this way. For example the skills of community nursing staff can be utilised to have a greater involvement in the planning and supervision of care provided by professional carers.

Excellent communication skills are essential in order to deliver care closer to home. Good quality communication between health and social care teams is important but even more important, is communication with patients and their carers, in order to ensure that they are well informed and are able to participate as equal partners in their own care. Enhanced information sharing between health and social care teams enables services to support caring for people closer to home or in community settings.

Admissions to hospital should be a last resort and the stay should be as short as possible with people returned home quickly. More integrated services will be locally based, with improved local access to multidisciplinary specialist advice and care. A single point of access for healthcare professionals, such as the one provided by Birmingham Community Healthcare NHS Trust, has delivered improved care co-ordination for patients with complex needs.

Figure 3: Single Point of Access - Birmingham Community Healthcare Trust



This service can be accessed by health and social care services professionals, including ambulance crews, and enables professionals to arrange the right care for urgent and non-urgent referrals, helping to prevent avoidable hospital admissions and effectively manage long-term conditions in the community. This ensures that people receive the most effective treatment, with an appropriate timescale, in the most suitable location. This model may offer a template for a potential future service development in Forth Valley.

Transfer from hospital to residential care or nursing homes must no longer be seen as the normal route. Multi-agency care assessments should take place in people's homes with the expectation of enhanced community and home based support whenever possible.

It is NHS Forth Valley's intention to:

- Make NHS Forth Valley a dementia friendly organisation, providing enhanced dementia services with our partners.
- Roll-out access for patients, families and carers to the local 24/7 advice line known as ALFY (Advice Line for You) to support people to remain well at home.
- Develop a single point of access for healthcare professionals, offering rapid access to a range of services to support people in their place of residence.
- Roll out the *Closer to Home* approach to provide a rapid response to people at home who have an urgent care need.
- Provide home care and recovery pathways to support people to be at home, or homely settings, rather than in hospital.
- Improve care co-ordination for patients with complex needs and ensure their health needs are proactively met.
- Develop specialist outreach services within the community so that specialist assessment, advice and decision-making is provided closer to home.
- Enable specialist staff to have enhanced general skills, and staff in community teams to develop extended roles.
- Provide rapid access to equipment and care at home to prevent hospital admission, where possible.
- Develop the use of tele-health to allow access to specialist advice for community based teams.

JANE'S STORY – DELIVERING CARE CLOSER TO HOME

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.

BILL'S STORY – AVOIDING HOSPITAL ADMISSIONS

Sheila called the 24/7 Advice Line for You (ALFY) at 5.30pm about her husband Bill. She was distressed and on the verge of calling 999. Bill had been feeling unwell for two weeks. They had been to the GP that morning and Bill had a blood test to check if anything was wrong.

After his GP appointment Bill had rested but woke needing the toilet. With Sheila's help he struggled to get there but had not made it. This resulted in heavy work for Sheila, having to strip beds etc. She found it hard to lift Bill who wasn't eating or drinking. Sheila was exhausted, couldn't cope and was about to call an ambulance.

Sheila called the ALFY line who arranged for a GP to visit and a nurse to come that evening.

Bill was diagnosed with a chest infection and treated at home. The out-of-hours nurse assessed Bill and organised aids and assistance for the next few days.

This included provision of a commode and zimmer frame. Crisis care was arranged and an assessment carried out. A rehabilitation team was contacted for a mobility assessment. The district nursing team were asked to visit for a few days and Sheila was advised to call ALFY back if there were any problems.

Bill's story demonstrates the benefit of having a dedicated advice line with access to patient information and the ability to organise crisis care, arrange assessments and co-ordinate support to help people to stay at home.

5.6 Working in Partnership

People are increasingly taking more responsibility for their own health and wellbeing. More people now use the internet to research common health conditions. The NHS needs to welcome and embrace this change and expect to work in partnership with interested and well informed patients. This will require a change in the way that health professionals work. The National Conversation (2016) and the public and staff engagement during the local CSR Review, highlighted that, in the 21st Century, a paternalistic approach to healthcare is no longer appropriate.

Joint decision-making with patients and where appropriate with family and carers, could eventually replace the expectation that a doctor "seeks consent" to treat a patient. For example, using a "request for treatment", the person records in their own words why they want a particular treatment, what they expect to achieve and their understanding of the risks and limitations.

Patients tend to choose less treatment when they are provided with greater detail of the impact, potential benefits and harms of a proposed intervention. The Chief Medical Officer for Scotland's Annual Report 2014-15 highlighted that there is both a cultural and legal expectation on people and professionals to collaborate in decisions, that help people live well, and die well, on their own terms.

There are two health and social care partnerships that cover the Forth Valley area, one for Falkirk (a partnership between Falkirk Council and NHS Forth Valley) and one for Clackmannanshire and Stirling (a partnership between Clackmannanshire and Stirling Councils and NHS Forth Valley).

By building on the many examples of existing partnership working, including the voluntary sector, these new Partnerships will ensure that local people receive joined up, seamless support and care and help ensure individuals can live independently in their own homes for as long as possible.

NHS Forth Valley has a proven track record in partnership working with other NHS Boards, participating in both the West and East of Scotland regional forums. Locally, strong links are enjoyed with the three Local Authorities.

It is NHS Forth Valley's intention to:

- Involve families and unpaid carers in providing individualised care, for example rolling out Wellness Recovery Action Plans, supporting people with mental health conditions.
- Work with families, unpaid carers and partners to ensure that the Carers Act (Scotland) 2016 is fully implemented.
- Roll out the further development of care pathways.
- Improve collaborative working and communication across service interfaces.
- Work with Scottish Ambulance Service to manage and support people who fall at home.
- Ensure community nursing staff have greater involvement in planning and supervising care provided by professional carers.
- Support the voluntary sector to provide enhanced self management approaches.
- Review working relationships between GP practices and care homes to support the allocation of new residents, development of care plans and proactive resident reviews.
- Ensure that electronic care systems are readily accessible across care sectors.
- Work jointly with partners to help discharge people from Community Hospitals.
- Develop a range of locality based community hubs, providing a range of health and social care services.

JOAN'S STORY – GOOD END OF LIFE CARE

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 organised 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.

5.7 Planning Ahead

Following standard pathways and agreeing anticipatory care plans will help ensure that more care is planned in advance, and patients and unpaid carers are involved in supported self care that anticipates their future care needs. Effective care planning, by health and social care professionals in partnership with patients and carers, will help to reduce the need for unplanned emergency admissions and A&E attendances.

Improved understanding of the emergency and out of hours services will ensure that people will know when they should use each service and how to access these appropriately.

Specialist care will move away from the traditional hospital focus to a model with specialist care in communities. A patient centred, multi-agency team approach will enable follow-up and ongoing support in community settings. This will support self-management and anticipatory care planning and enable wider access to after care, for example cancer care, mental health services, care for children with complex needs, services for frail older people and stroke care.

A proactive approach to anticipatory care planning and case management will reduce unplanned admissions and shorten the length of stay in the acute hospital. Initiatives such as continuity of community care, self management, use of technology, mental health case management and senior clinician review in the Emergency Department, will reduce avoidable admissions and allow resources to be transferred to the community setting.

A wider range of intermediate care options will offer alternatives to hospital in-patient care. Implementing a 'discharge to assess' model which assesses people in their own home to ascertain their capabilities and needs, rather than assessing them in an unfamiliar hospital setting will reduce demand on unplanned care services.

It is NHS Forth Valley's intention to:

- Ensure that people with complex needs have case management to help reduce avoidable hospital admissions.
- Redesign the model for 24/7 emergency and urgent care to further improve consistency across all services.
- Develop further day medicine services.
- Explore a wider range of options for providing intermediate care.
- Ensure that healthcare teams and practitioners communicate effectively with patients and families, to support patients to be partners in their care.
- Share the necessary information at the right time to ensure care is as seamless as possible especially around transitions.

ALICE'S STORY – PLANNING AHEAD

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.

5.8 Minimising Delays

Delays in treatment and care can mean that people stay longer than necessary in an inappropriate care setting or may find that their condition is exacerbated whilst they are awaiting access to care. The processes for admission and discharge to hospital will be streamlined and standardised to reduce the time people stay unnecessarily in hospital and to reduce same day cancellations.

NHS Forth Valley is working with its partners to minimise delays in discharge from hospital. Effective hospital discharge can only be achieved when there are robust joint working arrangements between all organisations, including hospital, primary care, social care, housing departments and the voluntary sector. These arrangements must be effective in supporting individual discharges, and in commissioning of services.

To return people home more quickly after treatment, there will be a focus on improving follow-up in the community after discharge, with access to specialist teams offering support over the first 48 hours at home. People will be better informed and encouraged to review their own progress and know when to seek help, following routine procedures. Where possible, more follow-up reviews by telephone or video consultation will be undertaken in order to reduce patient and unpaid carers travel.

More direct access to consistent specialist support, for example mental health nurses, paramedics and geriatricians, to manage health conditions in the community, including mental health, will be provided. This will also include maximising the use of modern technology, providing virtual reviews and rapid-access clinics.

GPs will be enabled to arrange more diagnostic tests without having to see a hospital consultant first and people will have greater access to advanced healthcare practitioners or pre-op assessment, without the need to see a hospital consultant. More minor surgery will be performed as an outpatient or day care procedure.

Local engagement, clinical advice and the national Out of Hours Review, suggest that there is scope to deliver a more integrated emergency, urgent care and out of hours care model across the community and hospital settings. This includes the Scottish Ambulance Service, community nursing, mental health teams, GP services and social care. Alternatives to the traditional emergency and urgent care services provided at Forth Valley Royal Hospital have been put in place and will be developed further. These will be more integrated, better co-ordinated and ensure that people get to the most appropriate service for their care. A single point of access for professionals to a range of care services which support people in their place of residence is seen as an important part of this future model.

NHS Forth Valley is committed to working together with organisations, including the Scottish Government and regional planning partners, to ensure that where people need complex or high risk procedures, they are delivered in the appropriate specialist

centres with the correct level of expertise. This will offer the best possible safety and outcomes for patients.

It is NHS Forth Valley's intention to:

- Minimise delays for patients waiting for treatment, care and results.
- Reduce length of hospital stay by enabling earlier discharge.
- Broaden direct access to a wider range of primary care professionals, which will release GP time to see those with the most complex conditions.
- Provide direct access to consistent specialist support to manage appropriate health conditions in the community.
- Develop an electronic direct booking system across health care services.
- Provide more one-stop-clinics for services such as oral surgery, urological assessment, dyspepsia management and some minor skin lesions.
- Learn from and extend the *ERAS* (Enhanced Recovery After Surgery) principles where planned admission is necessary.
- Develop Nurse and Allied Health Professional led primary care services and clinics.
- Provide greater access for GPs to book diagnostic tests for patients.

GRAHAM'S STORY – GETTING HOME MORE QUICKLY

Graham (81) lives alone and receives care in the morning to get ready for the day, and once in the evening to prepare for night. One evening he has a fall and goes to the Emergency Department. Arrangements are put in place to allow him to return home within 72 hours.

When Graham fell he also hurt his hand but crawled to the kitchen to wait for his care workers

The evening carers were unsure about the severity of the situation so phoned an ambulance.

As doctors and care workers worked together as part of a single team Graham was able to leave hospital within 72 hours. He was taken home by the community frailty team to assess him at home and support him. They decided it was safe to leave him there.

Graham is pleased to be at home. It also means he is not occupying a hospital bed.

Graham's story demonstrates the positive outcomes of a multidisciplinary team. It also shows that arranging a home assessment can lead to a quicker discharge and prevent patients deteriorating while in hospital. It also frees up beds and can improve outcomes as every additional day spent in hospital reduces the chance of the patient returning safely to their home due to increased risk of infection, loss of mobility and independence.

MICHAEL'S STORY – FAST TRACK ASSESSMENT

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.

5.9 Reducing Variations

Variation is and always will be a feature when delivering healthcare. Caring for people with individual needs and taking account of their wishes and unique circumstances within the complex and changing environment of the NHS is challenging. While variation cannot be totally eliminated nor should it be, there is a need to ensure that NHS services are delivered consistently, safely, efficiently and in a timely way.

There are recognised ways of minimising variation. These include greater use of information technology to present, share and analyse information, including benchmarking, establishing standardised care pathways, ensuring that clinical guidelines are complied with and using audit to measure compliance.

There is a need to ensure greater clarity for professionals as to what services are available and where these are located. By listening more actively to patients, decisions can be in accordance not only with best current evidence, but also with the patient's own values. There is growing evidence that giving people more information does not result in them accessing more care, treatments and investigations. In fact their preference may be for less.

Working with patients to share information about their condition and encourage supported self management together with anticipatory care plans that set out what to do when things change, will reduce unplanned and emergency demand and reduce the need for follow up appointments.

Optimising the use of services, by eliminating waste and ensuring that every step in the patient's journey adds real value, will assist in reducing variation. By educating and informing the healthcare professionals who make referrals and by involving patients, enabling them to make informed decisions about their care and treatment, we will ensure that all patient referrals are necessary.

Wherever possible, care will be provided in the least acute setting. For example, whilst day case surgery is now the norm, some procedures currently undertaken as day cases, may be moved to outpatient areas or community settings. When admission to hospital is necessary, there will be a focus on enabling earlier discharge and by providing services which support patients to return to their home.

By providing greater support in the community including clear diagnostic, treatment and care pathways for common conditions, demand for new outpatient appointments and investigations will be reduced.

Community pharmacy services will work more closely with GP Practices to review and make best use of medication (e.g. with older people and people approaching end of life).

It is NHS Forth Valley's intention to:

- Promote the use of standardised care pathways across all care settings.
- Ensure people are not admitted to hospital if they can be successfully treated as day cases.
- Reduce the number of beds occupied by patients awaiting discharge or not receiving active treatment.
- Learn from the "Let's Talk Medicine" campaign run previously in Forth Valley that encouraged people to engage with GPs and Pharmacists to discuss their medication to meet their needs more effectively.

JIM AND SALMA – DIRECT ACCESS TO CARE AND TREATMENT

Jim and Salma were both suffering knee pain

Jim and Salma attended their GPs with knee pain. They were given a direct phone line number for open access physiotherapy.

Jim phoned and received exercise advice and was signposted to the NHS Inform website for further information and advice. Salma also received exercise advice and a physiotherapy assessment.

Jim felt much better after six weeks and did not need a physiotherapy assessment. Salma was assessed and a treatment plan agreed, in addition to exercise.

After six weeks Salma's pain had not improved. The specialist physiotherapist discussed her case at a multidisciplinary team meeting and she was listed for surgery and had a knee replacement. With the enhanced recovery programme and post-op physiotherapy she recovered well and was back at work six weeks later.

This example demonstrates that for one patient, quick access to physiotherapy advice and recommended exercise resolved their knee pain quickly. For the other patient, the pathway to surgery was streamlined and there was no wait for an outpatient appointment. Salma was able to recover speedily using the enhanced recovery after surgery programme.

5.10 Workforce

The NHS is dependent on our hard working staff and the high quality of care they provide. Throughout this strategy, the challenges the NHS are facing and the fact that the status quo is not an option, have been illustrated. Attracting and retaining a workforce with the skills to deliver the highest quality services is essential. We must continue to demonstrate that NHS Forth Valley is a good place to work, where the workforce is supported to deliver the best possible care.

Enabling a healthy organisational culture and a sustainable and capable workforce with effective leadership, is supported by the iMatter programme. This provides a tool to gather feedback and use this to improve the experience of staff. The iMatter programme is associated with the NHS Scotland 2020 Workforce Vision: “Everyone Matters”.

Our 2020 Workforce Vision

We will respond to the needs of the people we care for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. We will continue to modernise the way we work and embrace technology. We will do this in a way that lives up to our core values.

Together, we will create a great place to work and deliver a high quality healthcare service which is among the best in the world.

As we deliver the transformational change set out in this strategy, we also need to ensure that our staff are supported to take on new roles and develop new skills. At present, many of our specialists are accustomed to working in the acute hospital environment. In order to deliver services which are more focussed on community settings, specialists will need to work in a more integrated way, across the community and our hospitals.

To implement the healthcare strategy, future workforce needs will be reviewed whilst recognising challenges such as the age profile of our staff groups, recruitment, training and education. Assessment of future needs, including delivering enhanced

community based teams and addressing challenges in a number of acute specialties, will enable appropriate staffing levels and skill mix to be determined.

To support the trend in caring for people in community settings, moving away from distinct acute and community teams will be necessary. More staff roles with generic skills plus additional specialist skills (extended roles) will be developed to enable people to become more independent. Community based care supported by multi-disciplinary teams, will require effective team working, which values the contribution of all disciplines. Teams will work together in more integrated ways across health and social care.

Delivering modern healthcare requires the workforce to have excellent skills in listening and communicating, for example further developing staff communication skills at the end of life. This will be underpinned by the development of leadership skills and quality improvement through lifelong learning and supported by the use of technology.

It is NHS Forth Valley's intention to:

- Ensure that our staff are supported to take on new roles and develop new skills.
- Recruit and retain a top quality workforce trained to the highest standards and working with the local community.
- Review future workforce needs, whilst recognising challenges such as the age profile of our staff groups, recruitment, training and education.
- Address challenges in vulnerable acute specialties to enable us to determine appropriate staffing levels and skill mix.
- Support AHP and nursing services to make speedier decisions regarding assessment, reporting and discharge planning, with assessments undertaken in the patient's own home.
- Work across health and social care and with the voluntary and independent sectors to implement the changes described in this strategy.
- Adopt more flexible working patterns to enhance community services at evenings and weekends and move towards more seven day working.

MEGAN'S STORY – DEVELOPING OUR WORKFORCE

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.

6 Clinical Services Review – Work Stream Recommendations

To guide the future shape of NHS services in Forth Valley a Clinical Services Review was undertaken which included consultation with patients, the public and staff.

Clinical leads, supported by senior managers were identified for each of eight work streams and undertook a detailed review of those services. There was input from a wide range of participants including staff from clinical, professional, managerial and support service backgrounds, advisory committees and other groups including Managed Clinical Networks and the voluntary sector. Work streams also met with patients and members of the public through open meetings, focus groups, events and workshops. A wide range of views were taken into consideration including over 500 individual responses from the public, patients and staff.

In addition, detailed data was collected and analysed to identify projected future demand, changes in technology and medicines plus evidence of best practice and benchmarking from the UK and internationally.

The eight work streams are inter-related and many of their recommendations showed clear consensus and made similar proposals for service change and development. We have used the learning from each of the work streams to inform our comprehensive and overarching strategy for change, in order to provide high quality person centred care in the future.

The cross cutting themes from the eight CSR work streams have been incorporated into our ten strategic priorities but where there are specific recommendations from a work stream, examples of these are included in the following sections:

Eight Work Streams

- Emergency and Out of Hours Care
- Planned Care
- Mental Health and Learning Disability
- Frail Older People and End of Life Care
- Long Term Conditions and Multiple Morbidity
- Cancer Care
- Women and Children Services
- Clinical Support and Infrastructure

6.1 Emergency and Out of Hours Care

Emergency and out of hours care is challenging due to the increasing health needs of the aging population, the numbers of people living with complex and often multiple long term conditions and the limited availability of skilled staff.

This work stream reviewed the available evidence and best practice models from Scotland, the United Kingdom and across the world, the Scottish Government's Unscheduled Care Programme and the National Review of Primary Care Out of Hours Services led by Professor Lewis Ritchie.

Increasing numbers of people are presenting to emergency and urgent care services and an increasing number of the people who present are frail.

There is considerable variation in who is accessing urgent and emergency care services and inpatient services, with 2.5% of the local population using 50% of health care resources and almost 80% of inpatient beds.

There is also seasonal variation in emergency and urgent care activity.

In order to ensure that emergency and out of hours care is sustainable, six strategic objectives for emergency and urgent care were identified by the work stream:

- A fully integrated emergency and urgent care service, delivered as close to home as possible.
- 24/7 urgent care provided, with clearly defined access points, quality standards and levels of care.
- Rapid access to appropriate care that supports people in their place of residence for as long as appropriate.
- A focus on skill mix and enabling staff to work up to their levels of expertise to maximise capacity and efficiency.
- Emergency and urgent care that supports self management for individuals with long term conditions.
- Improving access to rapid response community teams will help people remain well and happy at home for as long as possible.

EXAMPLES

Introduce an emergency and urgent care network to coordinate services.

Redesign urgent care pathways and develop an urgent community response team.

Implement practitioner led discharge.

Offer rapid access to specialist advice and diagnostics, and easier access to test results for community based staff.

6.2 Planned Care

Planned Care refers to a range of undertakings across all care settings which can be predicted and planned for in advance.

NHS demand is increasing as the population ages and the complexity of medical interventions develops. For the unwell or disabled and for the frail elderly in particular it is mentally and physically demanding to travel to clinics and hospitals and be treated in unfamiliar surroundings. Only people who need to be managed in hospital should have to go there.

In the future we will provide specialist services in the community as close to people's homes as possible. This will reduce travel and inconvenience for patients whilst using assets more effectively. One-stop clinics reduce the need for return visits or multiple attendances for tests and results. Technological advances including mobile devices and electronic decision support are making this model of health care safe, efficient and effective. Some community services already exist but are duplicated in hospital. Community optometry for example could replace much of outpatient and routine follow up by ophthalmology clinics in hospitals.

Supported self management reduces the need for routine follow up visits freeing up time for new patients and reducing queues. Co-ordinated standardised pathways that include prevention can release people from frequent travel to large hospitals or specialist centres.

These pathways will be backed up by early fast track access to specialist care when required to ensure quality and safety, reduce planned lengths of stay, support earlier discharge and move people from unplanned to planned pathways.

Increased use of day and 23 hour surgery and encouraging and integrating self care will increase productivity across both Hospital and Community settings.

A clear single point of access will direct professionals to the team best able to resolve their situation, with less duplication and onward referral. This will reduce transitions, referrals, handovers and delays.

EXAMPLES

Minimise unnecessary delays for patients awaiting treatment, care and results.

Offer planned care as close to home as possible.

Introduce more clinics in communities.

Further develop alternatives to bringing patients to hospital appointments.

Extend the range of rapid access clinics.

More patients managed as day cases.

6.3 Mental Health and Learning Disability

The mental health and learning disability work stream undertook a review of all NHS mental health services, including children and adolescents and learning disability services, excluding children with a learning disability.

Key factors which emerged from the work stream were:

- Managing individuals with complex needs and co-morbidities or with significant risk in the community.
- Managing demand.
- Adhering to a legislative framework and tackling stigma and discrimination.
- Implementing new models of care that promote early intervention and well being, support a recovery focused ethos, and are delivered in partnership.
- Ensuring the on-going development and implementation of patient pathways.
- Developing a single point of access for professionals.
- Ensuring sufficient workforce with key competencies.
- Identifying and utilising the most appropriate place of care.
- Addressing inequalities.

Growing numbers of people are diagnosed with dementia and the number of people with the condition is expected to double over the next 25 years. A need for additional capacity in old age psychiatry was identified.

Traditionally, NHS mental health and learning disability care systems have focussed on illness and related care support services. The work stream proposed going beyond this to recognise and invest in the ongoing management of acute, severe and enduring complex illnesses whilst addressing population health and wellbeing and recognising that mental wellbeing is everyone's business.

NHS Forth Valley will deliver person centred, safe and effective mental health and learning disability services, aiming to improve mental wellbeing, quality of life outcomes, promoting rights and recovery and addressing stigma.

EXAMPLES

Develop early intervention in psychosis at first presentation.

Enhance psychiatric liaison services to support patients in the acute hospital.

Enhance home treatment services as alternative to admission and support early discharge.

Deliver psychological therapy redesign.

Develop assessment, treatment and support for children and adults with autism spectrum disorder and ADHD.

Enhance community based services for dementia.

Enhance primary mental health CAMHS team to facilitate early intervention.

6.4 Frail Older People and End of Life Care

Frail older people and those approaching the end of life currently receive good quality care in Forth Valley but our services need to meet the changing needs of our aging population.

The aim is to provide holistic, person centred care that focuses on quality of life to support frail older people above 75 years of age and all adults over 16 years who require end of life care.

This will replace the traditional clinical focus on "*what is the matter with m*e?" with attention to "*what matters to me is...".*

This group of people should be supported and empowered to take more control over their own health and should be able to receive professional care in community settings rather than travelling to hospitals to be treated in unfamiliar settings.

There should be open and honest discussions about where and how the frail elderly and those approaching the end of life would like to be cared for.

The various services for these groups of people must be aligned more closely together so that they can work in partnership to deliver care.

The following six strategic themes will improve the care of frail older people and those approaching the end of life.

- Good communication and anticipatory planning so that priorities for care are identified and shared.
- Adopting a holistic approach which involves families and unpaid carerss to deliver individualised care.
- Co-ordinated and integrated care between the different professional groups providing support.
- Care provided as close to home as possible, with easy access to support overnight and at weekends.
- Addressing capacity issues and ensuring service efficiency so that there is a good skill mix which enables teams to provide care closer to home.
- Optimising the use of technology to support community based care through the use of tele-health and sharing of clinical information.

EXAMPLES

More services for the elderly available in the community.

Enhanced support for people in Care Homes.

Early discharge from hospital with planned follow up at home.

Reconfigure dementia services for older people.

Training to recognise when someone is near the end of life and take opportunities to improve communication.

Provide "Hospice at Home" services to enable and support a dignified death.

6.5 Long Term Conditions and Multiple Morbidity

As the population is living longer, more people have long term conditions such as diabetes, heart failure and chronic obstructive pulmonary disease.

Long term conditions currently affect four in ten people, predicted to rise to seven in every ten people over the next decade and many people will suffer from more than one condition at a time. This is called multiple morbidity. By the age of 50, half of the population will have at least one long term condition and by the age of 65 more than half will have two or more conditions.

For frail older people, it is mentally and physically demanding to travel to clinics and hospitals and to be treated in unfamiliar surroundings. An alternative is for people to be managed in their community. New models of care and technological advances, with a robust community infrastructure, support delivery of more specialist care closer to home.

Care pathways that include prevention, will standardise care, create a more holistic approach to multiple morbidity and release people from repeated travel to specialist centres. One stop clinics avoid patients having to attend separate hospital clinics for each condition.

There is a need to enable, educate and support people to self manage their conditions. Appropriate information, a holistic approach, positive lifestyles and signposting to achieve best outcomes can prevent complications and emergencies.

Workforce development aligned with the 2020 vision will support a culture based around flexibility to embrace individual needs and preferences. Shared information systems will support staff to work across multiple community locations, enabling greater access to supportive information for people to self manage their own conditions.

Care guided by shared management plans, developed with individuals following standard pathways, delivered close to home and backed up by early fast track access to specialist care when required, will avoid deterioration and unplanned admissions.

EXAMPLES

Implement a resilient multi-disciplinary model to deliver all care closer to home.

Extend supported self management and effective anticipatory care planning.

Improve diabetes care in the community.

Redesign care pathways for management of people with long term conditions and multiple morbidity.

Extend community based services supported by technology, mobile devices and telehealth.

6.6 Cancer Care

There will be 50% more people aged over 65 in Forth Valley by 2035 and currently, over half of cancer diagnoses are within this age group. This creates a compelling need to redesign our model of care.

The cancer work stream placed a very strong emphasis on promoting healthy living and on improving ways to alleviate the impact of a cancer diagnosis. This will improve the resilience of individuals, families and communities to deal successfully with the challenges and dilemmas they face.

Recommendations include the engagement of young people in health and wellbeing and cancer prevention and early consideration by patients and staff of each person's own particular circumstances.

A cancer diagnosis is a devastating event for any person as well as their family and friends with implications far beyond the medical situation. Around 25% of those diagnosed with cancer face poor health or disability after treatment. Four in five people with cancer are affected by the financial impact of cancer, while around one in eight cancer survivors are living with mental health problems. National surveys have suggested that around a quarter of cancer patients did not recall receiving information from health care professionals about their condition, its treatment and effects or support services in their area.

Practical, emotional and social support can include a range of supportive care programmes, such as those being piloted in Forth Valley under the Macmillan One-to-One and Transforming Care After Treatment programmes. The construction of a Maggie's Centre in Forth Valley will provide a valuable focus for support services to promote emotional and physical health and wellbeing, during cancer treatment and beyond.

73% of people who died from cancer would have liked to have spent the last weeks and days of their life at home, however only 30% of those actually die at their own home or residence. Increasing hospice at home services and developing a hospice model of care in community hospitals would enable more people to die with dignity at home or in a more homely setting.

EXAMPLES

Increase cancer screening uptake.

Promote holistic needs review including psychosocial needs assessment for cancer and other long term conditions.

Enhance local access to specialist medical and nursing oncology expertise.

Increase Hospice at Home capacity and develop hospice model of care in community hospitals, to support a dignified death.

6.7 Women and Children Services

For children the key policy driver is the Children and Young People (Scotland) Act 2014. This builds on the principles set out in Getting it Right for Every Child (GIRFEC), the Scottish Government National policy programme. Maternal Healthcare service principles are set out in the national Framework for Maternity Care in Scotland (2011) and sexual health services are described within the Scottish Sexual Health and BBV Framework (2011-2015).

This work stream did not include child and adolescent mental health services which were covered by the mental health work stream. Children were defined as up to age of 16 years and young people up to the age of 18 years.

Services from pregnancy through to adolescence and beyond should be of high quality, evidence based and safe, delivered at the right time and in the right place, by a trained, compassionate and supported workforce.

Integrated and co-ordinated services are required at the point of transition to adult services for young people who will continue to require regular health care as an adult. Single points of access to services will streamline communication and help to place children, young people and their families at the centre of any decision making that affects their health and well-being.

The work stream agreed a threefold vision that Forth Valley will:

- Promote pregnancy and childbirth as a social and emotionally significant event where women and their families are treated with dignity and respect.
- Ensure that children and young people achieve the best possible outcomes by having equitable access to safe, effective and child centred health services as close to home as possible.
- Improve the sexual health and wellbeing of the Forth Valley population, ensuring that inequalities in sexual health are addressed, fostering a culture of positive sexual health which encompasses race, ethnicity, disability, gender or sexual orientation, age or religion.

EXAMPLES

Better integrated services for transition to adulthood.

Review services for highly complex needs in mainstream school.

Additional support to meet the needs of the pre-term infant, especially with severe and complex needs.

Continue to tackle and support the rising numbers of children and young people with obesity.

Improve access to mental health services during and after pregnancy.

Acknowledge HIV as a long-term condition.

Identify children who are at risk of tuberculosis.

6.8 Clinical Support and Infrastructure

This work stream identified ambitious and innovative developments in services to support the other work stream outputs including technological, equipment and infrastructure solutions in Estates and Facilities, Laboratories, Information Management and Technology (IM&T), Medical Physics, Patient Administration Services, Pharmacy, Radiology and Sterilisation Services.

Optimising the use of new and existing technology and ensuring best value from costly medical equipment were considered. An example innovation is mobile ECG equipment in the community which enables monitoring to take place locally, with the results reported remotely to specialists. This avoids the need for patients to attend hospital repeatedly for follow up care, reduces patients' travel and provides care closer to home.

The key strategic recommendations focus on the following areas:

- Improving access to information to support communication between health and social care professionals and patients.
- Improving and simplifying processes including booking of appointments, discharge prescriptions, repeat prescriptions.
- Optimising the use of premises, IT and other capital assets to ensure that the right assets are available where and when they are needed, to support changes in how care is delivered.
- Developing technology enabled care.
- Modernising systems to enable diagnostic services to support the patient journey and deliver diagnostics in the community.
- Ensuring systems are as efficient and effective as possible.

The vision includes delivering technology enabled care, delivering accessible patient records for professionals in all sectors, providing direct access to booking appointments for staff and patients and efficient delivery of services close to home.

The work stream also identified the ambition of developing and supporting a flexible workforce with the necessary skills and competencies to deliver care in both acute and community settings, using the best technology available.

EXAMPLES

Provide technological solutions to facilitate more care closer to home.

Streamline the patient journey from access to discharge.

Support information sharing between services through the use of mobile technology and common, compatible systems.

Build on existing strategies – HR and IM&T.

Update the Property and Asset Management Strategy to support the Healthcare Strategy implementation.

7 Realising the Strategy

By 2021 we will have transformed the way in which we provide healthcare in NHS Forth Valley.

This strategy describes transformational service change to taken forward over the next five years. The Strategy will be implemented in partnership with other strategic organisations including the Health and Social Care Partnerships, voluntary and independent sectors and other NHS Scotland bodies, in addition to our Community Planning partners. The Board's Annual Plans, which outline the actions which will be delivered over a 12 month period, will be aligned to the Healthcare Strategy, as will the plans delivered by the clinical and corporate Directorates.

Health and Social Care Integration is intended to fundamentally change the way that care is provided in the future and successful delivery of this healthcare strategy is dependent on strong collaboration and shared objectives.

We will continue to collaborate with our regional partners in order to provide services jointly when this is more beneficial to people or would enable us to assure sustainable, safe and effective care.

It is important that individuals participate in delivering this strategy, both as partners in managing their own healthcare needs, but also in taking responsibility for their own health by making healthy lifestyle choices and taking up screening opportunities. Most people in Forth Valley, including many older people, are in good health, require minimal intervention from health services and are able to take responsibility for their own health and wellbeing.

We must also recognise the challenging economic environment within which the public sector operates. NHS Forth Valley has a requirement to live within the resources made available by the Government and to make the most efficient use of public funds. There is a continuing requirement to achieve cash releasing efficiency savings, in order to meet rising costs. It is essential that we continue to provide services which are efficient and sustainable and that we take every opportunity to redesign the way we provide our services in order to deliver excellent person centred care and to meet the changing demand outlined in the strategy.

In implementing the strategy, we will ensure that all resources, including our workforce, are used to the best possible effect. Difficult choices will need to be made, in order to make the transformational changes described and shape our future.

Detailed criteria for measuring how successful we have been will be developed alongside annual plans to guide the implementation of our ten key priorities and address the issues and challenges which public, patients and staff have told us are important to them.

8 Glossary

A&E	Accident & Emergency
ACP	Anticipatory Care Plan
ADHD	Attention Deficit Hyperactivity Disorder
AHP	Allied Healthcare Professional
ALFY	Advice Line for You
BBV	Blood Borne Viruses
CAMHS	Child and Adolescent Mental Health Services
CSR	Clinical Services Review
ECG	Electrocardiogram
ERAS	Enhanced Recovery After Surgery
GIRFEC	Getting it Right for Every Child
HIV	Human Immunodeficiency Virus
HR	Human Resources
IM&T	Information Management and Technology
KIS	Key Information Summary
KSF	Knowledge and Skills Framework
MA	Modern Apprentice
SVQ	Scottish Vocational Qualifications
UTI	Urinary Tract Infection

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.