This paper relates to
Agenda Item **5**

Falkirk
Health and Social Care
Partnership

Title/Subject: **Chief Officer Report**

Meeting: **Integration Joint Board**

Date: **3 February 2017**

Submitted By: **Chief Officer**

Action: **For Decision**

1. INTRODUCTION

1.1 The purpose of this report is to update members of the Integration Joint Board (IJB) on current developments within the Falkirk Health and Social Care Partnership.

2. RECOMMENDATION

The members of the IJB are asked to:

2.1 note the continued progress being made within available resources

2.2 note the process of the Pilot of the Discharge to Assess model and

2.3 remit the Chief Officer, in discussion with the Chief Executives and Chief Finance Officer to take appropriate action in relation to the Discharge to Assess Pilot set out in Section 4

2.4 note the Chief Officer will ensure that the Project Team continues to address emerging issues and to report back to the Board

2.5 remit the Delayed Discharge Steering Group to provide regular updates on key elements of the DD Improvement Plan with a full progress report on a 6 monthly basis

2.6 remit the Chief Officer to provide an update to the Special IJB meeting on any action required in relation to ward 5, Falkirk Community Hospital

2.7 note the response to the Scottish Government consultation on the draft National Health and Social Care Standards.

3. BACKGROUND

3.1 The Board has previously agreed key areas of work should be undertaken and the report provides an update on a range of activity.

3.2 Progress continues to be made in all the areas as detailed in this report.

4. STRATEGIC WHOLE SYSTEM APPROACH

4.1 Local Delivery Plan

The draft Local Delivery Plan will be presented to the IJB to consider at its next meeting.

4.2 Capacity Modelling

The partnership is continuing to work with i-Hub and TRIST to take forward work on whole systems mapping. This work has commenced and a number of meetings have taken place with a range of employees across all partners, including the Third and independent sectors. Since December 2016 approximately 55 people have participated in these individual or group discussions. Considerations is being given on how to incorporate the lived experience of service users and carers in this work. It remains the intention to conclude the first phase by 31 March 2017. The Board will be kept updated on this through the Chief Officer report.

4.3 CLiP leadership development training

Support has been provided by NHS Education for Scotland (NES) for three levels of collaborate leadership training:

- Strategic Leadership Team as detailed in Section 3.1
- Leadership development for the West Locality Pilot
- Reablement leads – 2 workshop sessions are being planned for February and March with key reablement leads and sessions will be facilitated by the Partnership's OD Advisor and NES.

4.4 Frailty Model

A Test of Change ran in FVRH in the week of 7 November 2016 and trialled:

- a potential screening process of patients over the age of 65 years for frailty syndromes
- a frailty assessment tool for those patients over 75 years presenting with frailty syndromes
- twice daily Comprehensive Geriatric Assessment (CGA)Team huddles

The CGA huddles took place twice a day and included: Consultant Geriatrician, Advance Nurse Practitioner, representatives from Adult Social Work Services, AHP, Pharmacy, Scottish Ambulance Service, Closer to Home team and Psychiatric Liaison Nurse. During the week 12 patients were assessed as suitable for Discharge to Assess.

Discussions are ongoing regarding the implementation of the Frailty Pathway to enable this to be a sustainable approach to assessment and planning appropriate care for patients.

4.5 **Discharge to Assess**

The Discharge to Assess pilot began on 13 December 2016. The pilot is based on the evidence from NHS Fife and is designed to dovetail with the Frailty pathway in the Emergency Department and Acute Assessment Unit. The pilot aims to prevent admissions and to reduce length of hospital stay and delays in discharge through supported early discharge of people over 65 years for assessment and care at home.

There has been a good level of engagement and commitment between hospital and community based health and social care staff to ensure the success of the pilot, including regular attendance at the Project Team meetings and review sessions.

The Project Team meets weekly and will continue to meet to monitor progress and take action to address emerging risks and issues. There are some issues with the daily huddles that are being addressed through the Project Team. The elements of the Frailty Model have not continued as anticipated beyond the test of change week noted at 4.4. The daily huddles are the engine room for multi-disciplinary assessment and decisions and therefore have an impact on the ability to fully test the model. The Project team has also recently identified an issue with tracking patients who have been admitted for 24 /48 hours to support their timely discharge. This has resulted in constructive involvement from the Acute Directorate to identify clerical support to support the team to collect information required for the daily huddles and to follow up/track patients who are admitted. It is anticipated this support will be made available in the near future.

The pilot is also under weekly review with practitioners and the care provider to ensure any emerging care related issues are appropriately addressed.

There is also continued dialogue between the Chief Officer and:

- General Manager – Medical Directorate
- Discharge to Assess Project Team
- General Manager - Community Services Directorate
- Falkirk Delayed Discharge Steering group
- Falkirk Council procurement team.

<u>Discharge to Assess Performance</u>
As of 18 January 2017, in summary:

- 64 people have been assessed and received care from the care provider
- 25 people have been discharged from the service
- 15 of whom are receiving on going care
- people have been readmitted
- 1 person is being supported by the Reach team but needs no care package
- 1 person died following readmission
- people need no care package.

The following table 1 provides information on the average length of service of those discharged from the care provider.

Table 1

Number of people with completed a care package	25
Total Number of Days Service	126
Average Number of Days Service	5

The IJB has committed considerable financial investment to tackle the underlying causes of delayed discharge. While the pilot is demonstrating positive impact, more support is required to properly test the model and realise the full potential.

The pilot is due to run until mid-March 2017. If it is found to be successfully preventing admissions and reducing delays in discharge to achieve the Scottish Government target, it will be helpful to extend the pilot to help sustain improvement and to support the closure of the Winter Plan beds. It is proposed that in this circumstance the IJB remit the Chief Officer, in discussion with the Chief Executives and Chief Finance Officer to take appropriate action to extend the pilot period to sustain improvement while services are developed to adopt this model.

Decisions would utilise funds at the disposal of the IJB, including Partnership Funding, and any actions taken would be reported at the next IJB Meeting.

5. PRIMARY CARE AND GP UPDATE

5.1 NHS Forth Valley and NHS Fife have been working closely with the Scottish Government's Health Workforce Directorate and NHS Education for Scotland (NES) over the last year to design, test and support the development of a new career model for GPs (GP Fellowship). On the 9 January 2017 NHS Forth Valley introduced three GP Fellows to work across the interface between primary and secondary care.

5.2 This is a project that also aims to test a new model to contribute to supporting people to remain well at home. The project will commence in the Bo'ness, Grangemouth, Braes (BGB) locality for frail elderly patients and those with complex multi-morbidities. Their key focus will be to avoid unnecessary admissions to hospital.

5.3 The drivers are to:

- improve personal resilience and reduce the time people spend in hospital rather than at home
- aim to Increase sustainable seven day services in hospital and the community
- alleviate access pressure in general practice which in some cases leads to presentations at ED

- deliver improved care in the community; supporting a more coordinated health and social care response to patient's need particularly during times of crisis
- increase the number of doctors able to assess and manage patients with more complex multiple conditions
- address the national shortage of GPs in Scotland and provide an opportunity to develop a more varied approach to the working pattern which may appeal to some GPs and could be more attractive at certain stages of a career.

5.4 The GP Fellows will be integrated within the existing Closer to Home model and provide the medical input to the Enhanced Community Team. The GP Fellows will provide cover 8am – 6pm, Monday to Friday and will:

- be integrated with and provide the medical input to the Enhanced Community Team under the broader Closer to Home model of care, including rapid access to diagnostics.
- manage at least 1 step-up hospital bed in Bo'ness Community Hospital.
- work a minimum 2 sessions a week (FTE) hosted by a GP Practice to remain on the Performers List.
- have 1 session a week (FTE) SPA.

5.5 GP Fellows are anticipated to add value particularly in their ability to work with colleagues to identify and provide medical input to:

- people who are at risk or who are on the verge of admission
- people whose needs are escalating / health & wellbeing or means of support are deteriorating e.g. carer is becoming ill or less able to provide support.

5.6 Initially the model will focus on supporting frail elderly patients and those with complex multi-morbidities resident in the Bo'ness, Grangemouth and Braes Locality. Information collected will be used to improve the model and guide a phased expansion to other localities in Forth Valley from January to May 2017. The Scottish Government has commissioned an external evaluation of aspects of the project.

6. IJB FINANCIAL UPDATE

6.1 The Leadership group has been meeting regularly to monitor the Recovery Plan and is now beginning work to develop the budget strategy for 17/18. An update on the budget position is detailed in the IJB report at agenda item 6.

7. CHIEF FINANCE OFFICER POST

7.1 A verbal update will be provided at the meeting.

8. HSCP LEADERSHIP TEAM AND SERVICE ARRANGEMENTS

8.1 There continues to be discussion to secure the appropriate level of representation at the Leadership team meeting. A 'Collaborative Leadership in Practice' (Clip) workshop is being arranged with support from the iHub from NHS Education for Scotland (NES), to bring the strategic leads for in-scope services together. This provides an excellent opportunity for strategic leads to shape the Leadership Group in its early stages of development. It would be beneficial to secure representation at the earliest opportunity to enable this external support to start.

8.2 Discussions are ongoing in relation to the requirements to confirm the ongoing resource commitments and set out in the Support Services agreement. An update will come to the next Board meeting.

9. DELAYED DISCHARGE

9.1 As of the December census date, in relation to delays which count towards the national, published delayed discharge target (standard delays), there were:

- 37 people delayed in their discharge
- 26 people who were delayed for more than 2 weeks
- 5 people identified as a complex discharge (code 9)
- 7 people proceeding through the guardianship process
- 3 people identified as a Code 100 delay.

9.2 Table 2 below shows the total number of delays. This position remains an ongoing challenge and is being closely monitored.

Table 2 (excluding Code 9 & Code 100)

	Dec '15	**Jan '16**	**Feb '16**	**Mar '16**	**Apr '16**	**May '16**	**Jun '16**	**Jul '16**	**Aug '16**	**Sep '16**	**Oct '16**	**Nov '16**	**Dec '16**
Total delays at census point	35	27	23	29	27	23	32	45	51	46	39	35	37
Total number of delays over 2 weeks	24	20	14	18	18	12	18	30	33	29	25	22	26

9.3 Table 3 shows the total picture of delays in Falkirk Partnership across all categories expressed as occupied bed days. These figures are for full months to the end of November and show increasing pressure on bed days compared with February 2016.

Table 3 - total occupied bed days in 2016

	Nov '15	**Dec '15**	**Jan '16**	**Feb '16**	**Mar '16**	**Apr '16**	**May '16**	**Jun '16**	**Jul '16**	**Aug '16**	**Sep '16**	**Oct '16**	**Nov '16**	**Equiv Beds (Nov)**
Standard delays	1001	1085	926	797	990	975	875	854	1247	1468	1432	1393	1247	40
Complex Delays / Guardianship (Code 9)	231	248	236	217	265	277	186	158	256	275	376	454	374	12

9.4 **Delayed Discharge Performance: Meeting with Shona Robison, Cabinet Secretary for Health and Sport**

In December, the Health Board Chief Executive and the Chief Officers of the Health and Social Care Partnerships in Forth Valley met with the Shona Robison, Cabinet Secretary for Health and Sport. The purpose of the meeting was to discuss performance against the national delayed discharge target and the actions the Health Board and both IJB Partnerships intend to implement to improve the position.

This was a constructive meeting the outcome of which was agreement that by the end March, Forth Valley will have delivered a fifty percent reduction in the numbers of people delayed in their discharge. This includes all standard and code 9 discharges but not code 100 delays, against the November census baseline.

The trajectory below shows what the Falkirk Partnership requires to deliver to achieve the agreed reduction and the progress as at December census point. This shows that the Partnership is on trajectory however it should be noted that improvements to date have been in package of care delays. Care home delays continue to be a challenge with overall numbers of people waiting for a care home remaining high (currently 30).

Falkirk 2016/17 – Trajectory

	December	January	February	March	April
Target	56	47	42	34	30
Actual	49				

9.5 **Delayed Discharge Improvement Plan**

The Partnership Delayed Discharge Steering Group has developed an Improvement Plan which covers in a single plan all of the strategic and operational actions that partners require to take to improve and maintain the delayed discharge position. A copy of the Plan is attached at Appendix 1 for information and to provide assurance to the Board of the commitment to delayed discharge as a key priority. Updates on elements of the Plan will be provided on an ongoing basis as appropriate with a proposal that a full update is provided to the IJB on a six monthly basis.

9.6 **Winter Beds**

Ward 5, Falkirk Community Hospital remains open to provide planned additional bed capacity over the winter period and funded through the Health Board's Winter Plan. The ward will close at the end of March 2017. Given the continuing challenges the Chief Officer will report back to the Special meeting proposed in the IJB Financial Report to provide an update on any action required in relation to ward 5, Falkirk Community Hospital.

10. TRANSFER OF OPERATIONAL RESPONSIBILITY FOR NHS COMMUNITY SERVICES TO CHIEF OFFICER

10.1 Arrangements are progressing to transfer operational responsibility for Community Mental Health and Community Learning Disability Services to the Chief Officer from 1 February 2017. These services have a longstanding track record of joint working to improve services and outcomes for people with a serious mental health problem or people who have complex needs relating to their Learning Disability.

10.2 Learning Disability Health and Social Care Community Services have worked within an integrated team arrangement for a number of years with a joint team manager, hosted by Falkirk Council. The team is co-located in Council accommodation in Camelon.

10.3 Community Mental Health staff across health and social care in Falkirk have been co-located in Woodlands Resource Centre since it opened in 2015. Significant progress has been made since then to improve joint processes including joint assessment to improve the pathway for patients.

10.4 Transferring operational responsibility for the day to day management of these services to the Chief Officer is an important next step in the development of integrated provision at the frontline.

10.5 Scoping the workforce and budgets to be transferred is complete. Initial discussions have taken place with staff side and arrangements are being made to meet with managers and staff groups ahead of the transfer. There is no change to the terms and conditions of services for frontline staff or to their immediate line management reporting arrangements.

10.6 The Health Board will make the necessary adjustments to enable the Chief Officer to have full delegated responsibility for these services.

10.7 At the time of writing the report a few outstanding issues are being discussed: access to clinical advice and support; amendment to the NHS scheme of delegation; management allocation; and full detailed budget breakdown.

10.8 Scoping work for a second phase of operational transfer of Community Health Services has commenced.

11. SCOTTISH GOVERNMENT CORRESPONDENCE

11.1 **Draft Budget 2017/18**

Correspondence received from the Scottish Government dated 15 December 2016 is attached at Appendix 2. The letter set out how financial arrangements for the Scottish Government's draft budget relate to Integration Authorities. The letter also set out plans to ensure the Ministerial Strategic Group for Health and Community Care have oversight on progress with implementation of integration.

Integration Authorities are responsible for planning and provision of social care, primary and community healthcare, and unscheduled hospital care, for, at least, adults. Integration priorities are to:

1. Reduce occupied hospital bed days associated with avoidable admissions and delayed discharges, focussing investment in care alternatives that can help people to continue living independently in their own homes and communities for as long as possible.

2. Increase provision of good quality, appropriate palliative and end of life care, particularly in people's own homes and communities and also, where appropriate, in hospices, so that people who would benefit from such care access it.

3. Enhance primary care provision, with particular focus on developing and expanding multi-disciplinary teams; sustainability of provision; development of GP clusters; and responsiveness to a new GP contract.

4. Reflect delivery of the new Mental Health Strategy, with particular focus on developing new models of care and support for mental health in primary care settings; improving the physical health of people with mental health problems, and improving mental health outcomes for people with physical health conditions; reducing unwarranted variation in access and assuring timely access; and developing services that focus on the mental health and wellbeing of children, young people and families, including improved access to perinatal mental health services.

5. Where children's services are integrated, continue to invest in prevention and early intervention, particularly in the early years, with the expectation that work will continue to deliver 500 more health visitors by 2018.

6. Support delivery of agreed service levels for Alcohol and Drugs Partnerships' work, in support of which £53.8m is transferring to NHS Board baselines for delegation to Integration Authorities.

7. Ensure provision of the living wage to adult care workers and plan for sustainability of social care provision.

8. Continue implementation of Self Directed Support.

9. Prepare for commencement of the Carers (Scotland) Act 2016 on 1 April 2018.

11.2 **Measuring Performance under Integration**

A Scottish Government letter is attached as Appendix 3 and was received on 19 January indicating that the Ministerial Strategic Group for Health and Community Care (MSG) invites each Integration authority to set out local objectives for each of 6 indicators for 2016/18 listed below by the end of February and thereafter submit a quarterly overview on progress to the MSG.

1. Unplanned admissions
2. Occupied bed days for unscheduled care
3. A & E performance
4. Delayed discharges
5. End of life care
6. The balance of spend across institutional and community services.

The Leadership Group, with support from the Performance Workstream group, will coordinate the work required in relation to both letters. This will include a review of the Strategic Plan and current relevant delivery plans and performance indicators to produce the required plan for consideration by the MSG.

11.3 **Primary Care Transformation: New GMS Contract Framework**
The Deputy Director and Head of Primary Care wrote to Chief Officers and Chief Executives on 3 November 2016. The letter and Memorandum set out how the Scottish Government and Scottish General Practitioners Committee (SGPC) will work together over the next few years to transform the GMS Contract. This will be in the context of wider transformation of primary care services.

At the heart of this is a transformation in how the role of Scotland's GPs are defined moving away from GPs as providers of defined services to GPs fulfilling a critical leadership role within wider multi-disciplinary teams, with specific responsibilities for dealing with complex care, undifferentiated presentation and local clinical leadership. The correspondence notes GPs will have to retain responsibilities for services considered as essential.

The letter and Memorandum draw out two of the main consequences:

- this change in role requires the Scottish Government to review how GPs are paid in future. Following the abolition of QOF the Scottish Government has agreed with SGPC that it will review the current pay structure with all options within scope. This review will take place in 2017 with recommendations in place for changes to begin in 2018, with an extended transition period likely to be needed to ensure stability

- in relation to how the Scottish Government ensure this redefined role for Scotland's GPs fits appropriately into local services, there will have to be a substantial emphasis on collaborative working between the Scottish Government, SGPC, Integration Authorities and NHS Boards in the months and years ahead.

11.4 Progress reports on the required areas of work will be through the Chief Officer's report.

12. PUBLICATIONS

12.1 The Scottish Government published its Health and Social Care Delivery Plan on 19 December 2016. The plan sets out the high-level actions and delivery framework for the key programmes of activity to realise the vision for health and social care in Scotland. The Scottish Government will work closely with partners on the detailed planning to implement those actions across Scotland.

13. CONSULTATIONS

13.1 **National Health and Social Care Standards**
The purpose of the new National Health and Social Care Standards (the Standards) is to set out what we can expect when we use health and social services in Scotland. This includes a diverse range of services from childminding and daycare for children in their early years, housing support and care at home for adults, to hospitals, clinics and care homes. From Spring 2018, the new Standards will provide a framework for registration and inspection of individually registered care and health services, but they will also be relevant to all care and health services including those not inspected by the Care Inspectorate or Healthcare Improvement Scotland.

13.2 The original 2002 Standards mainly looked at technical requirements, such as written policies and health and safety procedures. The new Standards need to reflect recent changes in policy and practice and also be fit for the future. How we inspect health and social care services has also changed. The Care Inspectorate and Healthcare Improvement Scotland continue to regulate each individually registered health and social care service, they also now work with other regulators and scrutiny bodies to carry out strategic inspections. These inspections look at how the wider health, social work and social care system is working for children or adults in a local authority and health board area. The new Standards need to be fit for purpose for assessing how well people's care needs are met on both a strategic and an individual service level.

13.3 The Scottish Government propose the following new Standards apply across health, care and social work services:

1. I experience high quality care and support that is right for me
2. I am at the heart of decisions about my care and support
3. I am confident in the people who support and care for me
4. I am confident in the organisation providing my care and support
5. And if the organisation also provides the premises I use
6. And if my liberty is restricted by law
7. And if I am a child or young person needing social work care and support.

The first four headings set out Standards for everyone. These are complemented by three additional headings with Standards that only apply in specific circumstances.

13.4 There are additional standards for people experiencing restricted liberty and for children and young people who need social work support.
Standards 6 and 7 reflect these particular care and support needs, and are different from, and additional to, those covered by the other Standards that are applicable to everyone.

13.5 The deadline was 22 January 2017 for comments on the draft standards. The response submitted is attached at Appendix 4 for information.

14. CONCLUSIONS

14.1 A strategic approach is required to address the range of issues that result in the current pressures faced and in realising the potential opportunities to work collaboratively to improve outcomes for service users and carers in Falkirk.

14.2 It is proposed that this is addressed through a 3 year plan as part of a wider Change programme underpinning the delivery of the Strategic Plan.

Resource Implications
The Chief Finance Officer will continue to report through the IJB Financial Budget and Recovery Plan.

There remains commitment from all partners to ensure the Partnership meet its statutory obligations under the Public Bodies (Joint Working) (Scotland) Act 2014 and the ongoing commitment will be confirmed in a future report to the Board on the Support Service agreement.

Impact on IJB Outcomes and Priorities
The delivery plan, change programme and infrastructure are being designed to deliver the outcomes described in the Integration Scheme and Strategic Plan.

Legal & Risk Implications
Risk issues will be considered as required.

Consultation
As the programme is developed staff, communities and stakeholders will be consulted in the development of the plans.

Equalities Assessment
There will be appropriate consideration of the equalities implications and equalities impact assessments will be completed as the programme develops.

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Approved for submission by: Patricia Cassidy, Chief Officer

Author – Suzanne Thomson, Programme Manager
Date: 25 January 2017

List of Background Papers:
Appendix 1 – Delayed Discharge Improvement Plan
Appendix 2 – Scottish Government Letter of 15 December 2016
Appendix 3 – Scottish Government Letter of 19 January 2017
Appendix 4 – National Care Standards Consultation Response

NHS Forth Valley

Falkirk Council

Falkirk Health and Social Care Partnership Delayed Discharge Action Plan

No	Drivers	Actions	Lead	Timescale	Progress	RAG
Avoiding Unplanned Admission						
1	Anticipatory care and crisis prevention	1.1 Design and implement new universal Single Shared Assessment framework with focus on anticipatory care planning	General Manager, Community Services, NHS	1.1 March 2017	Forth Valley wide Single Shared Assessment developed and being tested	
		1.2 Develop information sharing systems to allow assessments, including ACPs, to be shared across services to inform care delivery		1.2 March 2017	ICT leads developing options within existing systems to share information	
		1.3 Deliver training for staff in anticipatory care planning		1.3 March 2017	Review of ACP's being taken forward through multiagency ACP Steering Group	
		1.4 Review Anticipatory Care Plans and ensure that these are targeted towards the most appropriate care groups, including patients with respiratory conditions (from Winter Plan)		1.4 Feb 2017	As above	
2	Unscheduled Care Pathways	2.1 In conjunction with Falkirk partnership review and implement unscheduled care pathways for Falls Prevention	General Manager, Community Services/ Service Manager – Care at Home AHP Manager Acute & Rehab & Service Manager for comm. hospitals	2.1 March 2017	Progress ongoing. Being taken forward on a Forth Valley wide basis. Discussion taking place with SAS on uninjured falls pathway.	
		2.2 Review how pathway can be adapted for wider application to other conditions other than falls – e.g. infections, acute exacerbation of chronic conditions etc				

Falkirk Health and Social Care Partnership Delayed Discharge Action Plan

No	Drivers	Actions	Lead	Timescale	Progress	RAG
3	Risk identification, management and care co- ordination	Implement system to identify those at highest risk of admission	General Manager, Community Services	4.1 March 2017	Part of ACP Review Project	✅
4	Frailty Care Pathway	4.1 Develop a whole system Frailty Pathway and Comprehensive Geriatric Assessment process	General Manager - Medical Directorate	4.1 December 2016	Test of proposed change taking place in Falkirk during November 2016. Learning will be rolled out across both Partnership areas during 2017.	✅
		4.2 Review the existing frailty service jointly with Clackmannanshire and Stirling Partnership		4.2 March 2017		
5	Provision of reablement (AHP) services	5.1 Review ICF funded reablement services that will develop a strategic approach to intermediate care pathway, including frailty and reablement.	5.1 Programme Manager Service Manager –	June 2017	Work has commenced to review reablement services funded through ICF. To date three workshops have been held with relevant officers. Two further workshops are scheduled for February and march in conjunction with NES.	✅
6	Intermediate Care availability	6.1 Streamline access to the range of intermediate care services as an alternative to emergency admission and to enable discharge. This includes the Discharge to Assess model.	General Manager – Medical Directorate	6.1 December 2016	Test of Change for the Discharge to Assess model completed in FVRH ED w/c 6 November. Results being analysed to inform the roll-out of the pilot. Joint workshop held on 15 November and work underway to finalise arrangements for provider starting week	✅

Falkirk Health and Social Care Partnership Delayed Discharge Action Plan

No	Drivers	Actions	Lead	Timescale	Progress	RAG
					beginning 5 December Additional OT capacity being used to facilitate discharge to assess model as part of the Frailty Pathway framework Work with an independent care provider is well advanced to support the Discharge to Assess model	
		6.2 Facilitated session with Geriatricians and Physicians to be arranged for Jan/Feb to further embed D2A and Frailty.	General Manager – Medical Directorate	6.2 February 2017		
		6.3 Ensure the correct resources are targeted at different parts of the patient's journey where they can add the most value (links to the work already being done through the Closer to Home Pathway)	General Manager – Medical Directorate/ General Manager – Community Services	6.3 January 2017	GP Fellows will commence work with the Enhanced Community Team and expand patients that can be supported.	✅
		6.4 Extend the capacity for a reablement approach through the deployment of assessment and care at home services.	Head of Adult Social Work Services	6.4 March 2017	Three workshops with key reablement staff across the partnership have been facilitated.	✅
7	Provision of Social Work Services	7.1 Review eligibility criteria for Social Work Services and implement revised framework	7.1 Head of Adult Social Work Services	7.1 April 2017	7.1 Review of eligibility criteria will be considered by the Falkirk IJB on December 2016. Subject to approval, the proposal is to implement a new	✅

Falkirk Health and Social Care Partnership Delayed Discharge Action Plan

No	Drivers	Actions	Lead	Timescale	Progress	RAG
					framework for 1 April 2017. This will ensure the better targeting of resources.	
		7.2 Proactively review care packages including home care packages to identify whether there is ability to release capacity; this will be in line with eligibility criteria and a reablement focus	7.2 Service Manager – Community Care Teams	7.2 Ongoing	Adult SW Services review team established to review identified cases within a reablement focus. Care at Home staff actively reviewing care packages.	
		7.3 Actively managing the commissioning process for care at home and care home services through the Procurement Team	7.3 Head of Adult Social Work Services	7.3 Ongoing	Procurement team and Central Matching Team are actively managing this, including regular dialogue with providers to source POCs, grouping them in geographical groups where possible. Timeframe for POC retention due for hospital admissions extended to 2 weeks to reduce need to resource POC after hospital stay.	
		7.4 Develop a new Care at Home contract tendering framework which will facilitate a responsive service based on a reablement ethos	8.4 Head of Adult Social Work Services/ Procurement Team	7.4 October 2017	Market Facilitation Plan developed. Tendering process to commence in March 2017 with the aim to have a new contract in place for October 2017.	

Falkirk Health and Social Care Partnership Delayed Discharge Action Plan

No	Drivers	Actions	Lead	Timescale	Progress	RAG
8	Provision of appropriate Care Home Services	Review of bed based care, including long-term, intermediate and respite provision	Head of Adult Social Work Services	March 2017	Intermediate care beds at Summerford increased from 10 to 20 Capacity modeling work being undertaken by the Partnership, supported by TRIST, which will incorporate bed based care Liaison ongoing with Procurement Team and a new local care home (capacity 33 care of the elderly beds) scheduled to open in December 2016	
9	Access to community response services	9.1 Review partnership out of hours health and social care services, to progress work on preventing unnecessary admissions.	General Manager, Community Services, NHS / Head of Adult Social Work Services	3.1 March 2017	The service has extended the age range for people to access the scheduled night service. An additional 2 staff have been recruited to extend service available through the Social Care 24 hour team to support more people to return home and prevent admission to care homes.	
		9.2 Identify gaps in community response provision		3.2 March 2017	Developing a reablement approach	

Falkirk Health and Social Care Partnership Delayed Discharge Action Plan

No	Drivers	Actions	Lead	Timescale	Progress	RAG
		9.3 Extend provision of telecare and telehealth services and response availability		3.3 March 2017		✓
		9.4 Work with SAS, Independent and Third sectors to develop new models of community responder services and increase the capacity of the Independent and Third sector to respond effectively		3.4 Ongoing	Both HSCP's are involved in the development of the Transforming Out-of-Hours services proposal and test of change	✓
Delayed Discharge From Hospital						
10	Care co- ordination in hospital	As part of the ICF monitoring process, complete a review of Discharge Hub arrangements and make any necessary changes to improve the efficient operation of the Hub. This will be a joint review with Clackmannanshire and Stirling Partnership	General Manager – Community Services	March 2017	The Discharge Hub is regularly monitored through the ICF arrangements. A joint review is underway and will report to the IJB in March 2017.	✓
11	Application of Choice to interim placement	Review application of process to confirm it is being applied robustly in relation to both discharges to the community and care homes.	General Manager, Community Services, NHS / Head of Adult Social Work Services	March 2017	Audit to be undertaken	
12	Use of Care Experience Feedback Questionnaire	12.1 Develop a Care Experience Feedback questionnaire for all individuals and carers who have experienced hospital admission and discharge	General Manager, Community Services	March 2017		✓
		12.2 Utilise results to inform ongoing improvements		Ongoing		

Falkirk Health and Social Care Partnership Delayed Discharge Action Plan

No	Drivers	Actions	Lead	Timescale	Progress	RAG
13	Data	13.1 Agree data set and reporting framework and governance	General Manager, Community Services, NHS / Head of Adult Social Work Services	March 2017	Work has been completed to agree a data set that is reported regularly to the IJB	✓
		13.2 Develop a Delayed Discharge Patient Tracking system to assist in identifying key points in the pathway through hospital to address blockages			Further work is ongoing to develop a reporting framework for Delayed Discharges across the system. Work to collate process flow maps and volume charts is ongoing.	
Winter Plan 2016/17 [additional short term focused activity]						
14	Management of staffing capacity	Proactive planning and management of annual leave and staffing rotas across all services to ensure limited interruption to service during the festive period and to meet the predicated demand	General Manager – Medical Directorate/ General Manager – Community Services/ Head of Adult Social Work Services	October 2016	Complete – management of leave and cover arrangements in place. Festive Plan produced, Rotas in place completed	✓
15	Minimising Delayed Discharge	15.1 Increase the fortnightly Delayed Discharge tactical group meetings to weekly over the winter period and escalate to a daily discharge huddle when required.	Service Managers – NHS and Falkirk Council	Ongoing	In place, subject to weekly review, dependent on hospital capacity	✓
		15.2 Maximise the discharges in lead into the festive period with emphasis on: ▪ 22/23 Dec ▪ 29/30 Dec ▪ 4/5/6 Jan 2017	Service Managers – NHS and Falkirk Council	Complete		

Falkirk Health and Social Care Partnership Delayed Discharge Action Plan

No	Drivers	Actions	Lead	Timescale	Progress	RAG
		15.3 Ensure patients over 14 days LOS (Length of Stay) have an action plan agreed with an appropriate member of senior staff.	General Manager – Medical Directorate		All patients with LOS have action plan in place agreed with key stakeholders/Discharge Hub. Evidence of reduction in last year	
		15.4 Review process and include timescales for each stage of the process for Adults with Incapacity and Guardianship to minimise delays.	General Manager – Community Services/ Head of Adult Social Work Services	December 2016	Weekly review of guardianships undertaken. Wider review of process still to be undertaken.	
		15.5 Develop practice guidance in relation to AWI for all services, including providers, supplemented by public awareness raising Increase public awareness of AWI issues generally and specifically to increase the number of people with POA	General Manager – Community Services	Ongoing	Work being co-ordinated through CVS Falkirk Public awareness campaign started in May 2016, supported by community organisations such as Making it Happen and Solicitors for Older People.	
16	Discharge Planning	16.1 Re-launch the Admission and Discharge Policy with clear pathways, and roles and responsibilities across health and social care services, supported by training for managers and staff.	General Manager – Medical Directorate/ General Manager – Community Services/ Head of Adult Social Work Services	16.1 December 2016	Consultation on revised policy complete Education sessions have been rolled out across acute and community hospital services Final amendments to policy now being made	
		16.2 Improve written information by reviewing the discharge pack for use in each hospital.	General Manager – Medical Directorate	January 2017	Ongoing, will be complete by February	
		16.3 Refresh the discharge target for each ward, matching this to predicted demand and improve timely use and accuracy of Predicted Date of	Executive Nurse Director/ Associate Nurse Director	Ongoing		

Falkirk Health and Social Care Partnership Delayed Discharge Action Plan

No	Drivers	Actions	Lead	Timescale	Progress	RAG
		Discharge, including the percentage of discharges that are criteria led.				
		16.4 Implement and monitor criteria led discharge to empower front-line staff in risk based decision making aligned to Institute of Healthcare Optimisation (IHO) ward based programme	General Manager – Medical Directorate Executive Nurse Director			
17	Discharges at Weekends and Bank Holidays	17.1 Optimise allocation of AHP staffing to support rehabilitation at weekends in both acute and community to increase the number of weekend discharges	General Manager – Medical Directorate		Complete	✅
		17.2 Enhance weekend and evening cover by extending the Discharge Lounge opening hours, increasing OT cover through the REACH service and providing Community Nursing and additional carers via Closer to Home	General Manager – Medical Directorate	Now	Complete	✅
		17.3 Utilise weekend pharmacy services help to facilitate weekend discharges, including the out of hours on-call pharmacy service.	General Manager – Medical Directorate	Ongoing	Complete	
		17.4 Continue to admit patients at the end of life, with clear management plans, direct to Bo'ness Community Hospital and explore extending direct access for patients at the end of life to the other community hospitals.	General Manager – Medical Directorate	Ongoing	Complete	✅
18	Hospital Flow	Implement a test of change over 7 days to identify, assess and discharge frailty patients at the Emergency Department.	General Manager – Medical Directorate	Now	Complete	✅

Falkirk Health and Social Care Partnership Delayed Discharge Action Plan

No	Drivers	Actions	Lead	Timescale	Progress	RAG
19	Care at Home	Investigate the potential role of the nurse bank in bringing additional staffing capacity to the care at home service	Service Manager – Care at Home/ Service Manager, NHS	November 16	Additional capacity has been identified and necessary HR checks are being progressed	
		Contact additional non contract , out of area home care providers to explore the option of them bringing additional home care capacity	Procurement & Commissioning Team	Ongoing	Discussions are ongoing with providers and additional care package hours have been commissioned as a result of this	

	On target		Risk of delay		Significant Issues

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Appendix 2

Ms Shiona Strachan – Chief Officer –
Clackmannanshire and Stirling Integration Authority

Ms Patricia Cassidy – Chief Officer – Falkirk
Integration Authority

15 December 2016

Draft Budget 2017/18

Dear Colleagues

We are writing to you regarding the Scottish Government's draft budget for 2017/18, as set out by the Cabinet Secretary for Finance and the Constitution in Parliament today. Letters have also been sent today to Local Authorities and the NHS regarding the budget. This letter lays out how these financial arrangements relate to Integration Authorities. Please take account of all three letters to ensure a full understanding of the financial position and its implications for your responsibilities for the coming year.

This letter also sets out our plans to ensure the Ministerial Strategic Group for Health and Community Care, which is chaired by the Cabinet Secretary for Health and Sport, is well-briefed to fulfil its remit to provide joint political oversight between COSLA and the Scottish Government on progress with implementation of integration.

Priorities

Integration Authorities are responsible for planning and provision of social care, primary and community healthcare, and unscheduled hospital care, for, at least, adults. Integration priorities are to:

1. Reduce occupied hospital bed days associated with avoidable admissions and delayed discharges, focussing investment in care alternatives that can help people to continue living independently in their own homes and communities for as long as possible.

2. Increase provision of good quality, appropriate palliative and end of life care, particularly in people's own homes and communities and also, where appropriate, in hospices, so that people who would benefit from such care access it.

3. Enhance primary care provision, with particular focus on developing and expanding multi-disciplinary teams; sustainability of provision; development of GP clusters; and responsiveness to a new GP contract.

4. Reflect delivery of the new Mental Health Strategy, with particular focus on developing new models of care and support for mental health in primary care settings; improving the physical health of people with mental health problems, and improving mental health outcomes for people with physical health conditions; reducing unwarranted variation in access and assuring timely access; and developing services that focus on the mental health and wellbeing of children, young people and families, including improved access to perinatal mental health services.

5. Where children's services are integrated, continue to invest in prevention and early intervention, particularly in the early years, with the expectation that work will continue to deliver 500 more health visitors by 2018.

6. Support delivery of agreed service levels for Alcohol and Drugs Partnerships' work, in support of which £53.8m is transferring to NHS Board baselines for delegation to Integration Authorities.

7. Ensure provision of the living wage to adult care workers workers and plan for sustainability of social care provision.

8. Continue implementation of Self Directed Support.

9. Prepare for commencement of the Carers (Scotland) Act 2016 on 1 April 2018.

Ministerial Strategic Group for Health and Community Care

As you know, the Ministerial Strategic Group for Health and Community Care provides the forum for joint political oversight of progress with integration by Scottish Ministers and COSLA. The Group has recently considered its requirements in terms of understanding progress on integration. We will take forward work involving Scottish Government officials, COSLA, Chief Officers, and colleagues at NHS NSS leading on the Source and LIST data projects, to establish a suite of appropriate metrics for the Group's routine consideration. This will include agreeing data definitions and an appropriate methodology via which Integraton Authorities can share their objectives for progress in 17/18 and beyond; we will also ensure the work is tied in with Sir Harry Burns' review of health and social care targets and indicators.

You will see from Christine McLaughlin's letter to Health Boards on the budget that we also intend to give some consideration to the efficacy of current arrangements for delegating appropriate hospital budgets, including set aside budgets, to Integration Authorities. We will report on that to the Ministerial Strategic Group in due course as well.

I trust this letter is helpful to you, and look forward to continuing to work with you as we embed integration across health and social care in Scotland.

Yours faithfully

Geoff Huggins

Paula McLeay

GEOFF HUGGINS
Scottish Government

PAULA McLEAY
COSLA

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COSLA

To: Chief Officers – Integration Authorities

19 January 2017

Dear Colleagues

MEASURING PERFORMANCE UNDER INTEGRATION

The Ministerial Strategic Group for Health and Community Care (MSG) discussed how to measure progress under integration at its meetings on 16 November and 21 December.

At the meeting on 21 December MSG agreed that for 2017/18 we will track across Integration Authorities:

(1) unplanned admissions;
(2) occupied bed days for unscheduled care;
(3) A&E performance;
(4) delayed discharges;
(5) end of life care; and
(6) the balance of spend across institutional and community services.

You are each invited to set out your local objectives for each of the indicators for 2017/18 by the end of February. MSG has agreed that it will receive a quarterly overview on progress across the whole system and you are asked to produce your objectives on that basis. We are meeting with the Executive Group of Chief Officers on Friday and will discuss what national support you would want us to offer for this process. Our objective will be to adapt and use existing data collection methodologies where possible and to establish a clear process for the work.

When we met on 16 December we had indicated that as a minimum we would provide data for each partnership covering each of the indicators. The data would show the position for all partnerships to enable individual Integration Authorities to understand the shape and

nature of their service relative to others. We are still working on the structure and format of that data. For now, we attach high level data covering a number of the areas (**Annex A**). Again we would intend to use the conversation on Friday to discuss the structure and format of the data with the intention of writing shortly after to all Chief Officers with the necessary material.

MSG noted that the approach for future years may change as a consequence of the Review into Targets and Indicators being undertaken by Sir Harry Burns and also as data sources for particular areas of service delivery improvement. It also noted that most key service delivery areas under integration have a direct impact on these higher level system indicators. In particular, it is important that we are able to understand both the contribution of social care and primary care services to these higher level system indicators, but also how they support important outcomes in respect of independent living and the protection and maintenance of health.

Local partnerships are already using a wide range of data to support their commissioning and delivery activity and will continue to operate under the duties in the 2014 Act in respect of public reporting. This process is not intended to duplicate or substitute for that process.

The Local Delivery Plan (LDP) Guidance for 2017/18 has been issued to NHS Chief Executives and sets the expectation that Boards and regional planning partnerships ensure that their objectives and plans are consistent with Integration Authority plans. Similarly, given the interaction with the hospital system you will need to ensure that your objectives and plans are consistent with NHS Board and regional plans for 2017/18.

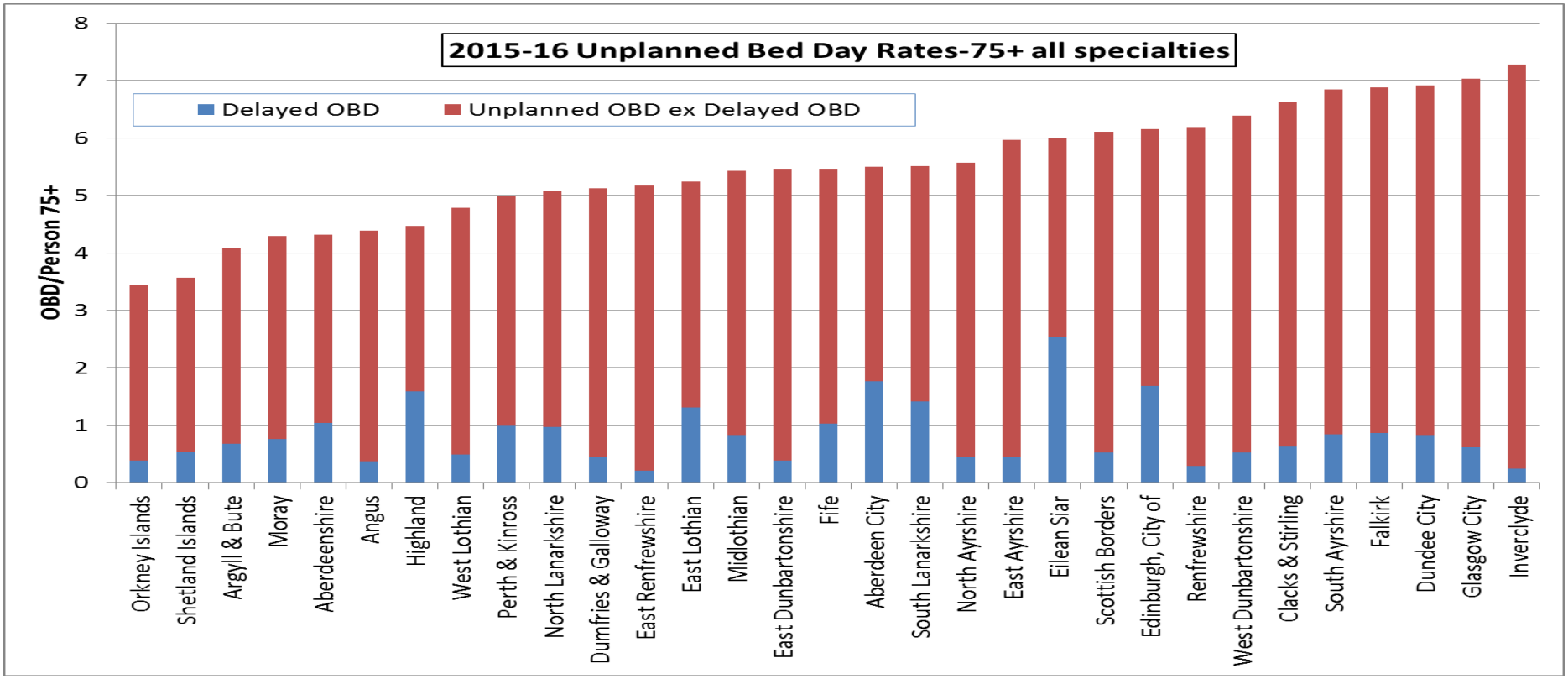
Yours sincerely

GEOFF HUGGINS
Scottish Government

PAULA McLEAY
COSLA

Annex A: example of data on key indicators

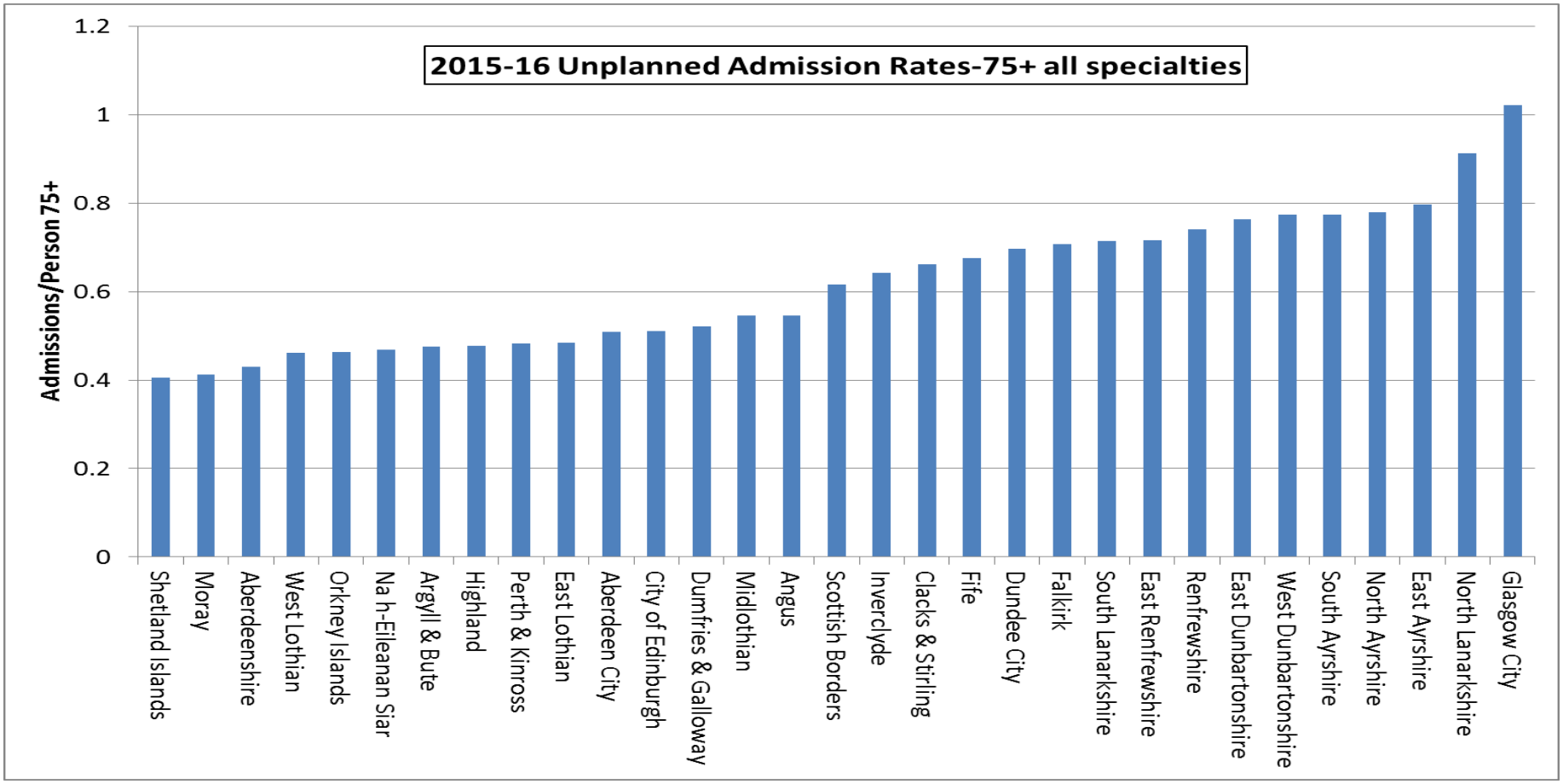
Unplanned Bed Days



Notes: This chart shows the unplanned bed days per capita for people aged 75+ for each partnership (in 2015/16). It is for unplanned bed days in all specialties and differentiates between the bed days used by delayed patients and other non-delayed bed days. A total of 2.5m bed days were used by people age 75+ of which 400k were by delayed patients, an average of 16% of the total bed days for this age group and varying across partnerships from 3.4% to 42%. There is a two-fold variation in the overall bed day rates across partnerships and a 12 fold variation in delayed bed

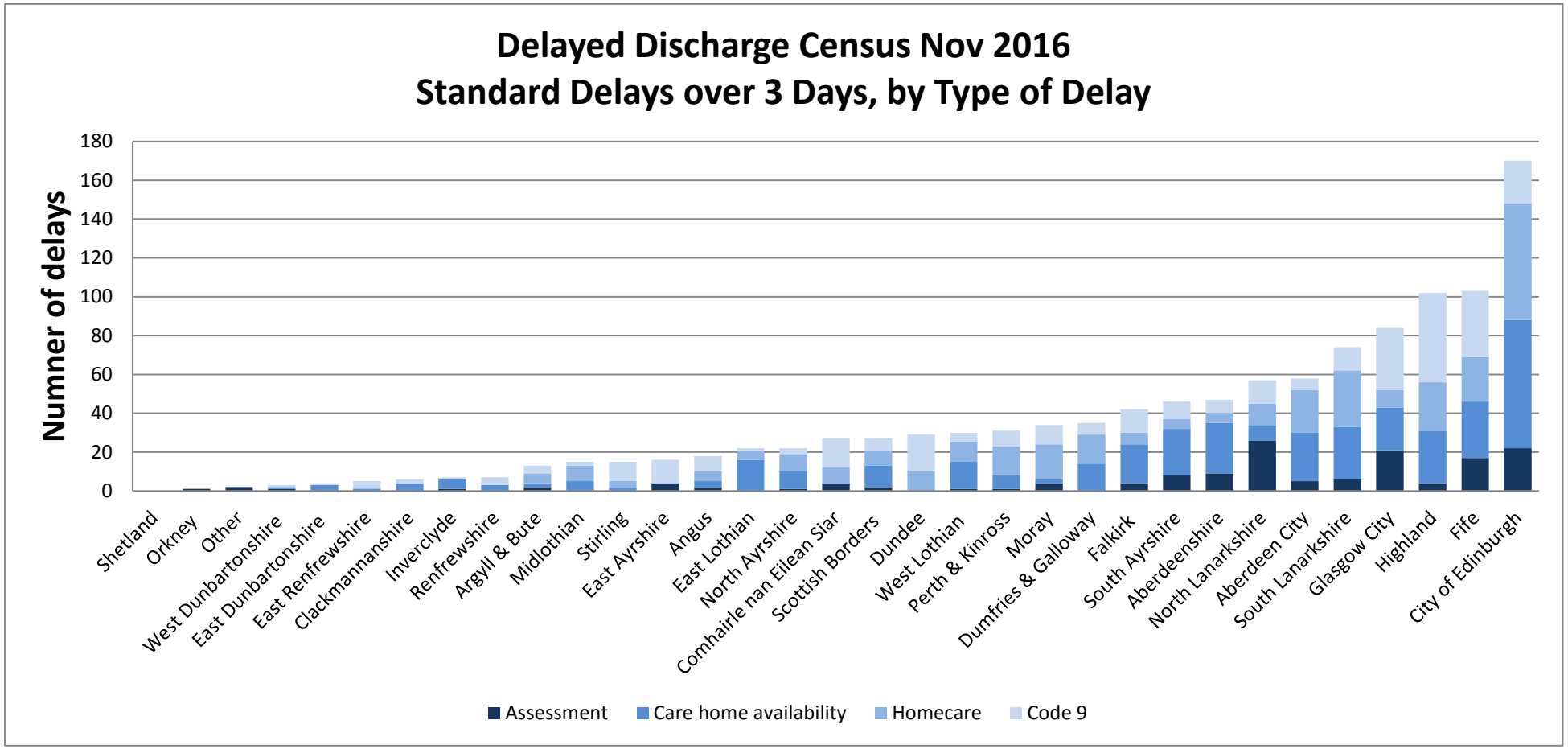
day rates. There is no association between delayed bed day rates and overall bed day rates. We can develop this analysis to include other age groups and to differentiate between specialties and type of delay.

Unplanned admissions



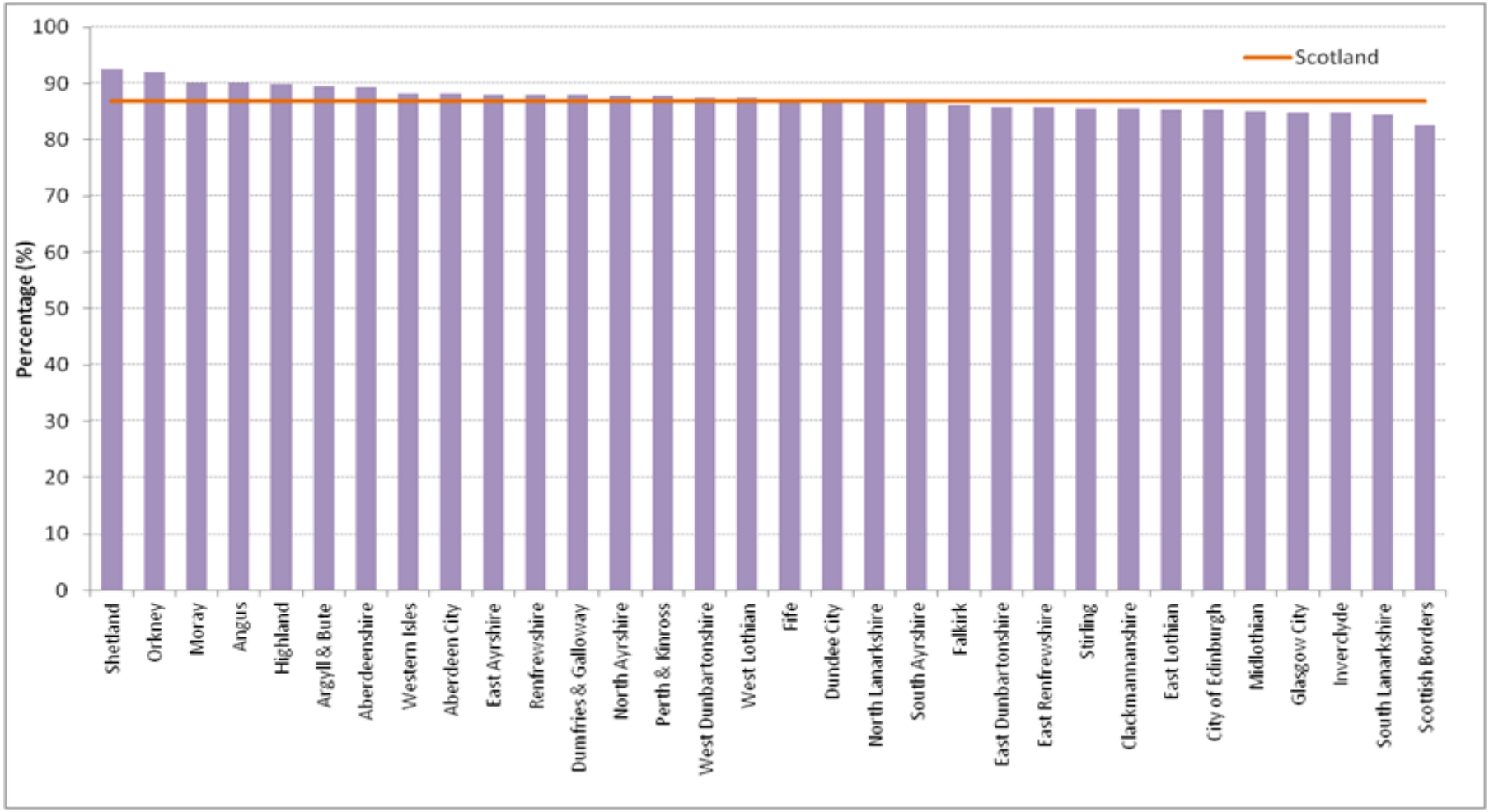
Notes: This chart shows the unplanned admissions per person aged 75+ in all specialties in 2015/16. We can see that the two fold variation seen in the bed days chart is evident here, although there is some slight re-ordering which is to be expected as bed day rates are a function of admission rates and length of stay. We can develop this analysis to consider different age groups and specialties.

Delayed Discharge Census: Standard Delays > 3 days by type of delay



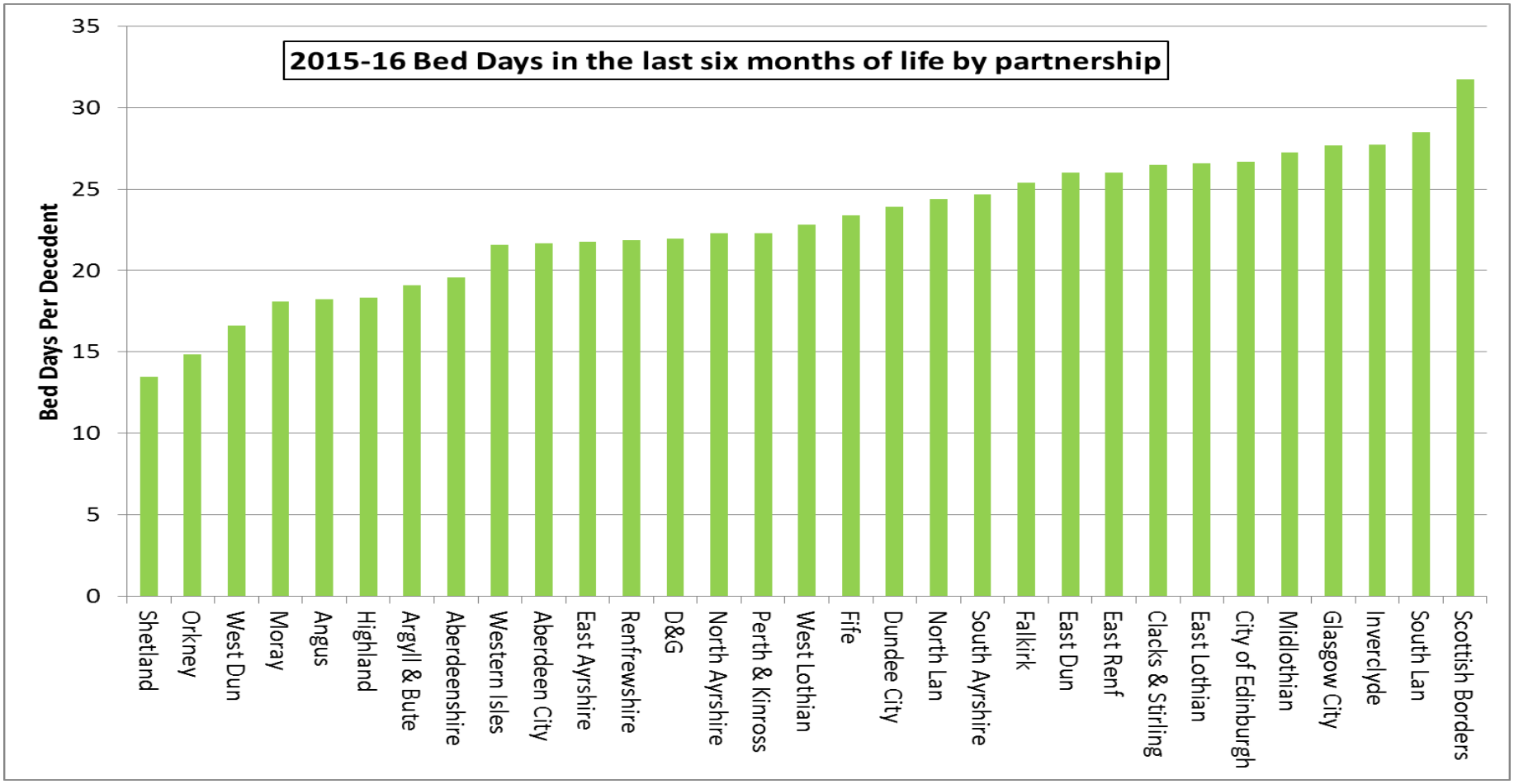
Notes: this chart shows the number of delays by type of across all partnerships. These figures exclude family reasons. There is considerable variation across partnerships. There are also differences in the main reason for delays. For example while care home and home care are key reasons for some partnerships, Code 9 categories appear to be the main reason for others

End of Life (a)



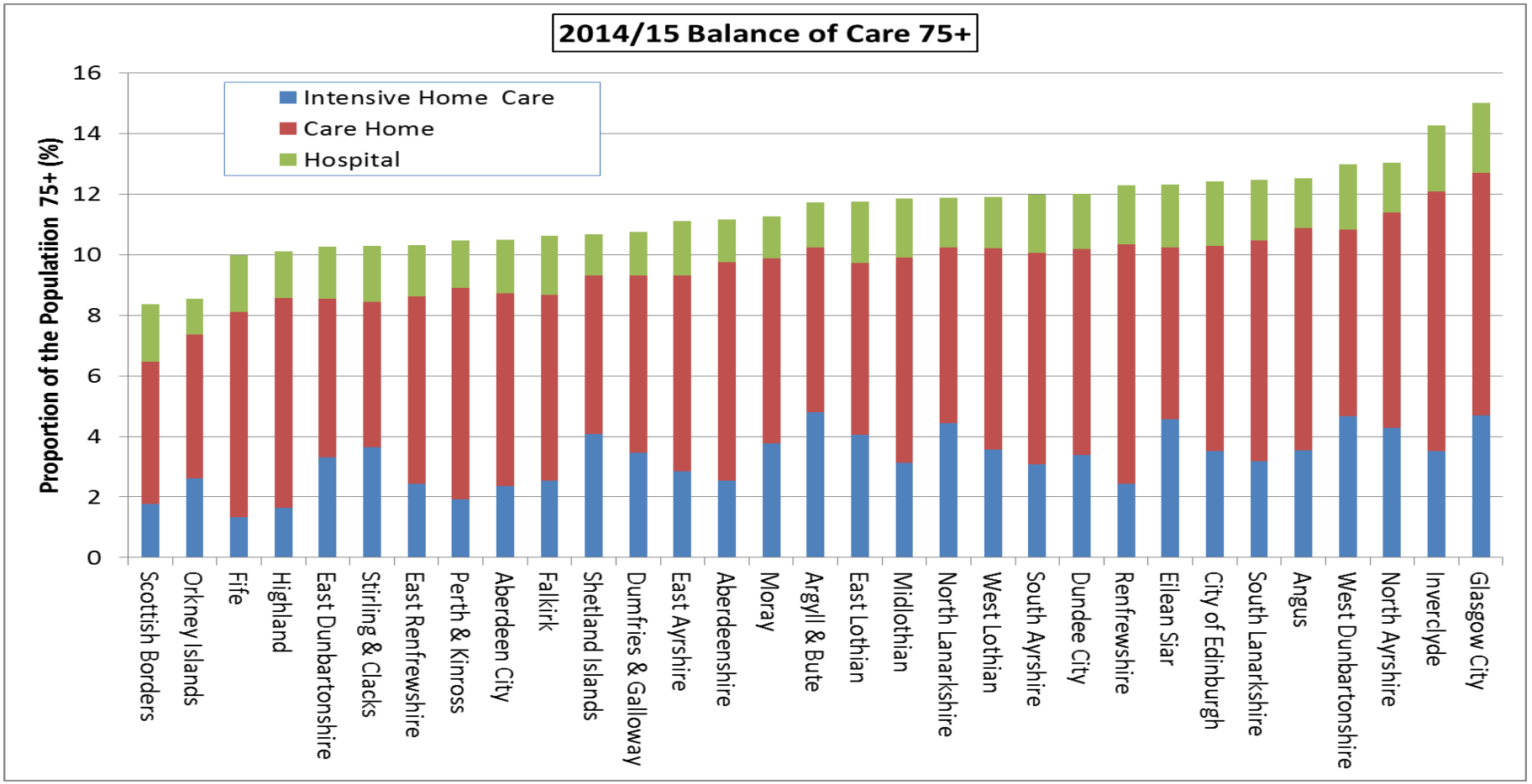
Notes: This chart shows the proportion of the last six months of life spent at home or in a community setting for people who died in 2015/16. There is a difference of 10% across partnerships. We can develop this analysis by considering different age groups and by differentiating between settings.

End of Life (b)



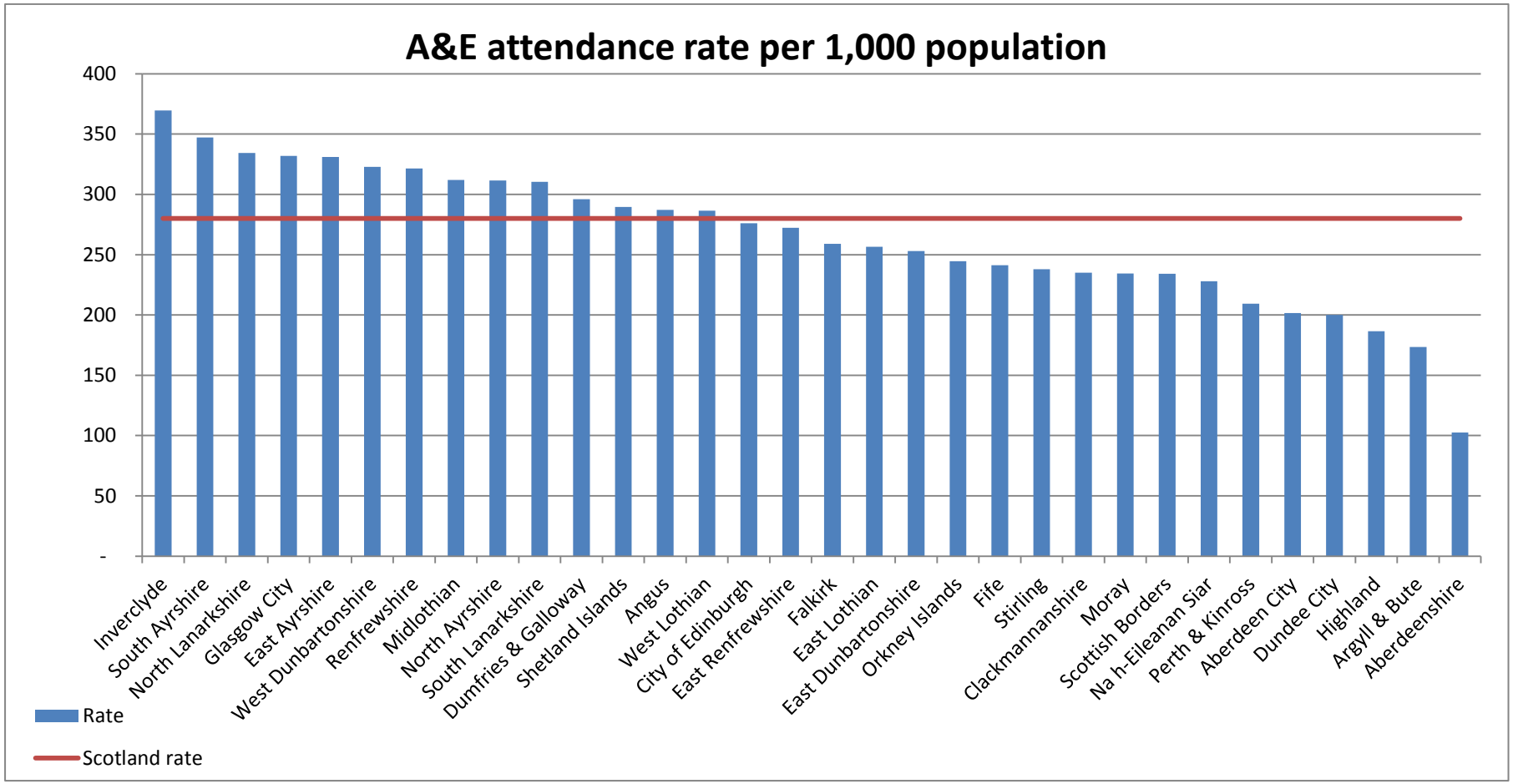
Notes: This chart shows the average unplanned bed days in the last six months of life for people who died in 2015/16. There is a two- fold variation across partnerships. If all Scottish partnerships could attain the same bed days per decedent as Shetland, half a million bed days could be saved-equivalent to the 10% commitment in the Delivery Plan.

Balance of Care



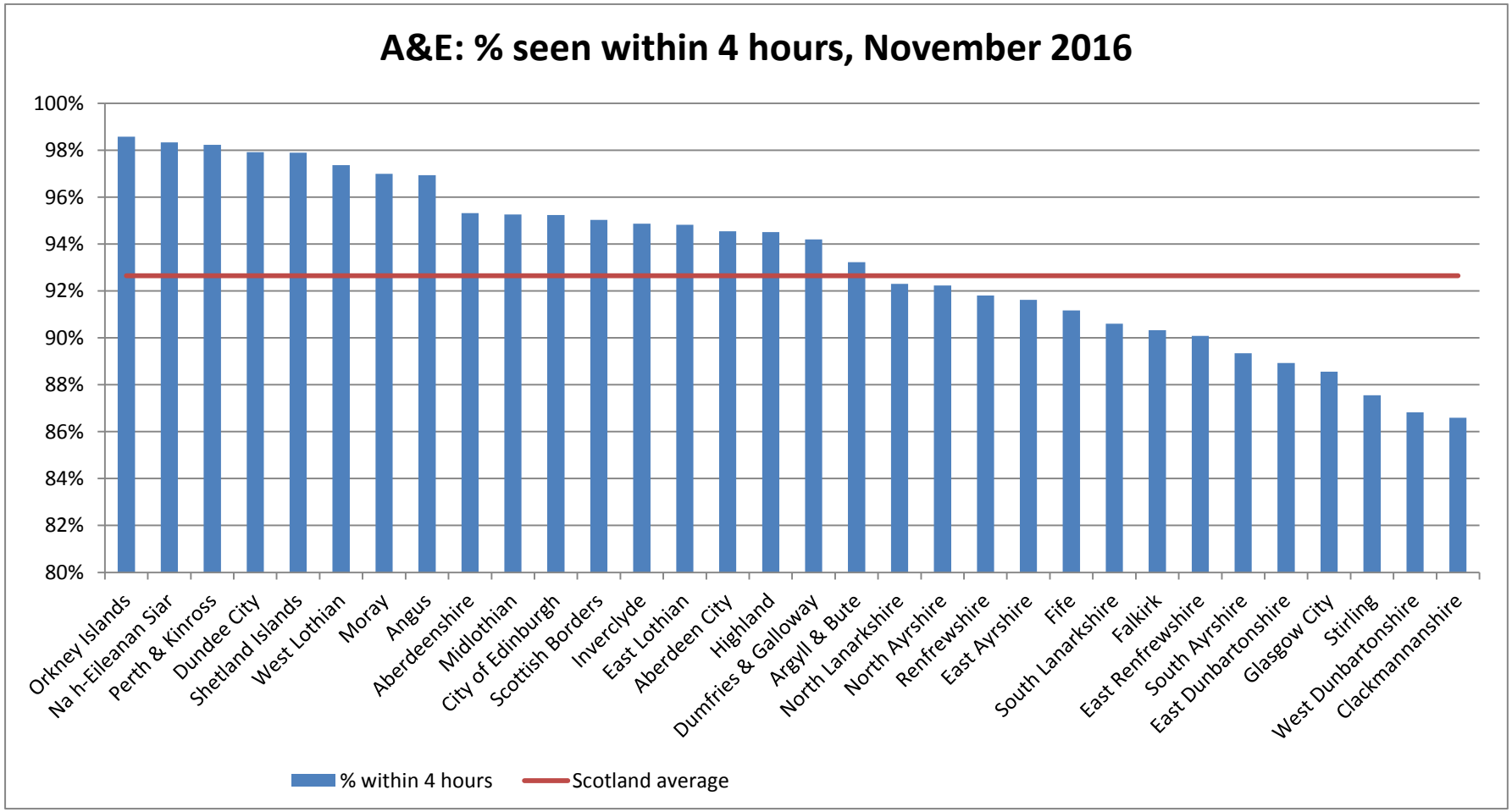
Notes: This chart looks at balance of care for people aged 75+ and shows the proportion of partnership populations aged 75+ who were either in hospital, in a care home or in receipt of 10+ hours home care in 2014/15. There is an almost two-fold variation (8% c/w 15%). Across Scotland, 8.5% of people aged 75+ were either a care home or hospital varying from 5.9% to 10.7% across partnerships. We can develop this analysis to include other age groups and to reflect the balance of care as a spectrum of settings; we can also look at spend across the spectrum.

A&E (a) : **A&E attendance rate per 1,000 population by Partnership 2015/16**



Notes: this shows the attendance rate at A&E per 1000 population by Partnership. There is considerable variation between Partnerships –370 per 1000 population in Inverclyde while 102 attendees per 1000 population in Aberdeenshire (Scotland – 280 per 1000). The difference is likely to reflect a range of issues including demographic factors, proximity of population to A&E facility as well as other healthcare provision .

A&E % seen within 4 hours



Notes: This chart shows performance on the 4 hour wait target by partnership. There is a difference of 11% between the highest performing area and the lowest performing area. The Scotland average is 93%. We can also provide A&E data on conversion rate- eg the proportion of A&E attendances which result in admission to hospital

(a): Respondent Information Form (RIF)

Please Note this form **must** be returned with your response.

Consultation on the National Health and Social Care Standards

Are you responding as an individual or an organisation?

☐ Individual (See Part (i) below) ☒ Organisation (See Part (ii) below)

Did you attend an engagement event / workshop before competing this response?

No ☒ Yes ☐ Date …… Name of Event:……..……..….

Full name or organisation"s name

Falkirk Health and Social Care Partnership

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Postcode

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Email

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Phone number

01324 504133

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

☒ Publish response with your name of organisation

☐ Publish response only (anonymous) – Individuals only

☐ Do not publish response

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for the Scottish Government to contact you again in relation to this consultation exercise?

Yes ☒ No ☐ Date Completed: …20 January 2017……

(b): CONSULTATION QUESTIONNAIRE

Q1: To what extent do you think the Standards will be relevant and can be applied across all health, care and social work settings?

Strongly Agree	
Agree	x
Neither agree nor disagree	
Disagree	

Comments

The Standards provide a helpful framework, however in order for these to become standard for all services, including those who are not registered with CI or HIS, local level commissioning will have to consider how to include these as compliance standards. It may be challenging to regulate standards within organisations operating out with a funding relationship – there will be no formal accountability.

Q2: To what extent do these Standards reflect the experience of people experiencing care and support?

Strongly Agree	
Agree	x
Neither agree nor disagree	
Disagree	

Comments

Services will be taking a person-centred approach with people, taking into account their personal outcomes. The standards appear well aligned with this approach.

Q3: (Standard 1: I experience high quality care and support that is right for me.) To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	x
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

It is suggested that there should be mention to care being "safe, effective and evidence based. "

Linked to the above, it would be helpful for clarity to be given on how this will be measured, especially so that people know that the care they receive is of a high quality. This will also assist to consistently benchmark services across other geographical areas.

It is also suggested an addition to read care and support is "right for me and my personal circumstances"

1.13 notes that 'needs are assessed by a qualified professional at an early stage'. Local support agencies may not have 'qualified professionals', but instead be established to provide informal support for specific emotional or physical issues based on self-referral. The introduction of standards locally should not preclude this type of support being delivered – a pragmatic approach is required to implementation.

Q4: (Standard 2: I am at the heart of decisions about my care and support.)
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	x
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

There are no proposed suggestions to add to this standard.

Q5: (Standard 3: I am confident in the people who support and care for me.)
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

There are no proposed suggestions to add to this standard.

Q6: (Standard 4: I am confident in the organisation providing my care and support.)
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

There are no proposed suggestions to add to this standard.

Q7: (Standard 5: And if the organisation also provides the premises I use.)
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

It is not clear what this standard means read on its own and benefits from the Annex to fully clarify the expectations.

Q8: (Standard 6: And where my liberty is restricted by law.) To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	x
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

There are no proposed suggestions to add to this standard.

Q9: (Standard 7: And if I am a child or young person needing social work care and support.) To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	x
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

There are no proposed suggestions to add to this standard.

Q10: To what extent do you agree these new Standards will help support improvement in care services?

Strongly Agree	
Agree	x
Neither agree nor disagree	
Disagree	

Comments

Given the intended role of the Care Inspectorate and Healthcare Improvement Scotland's to respond to these new standards, it would be helpful to understand how inspection/evaluation methodology will be developed. In addition, if this will be done in discussion with partnerships to ensure there is sufficient time to develop the necessary arrangements to demonstrate compliance with the new standards.

Q11: Is there anything else that you think needs to be included in the Standards?

Yes	
No	x

Comments

The Standards provide a helpful framework, however could be potentially be stifling to smaller organisations if implemented in totality. It may be helpful for local commissioners to use points within each standard as a 'menu' in order to ensure that services are working to appropriate points rather than all points. This may be particularly true for smaller organisations/community based supports.

Q12: Is there anything you think we need to be aware of in the implementation of the Standards that is not already covered?

Comments

With the Carers Act implementation on the horizon it will be important to keep in mind that taking account of the unpaid care and support around the person is critical to getting support right for both the person and their family/carers. Under the new regulations and the current SDS regulations carers will be identified as 'supported persons' if they are eligible for support so presumably the standards will also apply to them.

Q13. What should the new Standards be called?

☐ National Care Standards

X National Health and Social Care Standards

☐ National Healthcare and Social Care Standards

☐ National Care and Health Standards

☐ National Care and Support Standards

☐ Other - please provide details.....

Q14. Any other comments, suggestions:

Comments

None

(c): Additional Information
We recognise that people may have more than one experience of / involvement with health and care services. For example; you may work in a hospital or care home and also be a registered carer for a friend or relative receiving care services. For the purposes of this consultation please indicate the main capacity in which you are responding.

(i) As an individual **service user** (including on behalf of family) ☐

As an individual who **works or volunteers** in health/social care ☐

Please tick to select the services that you have used / have experience of:

Acute health care (emergency care, hospitals etc)	
Primary health care (GP and other community health services)	
Independent health care	
Adult social care	
Early learning and childcare	
Social work (including fostering, adoption, care homes for children and young people)	
Community justice	
Other: (please state)	

(ii) As a **representative of an organisation** / service provider

Please tick to select the type of services that your organisation provides:

Acute health care (emergency care, hospitals etc)	x
Primary health care (GP and other community health services)	x
Independent health care	
Adult social care	x
Early learning and childcare	
Social work (including fostering, adoption, care homes for children and young people)	x
Community justice	
Other: (please state)	

Other Formats
Once finalised these new Standards will be made available in various formats. It would be helpful to know which format(s) may be required. Please indicate from the list below which formats you are most likely to use.

Easy Read ☐ Large Print ☒ Audio ☐ Braille ☐

Other languages (please indicate which) …British Sign Language ……..……..

Please indicate how you are most likely to access these Standards:

online / electronic ☐ paper copy ☐ Both x