AGENDA ITEM 5

Agenda Item: 5

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Chief Officer Report**
Meeting:	**Integration Joint Board**
Date:	**30 March 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 (HSCP).

2. RECOMMENDATION

The members of the IJB are asked to:

2.1 note the IJB will receive a report on the Support Services requirements for consideration at its next meeting

2.2 note the response to the Scottish Government Ministerial Group as detailed in section 5 of this report

2.3 note work will be overseen by the Leadership Group and Chief Finance Officer, to finalise the HSCP Local Delivery Plan and present to the IJB at its next meeting

2.4 remit the Chief Officer to make the necessary arrangements to return the SPSO self-assessment and implement an IJB Complaints Handling Procedure as required

2.5 remit the Chief Officer to approve the Equality Outcomes and Mainstreaming report for publication by 30 April 2017 and provide an update to the next IJB meeting

2.6 remit the Clinical and Care Governance group to review the Healthcare Improvement Scotland inspection report and provide an update on any identified actions to a future meeting of the IJB

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

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. HSCP LEADERSHIP TEAM AND SUPPORT ARRANGEMENTS

4.1 **Chief Finance Officer Recruitment**

The Board previously agreed to commence a recruitment process for the permanent appointment to the Chief Finance Officer position for the IJB.

Since then, the advert has been placed on myjobscotland and the NHS Scotland recruitment website SHOW, ensuring both Local Government and NHS employees are aware and had access to the vacancy. The closing date for receipt of applications was 1 March 2017, and shortleeting took place on 14 March 2017. Interviews took place on 23 March 2017. In addition to the interview, this was supplemented with a presentation, on-line assessments and other relevant exercises. A verbal update will be provided to the Board.

4.2 **Support Services Arrangements**

There is growing demand and expectations being placed at a national and local level on the Integration Joint Board. This is providing evidence of the level of support that the IJB requires to meet its statutory obligations under the Public Bodies (Joint Working) (Scotland) Act 2014. The level of support provided by partners to date is acknowledged, however it is recognised there are capacity pressures within respective partners that has highlighted the informal approach to date is not sustainable. Work is underway to identify the ongoing dedicated resource commitments required, and this will be presented to a future IJB for consideration. This will ensure there is appropriate dedicated capacity to ensure the pace of change and ability to respond to growing demand expected by the Board.

5. MEASURING PERFORMANCE UNDER INTEGRATION – MINISTERIAL STRATEGIC GROUP (MSG)

In response to Scottish Government correspondence as reported to the last IJB meeting, a draft response was submitted on 1 March 2017. This is attached as Appendix 1. Integration Joint Boards were asked to set out local objectives for each of 6 indicators for 2016/18 listed below:

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 majority of the indicators relate to unscheduled care. The services though in scope, are currently being managed within NHS Forth Valley. The Medical Director has established a revised Unscheduled Care Group including both IJB Chief Officers, to develop the improvement programme and performance indicators. The Chief Officer will work with the Director of Nursing to develop the measures and plan for end of life care.

More work is required than originally anticipated to analyse the available data in order to develop robust, realistic measures and targets for submission to the MSG. These targeted improvements will be incorporated into the IJB Financial Plan, IJB Performance Framework, the HSCP Local Delivery Plan and the NHS Forth Valley Local Delivery Plan. The plan will be submitted for agreement at the next Board meeting.

6. HSCP CHANGE PROGRAMME

6.1 Local Delivery Plan

Work to conclude the draft Local Delivery Plan has been delayed to ensure adequate consideration is given to the:

- 9 national health and social care integration priorities and their alignment with the Strategic Plan outcomes and priorities. The Strategic Planning Group at its meeting on 17 March 2017 reviewed progress against these 9 national priorities and further work was agreed to conclude this.
- outcome of the IJB budget to ensure the appropriate alignment of budget with service priorities. This includes long term financial planning which is emphasised by Audit Scotland's report on local government challenges.
- review of performance measures, including the 6 national indicators, as reported at section 5.

This work will be overseen by the Leadership Group who will finalise the Local Delivery Plan to be presented to the IJB to consider at its next meeting.

6.2 Capacity Modelling

The partnership is continuing to work with i-Hub and TRIST to take forward work on whole systems mapping. Work is underway to identify service users and carers to participate in this work to include the lived experience. By incorporating this additional element into the project the timescales have been extended to June 2017 to conclude the first phase. The Board will be kept updated on this through the Chief Officer report.

6.3 **Adult Social Care Services Change Projects**

There are a number of change projects which are being developed to redesign and transform Adult Social Care services. These are aligned to Falkirk Council's 'Council of the Future' programme and include capacity to deliver the service redesign to support improved outcomes and generate efficiencies. The Council has approved an additional one year investment of £325,000. This will provide additional temporary staff capacity to lead key change projects, including the care at home tender, and support patient, carer, staff and community engagement and to develop community and third sector capacity. The Council Change Programme has allocated some programme management support for the delivery of the Adult Social Care change projects. Information on this welcomed additional investment is reported in the IJB Financial report at agenda item 6.

6.4 **Frailty Pathway**

The Frailty pathway has not been in place as anticipated following the Test of Change. The Programme Board has been reconfigured by the General Manager for the Medical Directorate to design and implement a Frailty Pathway for Forth Valley. This work is ongoing and will incorporate the comprehensive geriatric assessment process and appropriate links with Discharge to Access, Rapid Access Frailty Clinic and community services including the Enhanced Community Team (Closer to Home) and GP Fellows.

Availability of the Rapid Access Frailty Clinic has been more limited in recent weeks due to winter pressures and the need for Consultant Geriatrician's to provide clinical support for the additional winter beds. The Frailty Clinic has been operating at a reduced level – on average of 43% since April 2016.

Plans are being progressed to bring together key stakeholders to a whole system facilitated event to ensure various partnership initiatives, including Frailty, have appropriate links and to avoid duplication.

6.5 **Discharge to Assess**

The Discharge to Assess pilot has been operational from 13 December 2016. The pilot aims to prevent avoidable 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.

Up to the 16 March 2017, the Discharge to Assess performance is summarised:

- 145 people have been supported in their discharge and provided care as part of the pilot. Of these:
- 19 readmissions from a total of 119 patients (16.5 %) up to the end of February. This compares favourably with the 17.3% nationally reported rate for readmissions of 65+ years to acute medicine
- 7 people had been delayed and were on Edison
- 138 people were prevented from becoming delayed discharges
- 41% of people receiving the service are over 85+ years, with 30% aged 75 – 84 years

- 0.4 days average wait from referral to start of Avenue care service (this is based on 97 clients)
- positive impact on the availability of packages of care as noted in section 7.4 of the report
- patient experience surveys are positive (the current sample size is 25 surveys)
    - 92% reported the service started when they expected it
    - 92% reported the care plan reflected their views
    - 92% reported consistency of carers
    - 70% reported staff always discussed their progress with them when they completed their care plan, and a further 25% said this happened sometimes
    - 60% reported they were very satisfied and 40% fairly satisfied that the service supported them to return home from hospital.

The IJB has committed considerable financial investment to tackle the underlying causes of delayed discharge. The pilot has recently focused on patients waiting in FVRH for transfer to community hospital. Through multi-disciplinary team assessment this has supported a number of patients to be discharged home with support. This is a key element of work to develop a full Discharge to Assess model and will require further testing and an extension to the pilot. In addition there are early indications of the pilot's success in preventing admissions and reducing delays in discharge. This extension is in line with the IJB approval to remit the Chief Officer, in discussion with the Chief Executives and Chief Finance Officer, to take appropriate action to extend the pilot period. This will ensure there is additional capacity in the system to sustain improvement while services are developed to adopt this model.

6.6 **Collaborative Leadership in Practice (CLiP)**

Support continues to be provided by NHS Education for Scotland (NES) for three levels of collaborate leadership training:

- Strategic Leadership Team
- Leadership development for the West Locality Pilot
- Reablement - with key reablement leads.

7. DELAYED DISCHARGE

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

- 38 people delayed in their discharge
- 25 people who were delayed for more than 2 weeks
- 8 people identified as a complex discharge (code 9)
- 8 people proceeding through the guardianship process
- 2 people identified as a Code 100 delay.

7.2 Table 1 below shows the total number of delays. While the February position shows a decrease from January, the overall position remains challenging. The numbers of

people waiting over 2 weeks remains static

	Feb '16	Mar '16	Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sep '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17
Total delays at census point	23	29	27	23	32	45	51	46	39	35	37	45	38
Total no. of delays over 2 weeks	14	18	18	12	18	30	33	29	25	22	26	24	25

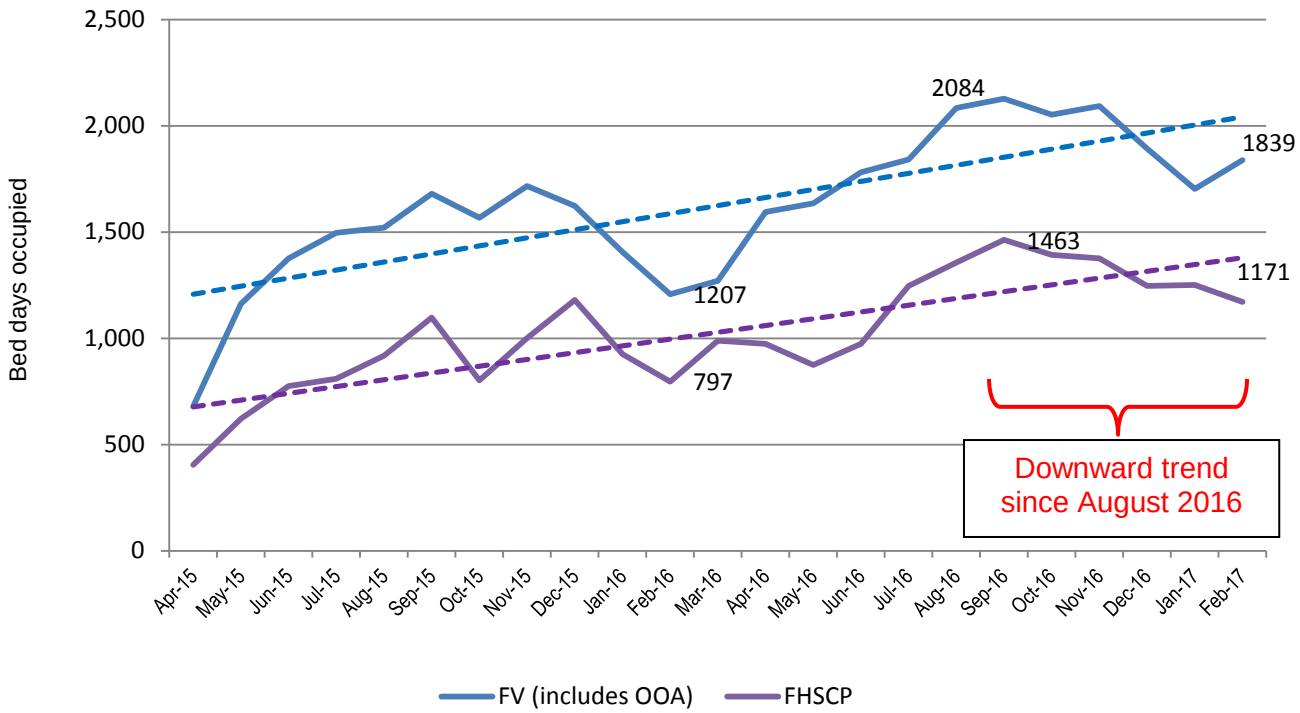
Table 1 (excluding Code 9 & Code 100) **Source: EDISON**

7.3 Table 2 show 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 February and show increasing pressure on bed days compared with February 2016.

	Feb '16	Mar '16	Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sep '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Equiv Beds (Feb)
Standard delays	797	990	975	875	854	1247	1468	1463	1393	1376	1247	1252	1171	42
Complex Delays / Guardianship (Code 9)	217	265	277	186	158	256	275	376	454	363	374	377	428	15

Table 2 - total occupied bed days up to February 2017**Source: EDISON**

Graph 1 – Number of bed days occupied (excl. Code 9 delays)

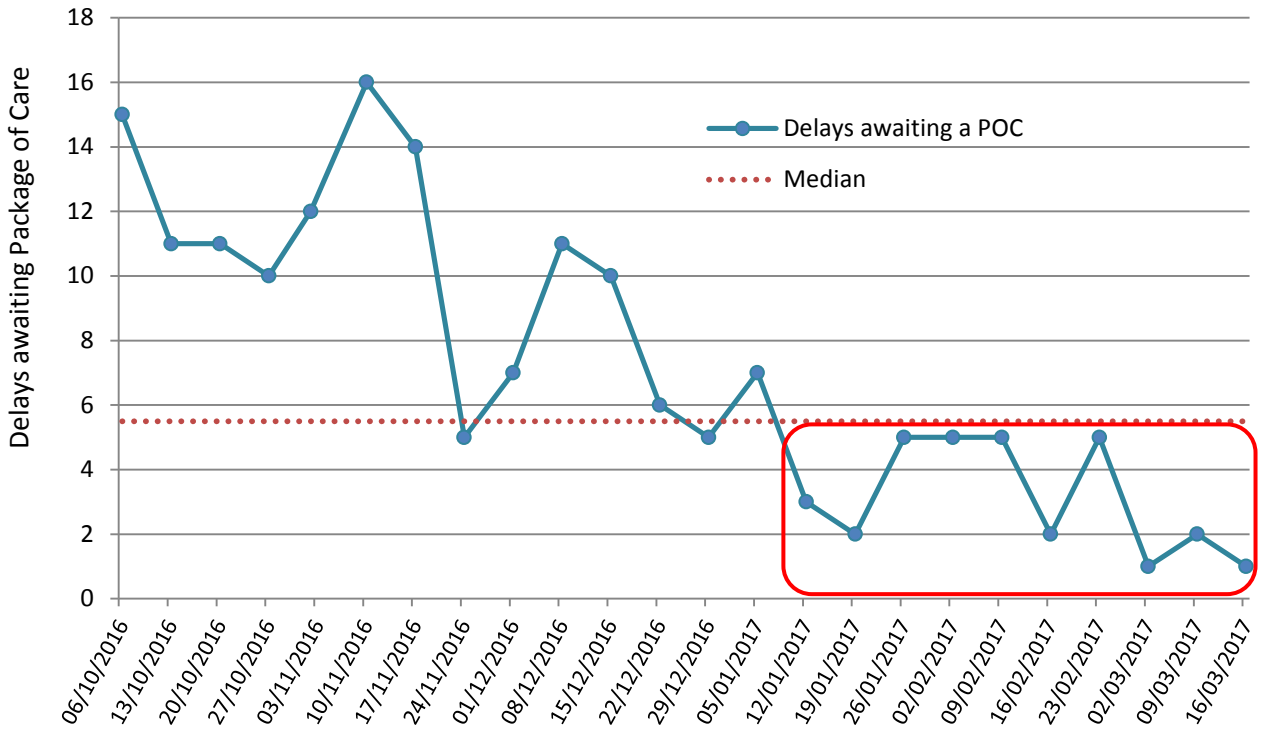


7.4 **Reduction in Delayed Discharges awaiting a package of care**

The graph below demonstrates improvement in reducing the numbers of people delayed in hospital awaiting a package of care. The data here is plotted in a run chart which can be used, alongside a number of rules, to identify non-random variation (real change) amongst typical random variation in a process.

There are four rules of run charts used to identify non-random variation; in the case of the chart below we can see a 'shift' (6 or more data points below the median) in the last 10 weeks of reporting. This shift signifies a sustained reduction in delays awaiting a POC and is highlighted on the chart with the red box.

Graph 2 – Weekly Falkirk delayed discharges awaiting a package of care



7.5 **Delayed Discharge IJB report**

Figures shown in this report come from NHS Forth Valley's EDISON delayed discharges system which includes Falkirk residents who were delayed in a Forth Valley hospital setting. Extracting figures from EDISON allows for the most up-to-date reporting possible with the limitation that Falkirk residents delayed in another health boards are not included in these figures.

The IJB Delayed Discharge performance report attached at Appendix 2 uses the ISD delayed discharge census as its source. The census counts delays for Falkirk residents in all NHS Scotland hospital sites, meaning that the number of delays and number of occupied bed days may differ slightly from those quoted on EDISON. The census figures are not as up to date as those provided

locally via EDISON which is a reflection the extra time required to collect and process national data at ISD.

7.6 **Weekly Monitoring**

The Discharge Hub shares tables of data on a weekly basis to key contacts in the partnership. Work is underway in conjunction with the LIST team analysts to use this data to create a weekly delayed discharge dashboard which will utilise statistical methods to aid interpretation and present the data in a more visual way. This should allow senior staff to easily interpret changes and trends in performance.

7.7 **Delayed Discharge Performance: Additional Target Agreed with 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 agreed an additional target of a fifty percent reduction in the numbers of people delayed in their discharge. This included all standard and code 9 discharges but not code 100 delays, against the November census baseline.

The trajectory below shows the Falkirk Partnership performance in meeting this trajectory at the February census point. This shows that the Partnership is currently behind the trajectory. However, improvements have been made in the weekly position in the last two weeks with an increased discharge rate. This rate of discharge will need to be sustained each week during March to achieve the target.

Falkirk 2016/17 – Trajectory

	December	January	February	March
Target	56	47	39	30
Actual	49	60	54	

7.8 **Delayed Discharge Improvement Plan**

The Improvement Plan presented at the last IJB remains in place and covers in a single plan all of the strategic and operational actions that partners require to take to improve and maintain the delayed discharge and position. The IJB is asked to note the following update:

7.8.1 **Policy on Choice of Care Home**

An audit of the Policy on Choice of Care Home has been undertaken and the results are being analysed and written up. Initial results show that there were 33 patients from Falkirk whose discharge was taken forward through the Policy on Choice.

This confirms that delays are significantly longer for people whose first choice of care home is unavailable. The average length of stay between patients clinically ready for discharge resolution of choice issue was 72 days.

The audit also showed that the majority of patients were able to be offered their choice in the course of the Choice Policy escalation process with only around 16% patients who required discharge to an interim placement. Only two cases required to be escalated to the Medical Director with most being resolved at an earlier point in the process.

The audit has identified potential for improvement in the timelines at all stages in the Choice Policy process. It is now planned to undertake process mapping with practitioners involved in supporting delayed discharges to identify how the whole process of discharge can be improved.

7.9 **Winter Beds**

Ward 5 and the other additional contingency beds in Falkirk and Bo'ness Community Hospitals were opened to provide planned additional bed capacity over the winter period funded through the Health Board's Winter Plan.

At the time of writing this report colleagues in NHS Forth Valley have drafted a plan for consideration by the NHS Operations Group for the closure of the winter beds.

8. IJB FINANCIAL UPDATE

8.1 The Leadership group has been meeting regularly and an update on the budget position is detailed in the IJB report at agenda item 6.

9. SERVICE ARRANGEMENTS

9.1 **Transfer of operational responsibility for NHS Community Services**

Arrangements to transfer operational responsibility for the integrated Community Mental Health and Community Learning Disability Teams to the Chief Officer were effective from 1 February 2017. However the professional and clinical support arrangements for these operational services remain within the Community Services Directorate. This is subject to on-going discussion to ensure that any associated risks are identified and managed.

The proposed transfer of the REACH and Community Nurses services from 1 April 2017 has been postponed pending discussions with the Chief Officer and Chief Executives as outlined at section 9.2.

The current team within the HSCP does not include capacity for planning and performance and will require a more formalised arrangement for support from NHS Forth Valley in order to move at the pace required to deliver transformation. This will be addressed in the ongoing Support Services discussions as outlined in section 4.2.

9.2 **West Integrated Locality Team pilot**

A draft management structure has been developed by the Head of Social Work Adult Services and HR colleagues to redesign adult services into locality teams to support integration and the West Integrated Locality Team pilot. NHS Forth Valley had proposed the transfer of community nursing and allied health professional staff into the operational management of the Falkirk HSCP in spring of 2017, which has been delayed. Discussions are underway with the Chief Executives to agree an integrated management structure to bring health and social care staff together in locality teams at the same time. The intention is to have these teams in place for early 2018. A further report will provided at the next meeting of the board.

9.3 **Eligibility Criteria**

Public consultation relating to the proposed revision of Eligibility Criteria for access to services from Social Work Adult services began on Monday 13 February and ran for 6 weeks until 26 March 2017.

Three main ways of engaging the public in this consultation were progressed as follows:

- All consultation documentation was placed on Falkirk Council's Consultation Hub and went live on Monday 13 February 2017. Contextual narrative, proposed policy document and access to completing online survey questionnaire was included. Information on where to request hard copies of all information was included. Hard copy responses continue to be returned to date, albeit not in large numbers

- Emails with links to information and survey questionnaires were sent to third sector organisations for information to Falkirk Council residents known to their organisation.

- Three public events have been held – presentation by officers regarding context of consultation followed by facilitated discussion with representative from independent organisation. Events were held in three different areas of Falkirk with one having translation/interpreter support available. The turnout at the public events was poor – with only five members of the public attending over the three events

An advert was placed in the Falkirk Herald on Thursday 16 February 2017 publishing all of the above.

Consultation with staff groups has also been progressed and will be gathered and analysed separately. This information will be included in subsequent report to the IJB.

Due to the low numbers in attendance at the public events, several more events are being planned to seek engagement with specific groups i.e. Carers Forum, Independent Living Association Users Group

The IJB are asked to note that all information and data will be collated, analysed and reported to the IJB meeting in June to support decision making regarding implementation of the revised eligibility criteria.

9.5 **Homecare and Community Care Services Contract**

The IJB will be aware of work being undertaken in relation to the delivery of a new Homecare and Community Care Services contract. At the IJB meeting on 3 February 2017, a contract timetable was presented highlighting the key stages leading to a new contract going live in October 2017.

Further consideration has now been given to this timetable and the opportunity will be taken to extend the current contractual arrangements by 6 months, to facilitate a revised start date for the new contract of April 2018. The revised contract start date will provide more time to ensure all relevant stakeholders are consulted and involved in the development of the contract strategy. Additionally, the revised timeline will align with the recruitment of additional Adult Services support to provide the necessary professional input and direction to the contract strategy. A further report will be submitted to a future meeting of the IJB to approve the completed contract strategy.

9.6 **Single Shared Assessment**

The Single Shared Assessment (SSA) Minimum Data Set has been agreed by the working group which has representation from Falkirk Council, Stirling Council, Clackmannanshire Council and NHS Forth Valley staff.

Further work is ongoing with ICT colleagues within NHS Forth Valley and Falkirk Council to build the SSA into electronic systems. It is anticipated that this will initially be built into MIDIS systems. It is recognised there is ongoing work within the Council to replace the SWIS system and interim arrangements to share the assessment form have been agreed.

Once NHS FV ICT has built the SSA form into MIDIS, this will be tested in a limited number of community services across Forth Valley. It is anticipated that initial testing will take place around May/June 2017. Once testing has been carried out, the Single Shared Assessment will be rolled out across all services starting with community based health services.

The Information Sharing Protocol has been signed off by both Health and Social Care Partnership Chief Officers and by General Manager within NHS Forth Valley. The principles of sharing information remain that this must be safe and secure, consent must be explicit and chronologies will be shared as part of this process if available.

9.7 **Social Work Complaints Handling Procedure**

The IJB received a report on 3 February 2017 noting the requirements to change the existing system for reviewing complaints about Social Work Services. This was to be in line with the SPSO Social Work Model Complaints Handling Procedure (CHP). This brings social work complaints in line with the Model used by Local Authorities and a new CHP for Health which also comes into force on 1 April 2017.

Since February there has been significant work undertaken to ensure there is compliance with the new arrangements. This has included:

- Development of the Social Work CHP for Falkirk Council – both a staff and public facing CHP
- Development of public information leaflets and updating the website content
- Liaison with Falkirk Council colleagues to update Council complaints information to refer to the new procedure
- Completed staff briefings – 77 front-line managers have received a staff briefing session and further sessions will be organised for those who were unable to attend
- Development of an e-learning tool
- Developing performance reporting arrangements

It has recently emerged there is a likely requirement for the IJB to adopt a Model CHP. The Board will be aware that they approved a Health and Social Care Integration Complaints protocol in March 2016. Further work will take place to ensure the IJB are compliant with any SPSO requirements.

There is a requirement for authorities to complete a compliance statement and self-assessment form and return to the Scottish Public Services Ombudsman Office no later than 7 April 2017. The IJB are asked to remit the Chief Officer to make the necessary arrangements to return the self-assessment and implement an IJB CHP as required.

10 EQUALITY OUTCOMES AND MAINSTREAMING REPORT

10.1 The Equality Act 2010 provides the legislative framework for preventing discrimination and advancing equality of treatment. All organisations are bound by its provisions but public organisations have additional duties. As the Board has previously been advised, it is a public organisation subject to these duties. Significant obligations arise firstly from the public sector equality duty (PSED) and, secondly, from the specific duties arising from regulations made by the Scottish Ministers.

10.2 The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 place specific equality duties on public authorities, including the Board. Not all of the duties are relevant as the Board is not an employer. The specific duties which are relevant to note include:

- reporting on the mainstreaming of the equality duty
- agreeing and publishing equality outcomes
- assessing and review policies and practices.

10.3 The IJB is required to publish an Equality Outcomes and Mainstreaming report by 30 April 2017. Work with equality leads in Falkirk Council and NHS Forth Valley has been ongoing to provide advice in the preparation of the report. The IJB is asked to remit the Chief Officer to approve the report for publication by 30 April 2017 and provide an update to the next IJB meeting.

11 SCOTTISH GOVERNMENT CORRESPONDENCE

11.1 Carers Information Strategy funding

Scottish Government correspondence was received on 27 February 2017 providing formal notification of Carer Information Strategy allocations for 2017-18. An update on this is included within the IJB Financial report at Agenda item 6.

12 PUBLICATIONS

12.1 Healthcare Improvement Scotland: FVRH Inspection

On 14 February 2017 Healthcare Improvement Scotland published their report on the unannounced inspection of services to older people in acute hospital.

The inspection took place over 15 – 17 November 2017 and inspected the following areas:

- Acute assessment unit
- A11 – Ageing and health
- A22– Stroke
- A32 – Acute medical ageing and health
- B11– Surgical
- B12 – Medical (including respiratory)
- B21/B22– Ageing & Health integrated care
- B32 – Medical/gastrointestinal
- the discharge lounge.

As part of the inspection, the inspectors spoke to staff, patients and carers and reviewed patient health records to check the care they observed was as described in the care plans. The inspection identified a number of areas of good practice and areas for improvement.

It is proposed that the report recommendations are referred to the Falkirk HSCP Clinical and Care Governance Group for consideration, and any identified actions are reported back to a future meeting of the IJB.

13 CONSULTATIONS

13.1 National Health and Social Care Planning Discussion Document

The Scottish Government published a discussion document on 1 February 2017. This was in response to the need to ensure the right staff for health and social care services are available now and in future. The document notes the different stages

employers in health and social care are at in planning for the workforce they need. The Discussion document seeks views on issues which will help improve planning for the health and social care workforce. These views will inform the development of the National Plan to be published in 2017. It is anticipated the Plan will bring about improvements where they are needed both now and in future to deliver enhanced primary and secondary care in Scotland.

Comments to the discussion document were submitted by 28 March 2017 and the Falkirk HSCP response is attached at Appendix 3 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:

List of Background Papers:
Appendix 1: MSG Measuring Performance under Integration response
Appendix 2: IJB Delayed Discharge Performance Report
Appendix 3: Consultation response: National Health and Social Care Planning

Falkirk
Health and Social Care
Partnership

Report for Ministerial Strategic Group for Health and Community Care

Measuring Performance Under Integration

February 2017

Purpose

This report provides an overview of the current work in Falkirk Health and Social Care Partnership (HSCP) to deliver the Strategic Plan, with monitoring through the agreed Performance framework and IJB financial plan. The Performance framework currently includes performance measures related to the six indicators for Integration agreed by the Ministerial Strategic Group, however further work will be required to develop these into 'smart' objectives with quarterly targets to be agreed at the next IJB meeting on 30 March 2017.

Background

Falkirk HSCP developed a Strategic Plan to deliver the vision for Falkirk:

"To enable people to live full, independent and positive lives within supportive communities."

The Strategic plan identifies five specific local outcomes which align with the Scottish Government's *2020 Vision,* the National Health and Social Care Delivery Plan*,* NHS Forth Valley Local Development Plan and the Falkirk Community Planning Partnership Strategic Outcomes and Local Delivery (SOLD) plan.

The outcomes are:

1. **Self-Management**: Individuals, carers and families are enabled to manage their own health, care and wellbeing
2. **Autonomy And Decision Making**: Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided
3. **Safe**: Health and social care support systems are in place, to help keep people safe and live well for longer
4. **Service User Experience:** People have a fair and positive experience of health and social care
5. **Community Based Support**: Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community. Using a logic modelling approach three models have been developed to identify the activity required to achieve the five outcomes. It was recognised there were some overlaps with the two remaining outcomes that were incorporated into the logic models.

Falkirk HSCP is continuing to develop the delivery plan, locality plans and associated performance measures to measure the impact of integration on improving outcomes for the people of Falkirk. This is being informed by joint work with iHub, HIS and NES.

The Strategy map attached as appendix 1 shows the links between performance measures and outcomes and identifies areas for development of local outcome measures and processes to capture patient experience and community capacity building.

In October 2016 the Falkirk Integration Joint Board approved a Change Programme to underpin the delivery of the Strategic Plan. The programme includes a whole system approach to improve outcomes including preventing avoidable hospital admissions and reducing delays in discharge.

Change Programme: Key areas of work

- Frailty Pathway Test of Change in Forth Valley Royal Hospital: November 2016
- Discharge to Assess Pilot: December 2016 to March 2017
- Reablement : development of Falkirk wide model for reablement including a staff training programme across all sectors
- Development of a whole system map
- Develop locality structures and integrated teams
- Develop of a new outcomes-based commissioning for Care at Home tender based on a reablement approach and the Discharge to Assess model (new contracts in place by October 2017)
- Review of Day Services model for adult social care

The ongoing review of Partnership funding will ensure the HSCP continues to develop a more integrated and cohesive system of pathways in and out of the health and social care. This will be within a range of local community based supports that have a focus on prevention, early intervention and self-management that support independence at home or in a homely setting.

NHS Forth Valley leads key work strands including unscheduled care, the development of the role of the GP fellows and the review of Emergency department. There are Partnership funded initiatives including the Frailty Clinic, .Discharge Hub, Closer to Home. And Rehabilitation at Home (REACH). Some of these projects are delivered across the Forth Valley area as is the work on Out of Hours Care and there is ongoing liaison with the Clackmannanshire and Stirling HSCP with reference to these projects.

The newly appointed Medical Director is the executive lead for Unscheduled Care. We will work across the partnerships and localities to further develop the unscheduled care programme to clearly integrate associated actions, targets and measures to sustain good performance and deliver improvements.

The current work underway is out lined in relation to the six performance areas in Appendix 2. Further data analysis is required to effectively project performance targets.

The Forth Valley Performance work stream will support the development of this work. The HSCP Leadership Group will oversee the development of local targets aligned to the objectives for consideration by the Integration Joint Board and submission to Scottish Government.

Falkirk Integration Joint Board Strategy Map

Falkirk
Health and Social Care
Partnership

Appendix 1

Vision	**To enable people to live full independent and positive lives within supportive communities**				
Local Outcomes	**SELF MANAGEMENT-** of Health, Care and Wellbeing.	**AUTONOMY & DECISION MAKING** –Where formal support is needed people can exercise control over choices.	**SAFETY** - H&SC support systems keep people safe and live well for longer.	**SERVICE USER EXPERIENCE** People have a fair & positive experience of health and social care.	**COMMUNITY BASED SUPPORT** - to live well for longer at home or homely setting.
National Outcomes (9)	**1)** Healthier living **2)** Reduce Inequalities	**4)** Quality of Life	**7)** People are safe	**3)** Positive experience and outcomes **8)** Engaged work force **9)** Resources are used effectively	**2)** Independent living **6)** Carers are supported
National Indicators (23) **(* Indicator under development nationally)**	**1)** % of adults able to look after their health well/quite well **11)** Premature mortality rate	**7)** % of adults who agree support has impacted on improving/maintaining quality of life **12*)** Rate of Emergency admissions for adults **17)** % of care services graded 'good' (4) or better by Care Inspectorate	**9)** % of adults supported at home who felt safe **13*)** Emergency bed day rate for adults **14*)** Readmission to hospital within 28 days rate **16*)** Falls rate per 1000 population 65+yrs	**3)** % of adults who agree that they had a say in how their help/care was provided **4)** % of adults supported at home who agree their health and care services are co-ordinated **5)** % of adults receiving care and support rated as excellent or good **6)** % of people with positive GP experiences **10)** % of staff who recommend their place of work as good **19)** Rate of days people aged 75+ spend in hospital when they are ready to be discharged, **20)** % of total health and care spend on hospital stays where the patient admitted as an emergency **(22*)** % people discharged from hospital within 72 hours of being ready **23)** Expenditure on end of life care	**2)** % of adults supported at home who agree they are supported to be independent **8)** % of carers who feel supported in their role **15)** % of last 6 months of life spent at home or in community **18)** % of adults 18+yrs receiving intensive support at home **21*)** % of people admitted to hospital from home then discharged to care home *Note linkage to 'Experience'* **19)** Rate of days people aged 75+ spend in hospital when they are ready to be discharged, **(22*)** % people discharged from hospital within 72 hours of being ready
Partnership Indicators (Under development)	• ED Attendances by locality and 65+, 75+, 85+ • Life expectancy age 65+ Deaths from Cancer/CHD	• *Dementia – post diagnostic a, • Mental Health/Learning Disability data • Self- directed support (SDS) • Care home capacity • Single shared Assessment (SSA) data • Anticipatory Care plans • Readmissions • Key information summary	• HAI community hospital • Telecare data 75+ • Adult Protection reporting • Falls data from ED, extended Community teams, telecare • Mental Health Commission reports • Care inspectorate reports • Mental Health Patient safety data	• Local Client/patient data • Patient/Service user Experience survey • Complaints • Staff Survey data • Financial and Budgetary information	• Care at home services, including Homecare service patterns for clients 65+ • Respite weeks provided • Community care assessments • Carers' assessments • Em/Admission 65+75+ per 100,000 • Discharge to Assess

Falkirk
Health and Social Care
Partnership

Falkirk Health and Social Care Partnership measuring performance for Integration **Appendix 2**

Performance Area	Objective	Measure	Action	Target & Timeframe
1. Unplanned Admissions.	• Reduce unplanned admissions. • Shift care from hospital to community based services.	• A&E Attendances adults 18+ • Unplanned admissions adults 18+ from A&E.	• Enhanced community team (Closer to Home) including GP Fellows. • Advice Line for You (ALFY). • Prevent unnecessary admission through a frailty assessment , pathway including comprehensive geriatric assessment • Develop Frailty Pathway based on Test of Change. • Extend Discharge to Assess pilot to further test the model. • Embed learning in new tender for Care at Home. • Develop whole scale Reablement Approach. • Staff training access all sectors – • Forth Valley 6 essentials actions Plan. • Preparation for the implementation of the Carers Scotland Act in April 2018 will be progressed during 2017/18 • continue to work with the Scottish Ambulance Service to review the pathway for patients who fall but who have not suffered harm, minimising admission to hospital Review of partnership funded initiatives to make a more cohesive integrated system to support care in the community	
2. Occupied bed days for Unscheduled Care	• Reduce unplanned admissions. • Reduce length of stay in hospital. • Work towards target of 40% patients discharged by noon.	No of unscheduled beds days geriatric long stay No of unscheduled bed days acute specialities No of unscheduled bed days long stay mental health	• Frailty Pathway. • Discharge to Assess. • Multi-Disciplinary Assessments. • Streamline pathway through hospital. • Reablement in community. • Forth Valley 6 essential actions Action Plan. As well as reducing unplanned admissions to hospital through the shift in care from hospital to community settings, the health and social care partnerships and NHS Forth Valley are working towards reducing the length of time which patients stay in hospital. Forth Valley 6 Essential Actions Action Plan associated with unscheduled bed days below. The actions relating to unscheduled occupied bed days and Accident and Emergency Performance are interlinked. <u>Facilitating Discharge</u> • Working towards the 40% target for patients able to be discharged by 12 noon, in order to improve the flow of patients through the acute hospital. Monitoring is in place.	

			• Improved use of the Forth Valley Royal Hospital discharge hub, which is in place over 7 days, in order to facilitate the discharge of patients. • Maximise the benefit of the HEPMA prescribing system in supporting pre-noon discharges and improving the flow of unscheduled care patients ready for discharge. • Working towards an increase in the number of discharges which take place at weekends in order to improve patient flow over 7 days. This is supported by weekend planning meetings in most ward areas and designated Senior Charge Nurses with the remit of aiding patient flow. • Mainstream the discharge to assess model. This has been piloted in the Falkirk area and will be rolled out if evaluation demonstrates a positive impact on reducing unscheduled admissions and increasing the volume of early discharges. • Establish a consistent approach to frailty screening and comprehensive geriatric assessment at the front door to ensure the most appropriate route for patients i.e. admission, discharge, discharge to assess. <u>Reducing bed days occupied</u> • The “save 10,000 bed days” project was launched in 2016 in order to raise awareness amongst staff of the importance of minimising the length of stay in hospital and optimising the methodologies for ensuring earliest discharge of suitable patients, by recording where bed days have been saved and how this has been achieved. • Develop services further by reinforcing clinical decision making and roles, in particular Clinical Directors, ward based Consultants, Charge Nurses and Advanced Professional Practitioners, to ensure patient flow is optimised across extended hours and weekends. Examples include the development of criteria led discharge. • Continue to undertake the fortnightly day of care audit to identify patients who are potentially delayed in accessing the most appropriate place of care or discharge home and to ensure that no inpatients have a length of stay greater than 28 days. <u>Optimising Patient Flow</u> • Standard Operating procedures and criteria are in place for pathways including referrals to Community Hospitals, REACH, Short term assessment etc. • Implement the recommendations from the Institute of Health Optimisation (IHO) programme in FVRH wards to reduce the length of stay. NHS Forth Valley is one of three national pilots working with the IHO to help reduce	

			delays for patients. The aim of the programme is to even out the peaks and troughs in the demand for and use of hospital beds. • Intermediate care services have been established in both Health and Social Care Partnership areas and clear pathways support referral and awareness of how to access these. • The range of rehabilitation and reablement options for patients has been extended, particularly access at weekends. For example, rehabilitation is now available across 3 community hospitals and all wards to facilitate greater flexibility of bed use, Intermediate care and reablement beds are available across Forth Valley • Review the use of the beds in the inpatient bed base, by working to reduce the average length of stay and decrease the reliance on contingency beds. • Plan to invest in a replacement for the Patient Administration System. This will bring a significant benefit of integrated patient information to support practitioners in the delivery of high quality patient care. ED and bed management modules will be part of the system implemented. Capital and revenue costs and the timeline to be finalised.	
3. A&E Performance	95% of patients attending ED/Minor Injuries will be seen, treated and discharged or transferred within 4 hours.	A&E attendances adults 18+. A&E adults 18+ seen within 6 hours. A& E attendances adults 18+admitted as in patient Adults 18+ Admissions from A&E	• 6 Essential Actions. NHS Forth Valley and the health and social care partnerships will work towards achieving and maintaining performance in respect of the target to see, treat and discharge or transfer ED and Minor Injury patients within 4 hours. A “6 Essential Actions” Action Plan is in place covering a range of unscheduled care actions including actions associated with A and E Performance. Reporting on the Action Plan is undertaken quarterly. Operational Management arrangements are in place in the Acute Hospital, in liaison with community health and social care providers, to manage patient flow on a day to day basis. These arrangements are reviewed regularly. Clear escalation plans support the operational arrangements and simulation exercises ensure the escalation plans are fit for purpose. • Review Redirection Policy to ensure Out Of Hours (OOH) and other healthcare service flow is working optimally. • The Board promotes the web based Know Who To Turn To information which aims to ensure that the range of alternatives to ED are well understood and communicated widely, supported by external communications and media initiatives. We will continue to promote and	

			Identify the use of the Minor Injuries Unit in Stirling. • Review and redesign the Forth Valley GP Out of Hours Service in line with the recommendations of the National Review of GP OOH Services (Ritchie Review). • Work is progressing with the SAS to smooth the arrival times for GP referrals. • A model is being implemented across front-door areas allowing for patients from ED and GP referrals to be allocated to either ambulatory (CAU) or inpatient (AAU) assessment areas directly. • Work has taken place within the ED to ensure specific pathways are in place for orthopaedics and mental health, which has helped to improve the flow of patients with these conditions. • A dedicated 24 hour flow call handling number is in place with Senior Clinical Nurse support to ensure patients in ED and the Assessment Units are discharged or transferred promptly to their next stage of care. This supports flow across the front door and within the wider FVRH site. • Information is provided on capacity and flow to support the clinical teams including real team information on patient status and electronic 2 hourly reporting, providing a clear picture in ED on presentations, wait for 1st assessment, downstream bed availability and community hospital bed availability. • The Pharmacy First initiative is in place across Forth Valley. This allows patients access to treatment for uncomplicated urinary tract infections and impetigo from a community pharmacy.	
4. Delayed Discharges	December 2016 NHS Forth Valley and the HSCPs committed to achieving 50% reduction in the total numbers of delayed discharges between the November census position and the end of March 2017, equating to a target total number of 47 discharges. During 2017/18, Falkirk will commit to maintain the delayed discharge performance at the agreed level of 47 discharges and will work towards delivering and maintaining the national target of no delays over 2 weeks.	Delayed discharge bed days all reasons. Delayed discharge bed days code 9. Delayed discharge bed days social care reasons. Delayed discharge patient care, family reasons. Delayed discharges over 14 days.	To deliver these targets, Delayed Discharge Improvement Plans have been agreed. The plan describe a range of actions aimed at delivering improvements both in the process and pathways of care and in whole system transformational change including:- • Development and implementation of frailty pathway and comprehensive geriatric assessment process. • Implementation of Discharge to Assess Service • Review and redesign of intermediate care and reablement pathways, and commissioning of homecare services. • Introduction of GP Fellows into Closer to Home Service to further support and develop prevention of admission pathways. • Clearer focus on and improvements in AWI and guardianship process. • Ongoing implementation of Anticipatory Care Planning and Falls prevention strategies.	

			Monitoring of progress with Improvement Plans will be through HSCP Leadership group and reported to the Integration Joint Board
5. End of Life Care	Falkirk HSCP is committed to enabling people to die in the place of their choice. We are aware that most patients, when asked, would prefer to die peacefully at home. We are also committed to avoiding bringing patients in to hospital as an emergency in the last few days or hours of their lives.	Falkirk HSCP % of last 6 months of life by setting. Falkirk HSCP number of days per setting. Falkirk HSCP % of last 6 months of life in a community setting Falkirk HSCP % of last 6 months of life in hospice /palliative care setting. Falkirk HSCP % of last 6 months of life in a community hospital. Falkirk HSCP % of last 6 months of life in the main hospital.	Actions to enable more patients with palliative and end of life care needs to be cared for at home or closer to home include the following: • Roll out Anticipatory Care Plan in order to plan ahead to meet the changing needs of palliative and end of life care patients. • Hospice at Home service. Strengthen the links with Strathcarron Hospice to support palliative and end of life patients to be cared for at home or close to home. • As part of the Healthcare Strategy implementation, identify how the speed of access to healthcare equipment can be improved to enable more care to be provided at home. • Sustain continuous improvement in the communication skills of staff involved in palliative and end of life care, supported by training packages offered in Forth Valley. • Identify how access to specialist palliative care advice and support in the hospital over 7 days can be improved, to facilitate earlier discharge home or close to home.	
6. Balance of Care	Shift in spend away from care homes, accommodation based social care and unplanned inpatient care towards community based health and social care, including care at home, intermediate care services and planned inpatient care and developing more community based support.	% of population living in an unsupported home. % of population living in an unsupported home aged 75 plus. % of population living in a care home. % number of people aged 65 plus receiving home care.	• Developing community capacity in partnership with range of providers at Locality levels. • Developing and embedding a reablement approach across all services. • Development of whole system map to improve pathways. • Continue to develop technology enabled care to support people to remain at home. • The revised single shared assessment. • Improved information sharing to support identification and proactive work with people who are at risk of admission. • The development of intermediate care bed provision, including the planning and revision of models of care • Continue to work with local providers of care homes to ensure appropriate admissions and support the care of those with complex needs. • Review pathways with acute services including those for uninjured fallers and frailty. • New tender for care at home focussed on outcomes and including a discharge to assess and reablement approach. • Development of Integrated Locality teams to support locality planning	

			and delivery of local health and social care.	

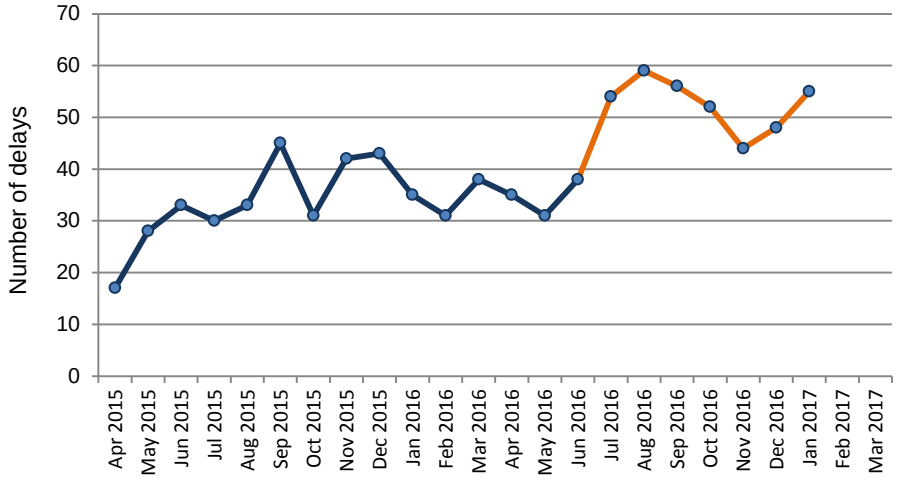
Appendix 2

Falkirk Delayed Discharges – Performance Report March 2017

1 Total Number of Falkirk Delays at Census Point – 2015/16-2016/17

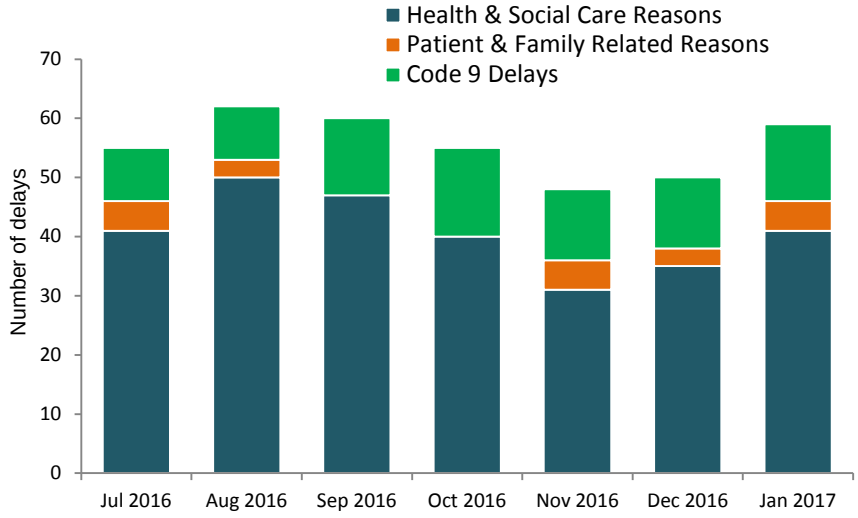
Definitions changed July 2016 – chart is a combination of revised and previous definitions [1]

Source: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/data-tables.asp?id=1681#1681



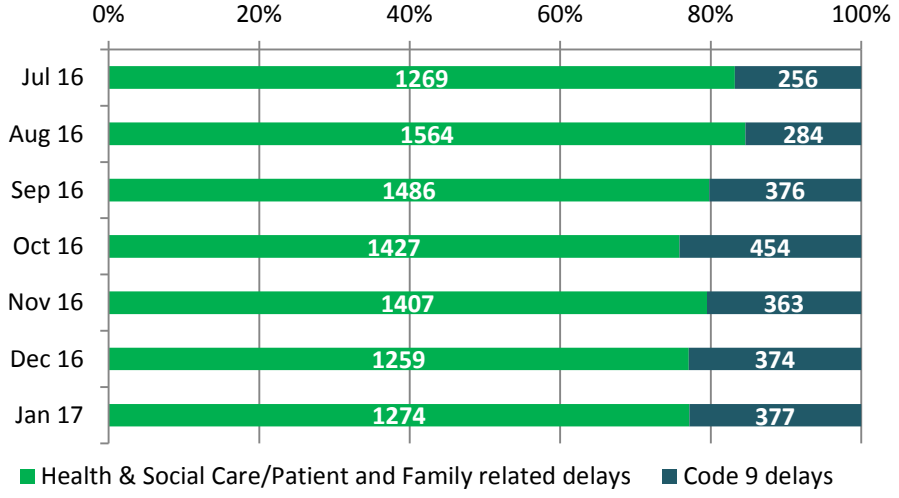
2 Primary Reason for Delay – Falkirk Jul 2016 to Jan 2017

Source: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/data-tables.asp?id=1681#1681



3 Delayed Discharge Bed Days – Falkirk July - Jan 2016/17

Source: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/data-tables.asp?id=1783#1783

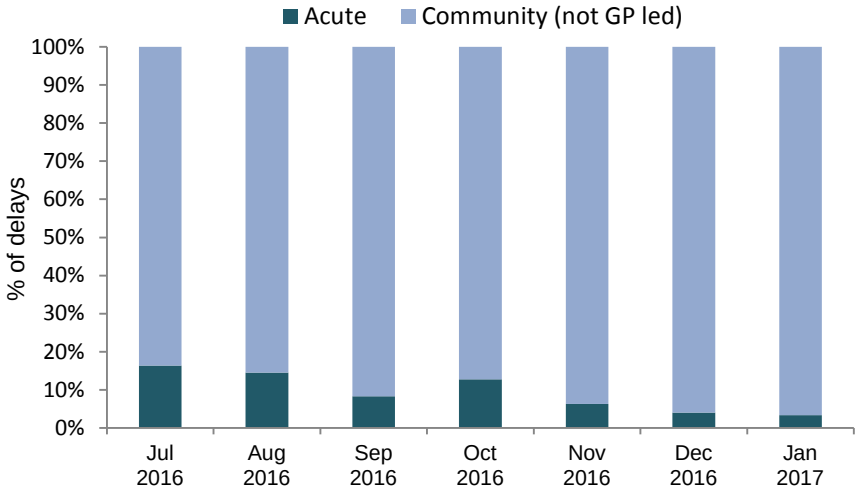


4

Primary Reason for delay	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Total delays at census point	**60**	**55**	**48**	**50**	**59**
Total health and social care reasons	**47**	**40**	**31**	**35**	**41**
Assessment	8	6	5	7	15
Place availability	22	23	20	21	20
Care arrangements	17	11	6	7	6
Total Patient and Family reasons	**-**	**-**	**5**	**3**	**5**
Disagreements	-	-	4	2	4
Legal/Financial	-	-	1	1	1
Total code 9 delays	**13**	**15**	**12**	**12**	**13**
Adults with incapacity (AWI)	7	10	6	7	6
Other code 9 reasons (not AWI)	6	5	6	5	7

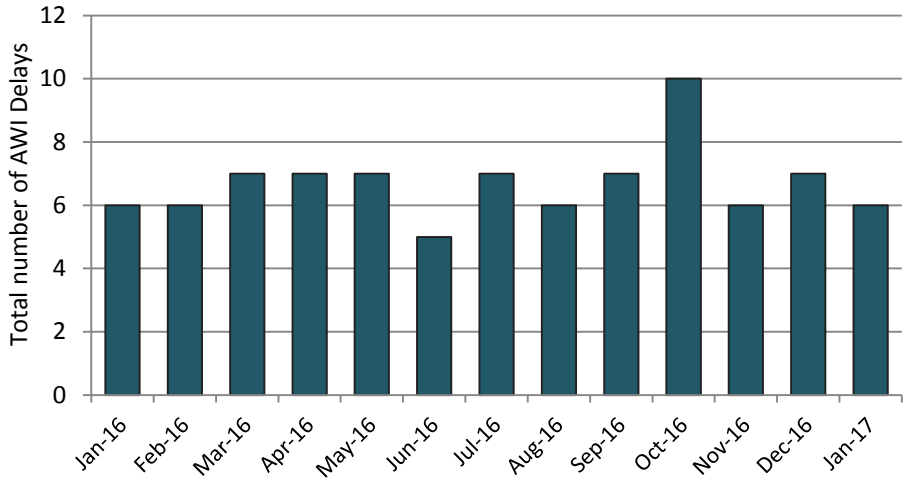
5 Delay Location – All Delays in Falkirk Jul 2016 to Jan 2017

Source: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/data-tables.asp?id=1681#1681



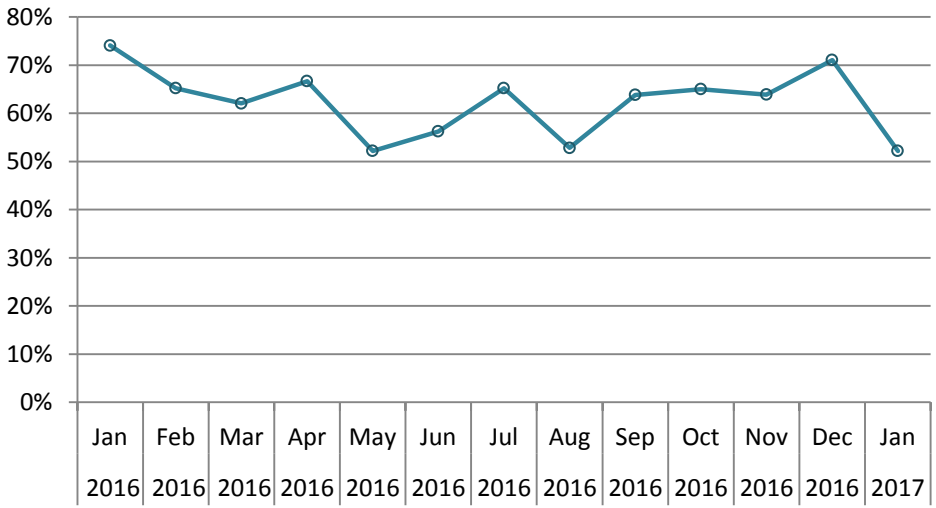
6 Number of delayed discharges in Falkirk coded as Adults with Incapacity (AWI) – Jan 2016 to Jan 2017

Source: Delayed Discharges Team - ISD



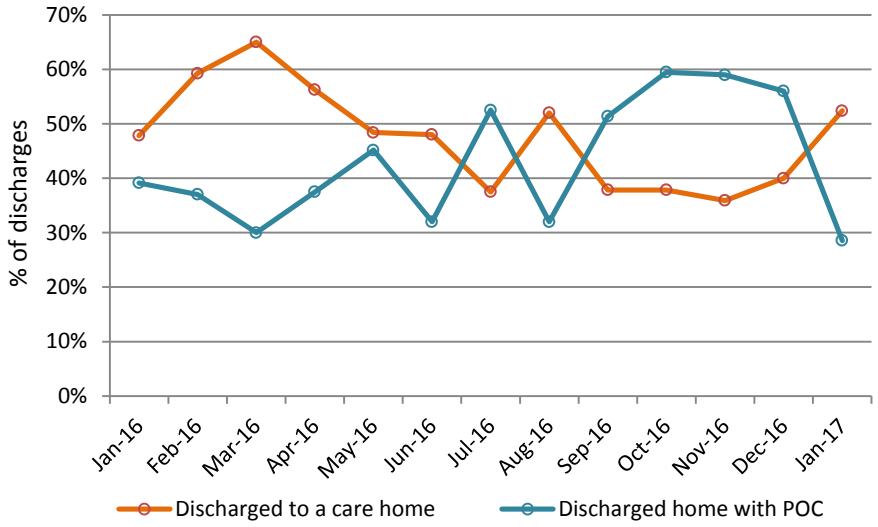
7 Percentage of Falkirk delays (excl. Code 9) that were over 2 weeks (Jan 16 – Jan 17)

Source: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/data-tables.asp?id=1681#1681



8 Hospital discharge destination of Falkirk residents referred to Social work*

Source: Gina Anderson - Social Care Team Manager

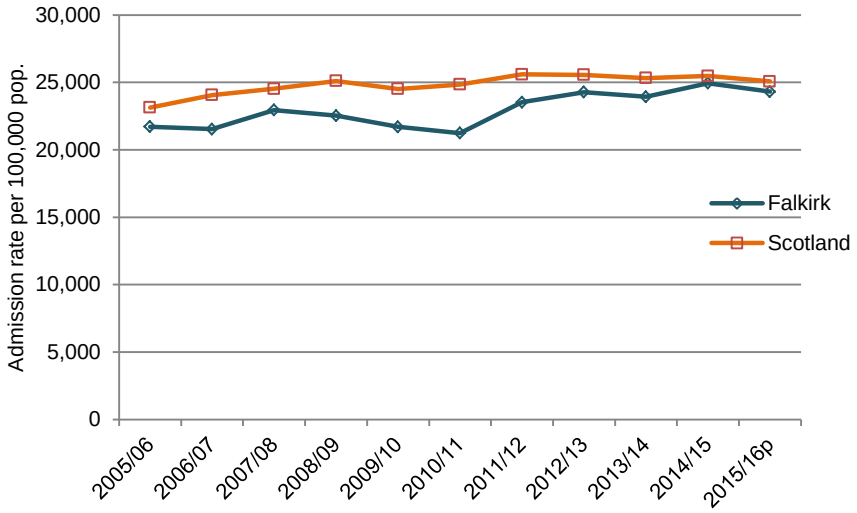


* Includes all adults over 18 years old who were resident in hospital and referred to Social work, whether a delayed discharge or not.

9

Admission Rates per 100,000 Population of All Emergency Admissions for Patients Aged 65+

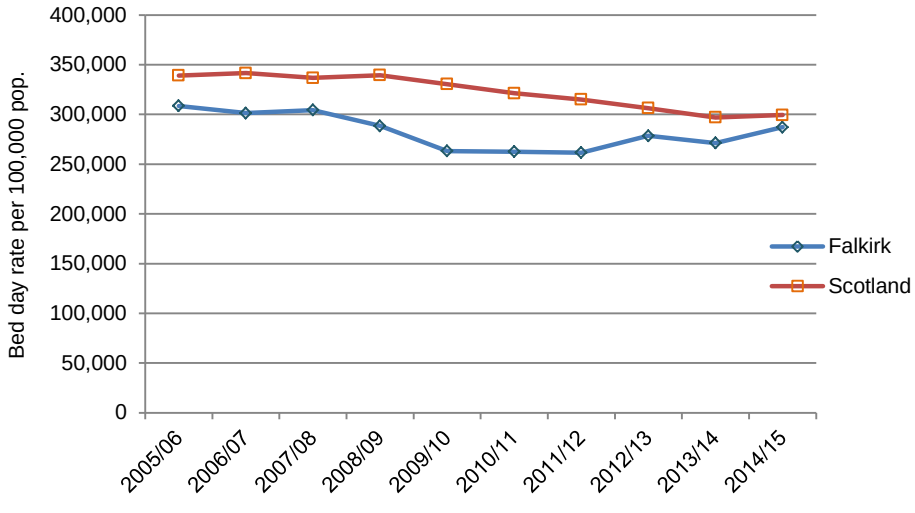
Source: http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/



10

Bed Day Rates per 100,000 Population of All Emergency Admissions for Patients Aged 65+

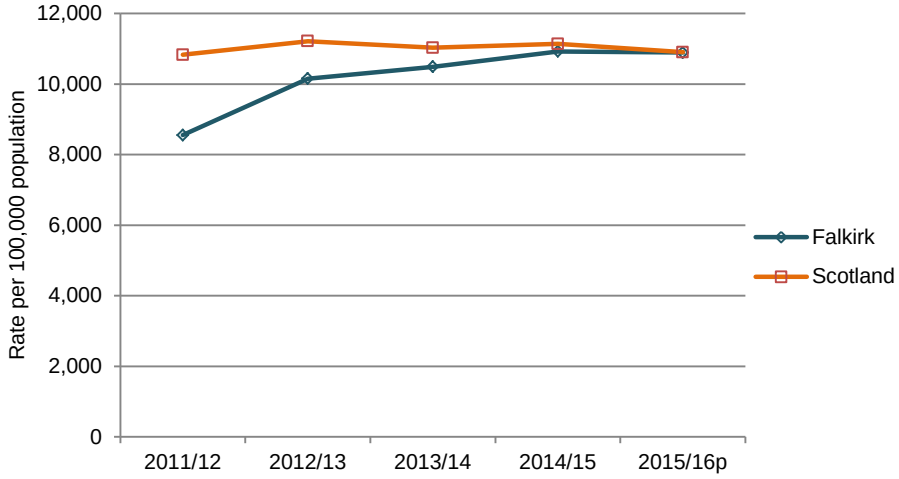
Source: http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/



11

Rates per 100,000 Population of Patients aged **85+** with 2+ Emergency Admissions

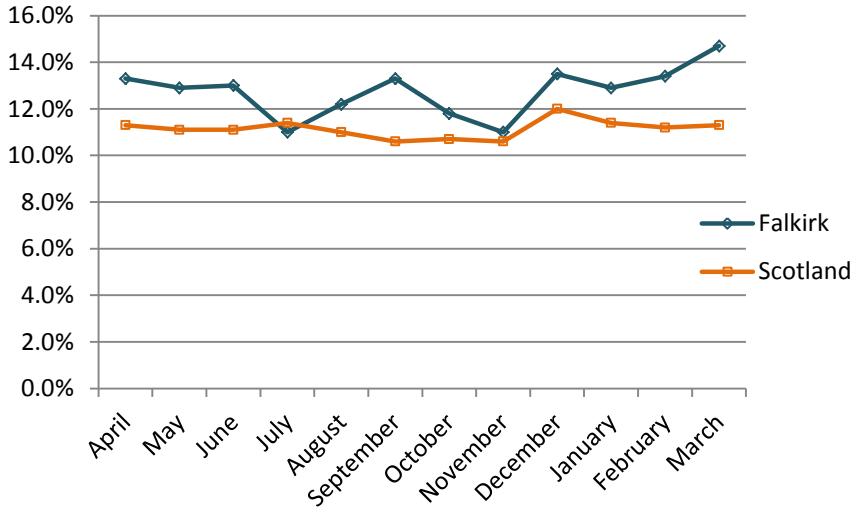
Source: http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/



12

Age **65+** Crude Readmissions Rate % within 28 days (2015/16)

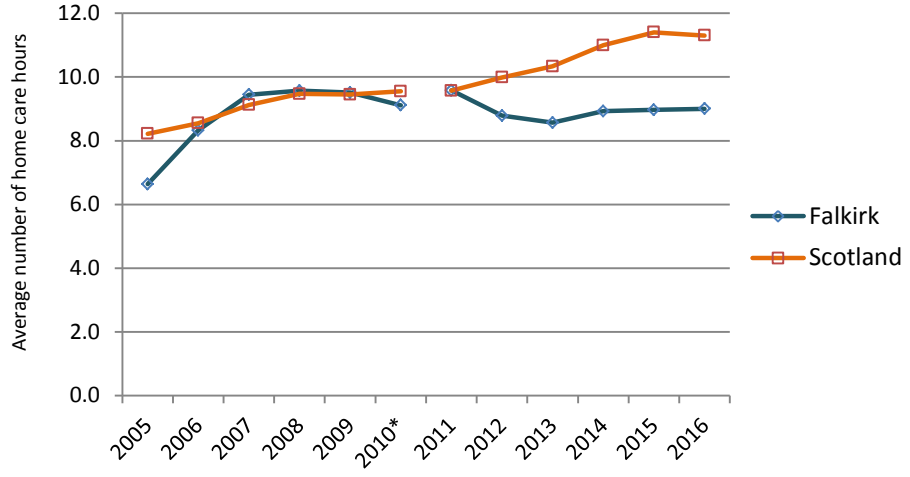
Source: ISD SMR01



13

Average Home Care hours per client [2,3]

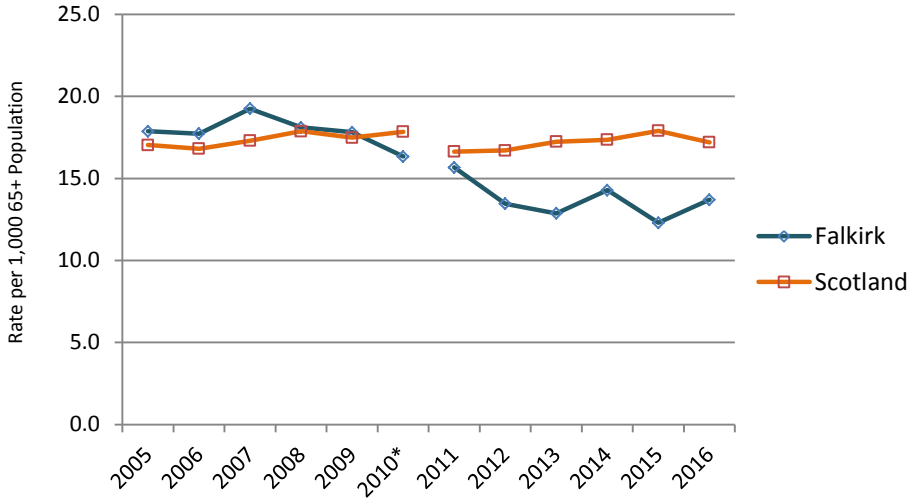
Source: http://www.gov.scot/Topics/Statistics/Browse/Health/Data/Homecare



14

Clients aged 65+ receiving **10 + hours** home care – rate per 1,000 population [3]

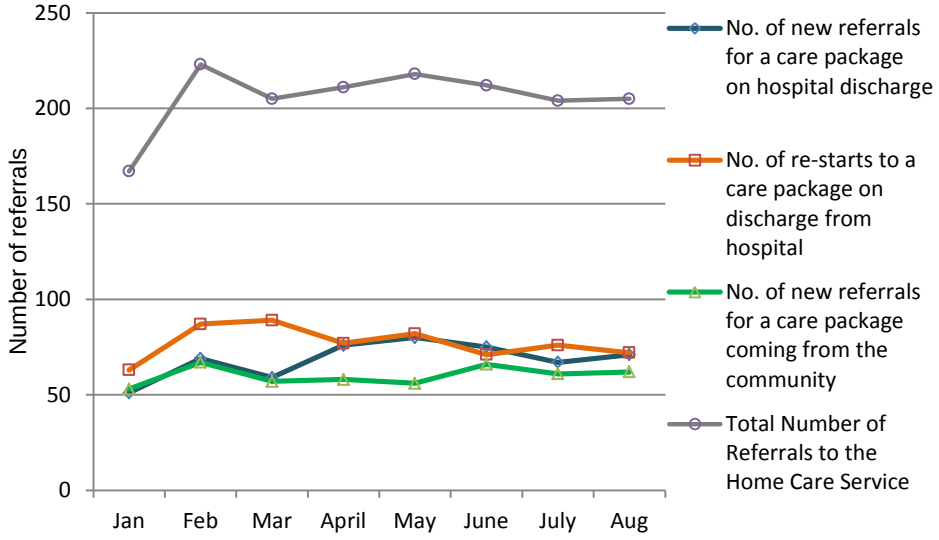
Source: http://www.gov.scot/Topics/Statistics/Browse/Health/Data/Homecare



15

Falkirk Home Care Service Referral Information – Jan 2016 to Aug 2016

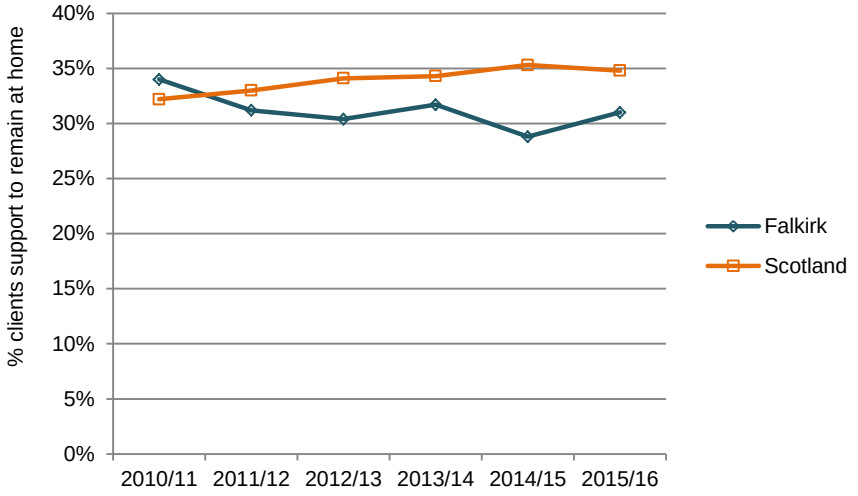
Source: Falkirk Social Work Services



16

Percentage of clients with intensive needs who are supported so that they can remain in their own home

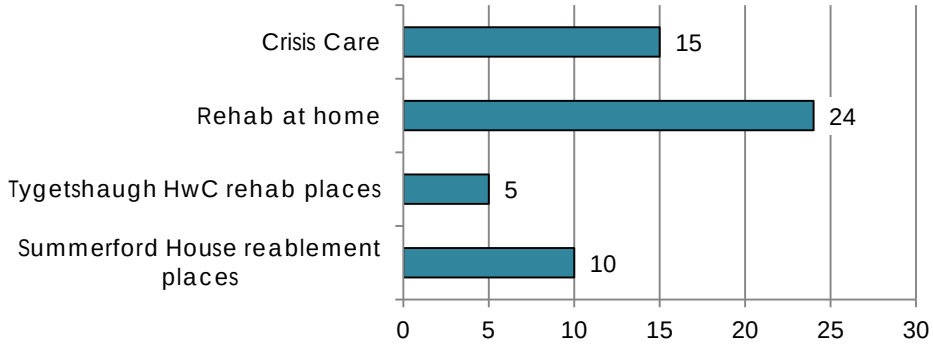
Source: http://www.improvementservice.org.uk/benchmarking/tool.html



17

Falkirk Intermediate Care / Reablement maximum capacity at March 2017

Source: Falkirk Social Work Services



*Rehab at Home - excludes two places for under 65s

**Crisis Care - no set number of places, 15 represents average number of service users per month (in 2016)

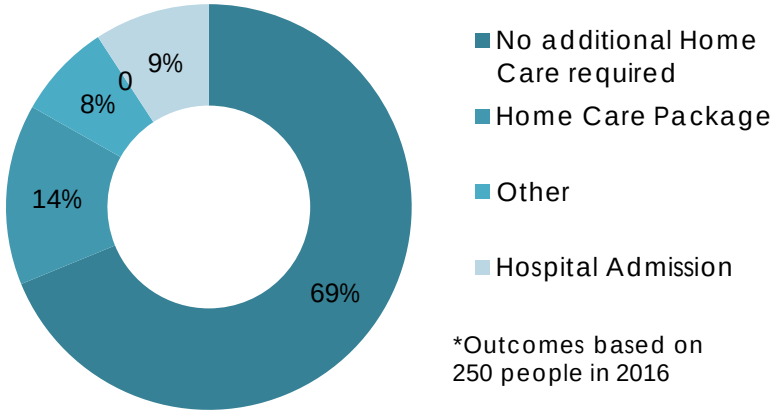
*** Summerford House is under refurbishment to accommodate the 10 IC beds lost due to the closure of Oakbank.

**** The 5 beds at Tygetshaugh are split into 2x Step –up and 3x Step-down beds.

18

Outcomes at the end of Falkirk Rehabilitation at home service(RAH/CRAH) (2016)

Source: Social Work Services 24/7 Team



*Outcomes based on 250 people in 2016

19

Summerford House Intermediate Care – 2016/17 Quarterly Performance

Source: Kenny Moran – Centre Manager Summerford House

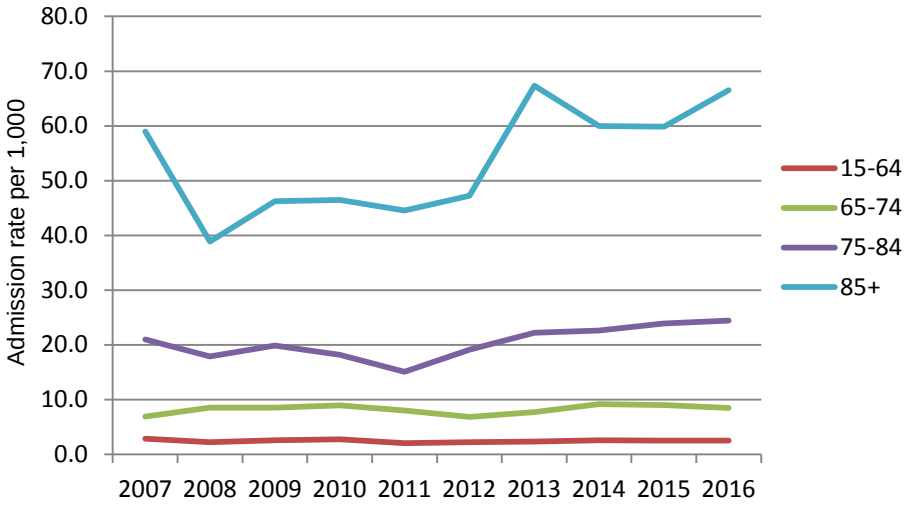
	Q1 2016/17	Q2 2016/17	Q3 2016/17
Number of new admissions	14	10	15
Number discharged home with POC	8	7	9
Number discharged home without POC	1	0	1
Number readmitted to hospital	3	2	2
Number identified to require Long-term care	2	1	0

Note - Average Occupancy Rate for Summerford House I/C beds during 2016 was **58%**

20

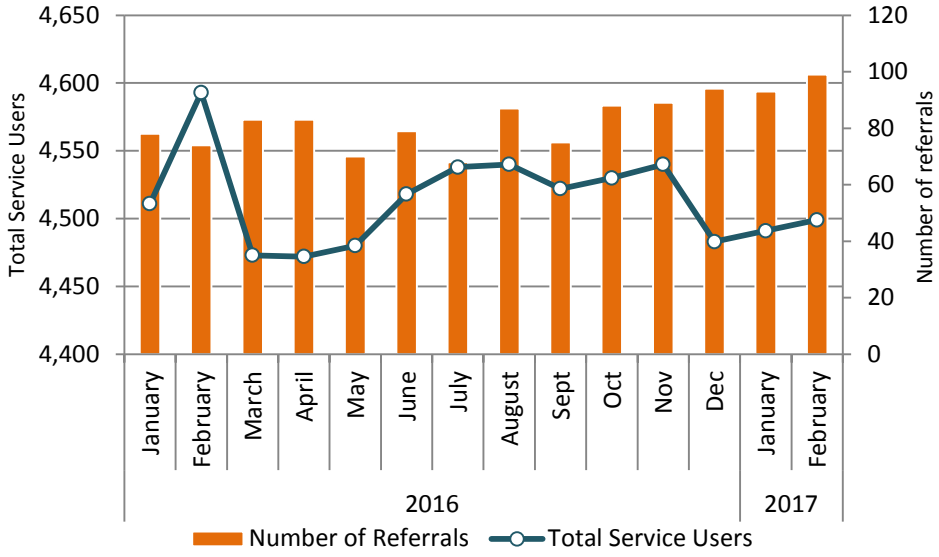
Falls Admission Rate per 1,000 population – Falkirk Population

Source: http://www.isdscotland.org/Health-Topics/Emergency-Care/Publications/data-tables2017.asp?id=1868#1868



Mobile Emergency Care Service (MECS) Number of referrals and Total Service Users – Jan 16 to Feb 17

Source: Kenny Moran – Centre Manager Summerford House



KEY POINTS – March 2017

- At the most recent Census date there were **59 patients delayed in their discharge** (Fig 4.) In the month of January **1,651 bed days** were occupied by delayed discharge patients.

- The top reason for delayed discharge at the last census date was 'place availability' (Fig 4.) which accounted for 20 of the delays. It should also be noted that in the most recent census month of January, delays due to Social Care assessment more than doubled on the previous month.*

- In 2016, 69% of clients required no additional Home Care at the end of rehab at home (RAH) (Fig 18.)

- During 2015/16 the 65+ crude rate of readmission at 28 days was consistently higher than Scotland (Fig 12.)

- Recently released figures for unintentional injuries show that the falls related admission rate has increased in 2016 for the 85+ age group. The 85+ cohort has a far higher admission rate due to falls than any other age band (Fig 20.)

*Census figures

Note – This report contains the latest available information at the time of production from a number of different sources. The most recent available data from one source may be more up to date than from other sources. Please ensure that you consider this when you are comparing charts.

NOTE: The ISD delayed Discharge Census changed in July 2016 to use new definitions. It is no longer possible to directly compare data prior to July 2016 with Census data since July 2016 – A number of charts have been updated to reflect the new census. The exception is chart 1 which uses combined definitions to show the number of delayed discharges over time (see note below).

[1] - Revised and previous definitions applied to all census data pre and post July 2016 in chart 1. The ISD delayed Discharge Census changed in July 2016 to use new definitions. It is no longer possible to directly compare data prior to July 2016 with Census data since July 2016. This means that delays due to healthcare reasons or delays in non-hospital locations are not included from July 2016 onwards. Additionally, delays within 3 working days of the Census date are included post July 2016. **For the purpose of this chart, delays due to healthcare reasons, delays in non-hospital locations and delays discharged within 3 days of census date are not included.**

[2] – The average number of home care hours is calculated from the total number of home care clients (rounded to nearest 10) and the total number of hours provided (rounded to nearest 10).

[3] - Figures for Home Care hours from 2010 exclude 24-7 care. This has resulted in a break in the time series between 2009 and 2010.

[P] – Provisional data.

• This report was prepared using data from the ISD delayed discharge census. Figures reported in some other IJB reports are sourced from NHS Forth Valley's EDISON System which only counts delays of Falkirk residents in Forth Valley. The ISD census collates delays of Falkirk residents in all Scottish Health Boards. Numbers delayed outside Forth Valley are very small and this makes a minor difference to the overall numbers of delays and bed days occupied.

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Appendix 3

Falkirk Health and Social Care Partnership

Draft response to the Scottish Government Health and Social Care Workforce Planning: Discussion Document

Governance: Question 1 - Are these roles the right ones, or do you have alternative models? What steps will be needed to ensure these proposals are fully effective?

National

Preparation of a national workforce plan requires to be flexible to take account of the different stage each Partnership is at in its workforce planning and development arrangements.

It would be helpful if levels of prescription should be kept to a minimum to ensure organisations do not have to adopt duplicate workforce planning arrangements for their organisations, as well as in-scope services, which are still part of their workforce.

Overall, the roles laid out (in the Discussion Document) at the national strategic level appear fairly broad and reasonably comprehensive.

It is possible that there is a need for a new "national scrutiny body". However, it would be preferable to look at the role and function of existing national "oversight bodies" (for example, SSSC, NES) to consider whether it is an option to absorb these roles into their existing functions. This would be a more efficient and cost-effective option.

It would be helpful to have some outline of the range and scope of consultations that will be undertaken, to enable any scrutiny body to discharge its roles and functions effectively.

Regional

Because the regional roles seem fairly broad, the issue of monitoring to ensure effective delivery is also (rightly) made explicit in the Discussion Document. Some clarity may be helpful in terms of the nature and scope of such monitoring, how it will be carried out and by whom.

It may also be helpful to have a clear definition of what would constitute a region in the context of the Plan, particularly given the wide variation of geographical and professional boundaries that exist.

Clarity on what is meant by "regional planning structure" would be useful. It is important to take into account that Councils have different levels of pay, pay structures, and terms and conditions. In addition, some job titles and job roles for similar jobs can be different. Add to this variation in the Third and Independent Sectors, and the context becomes more complicated.

Regional planning is moving in the opposite direction to the requirements for locality planning within the Community Empowerment Act and the Integration Joint Boards. Some regional planning for aspects of providing acute hospital services are positive and delivery of localised community health and social care requires locality planning and sensitivity to local workforce challenges and opportunities.

Workforce planning must also be directly linked to Partnership deliverables. If this is "regionalised", workforce planning may lose connection with such deliverables and with locality planning.

It may be more appropriate, as a national level, to look at this on a functional basis. Consideration could then be given to the gaps and issues for specific functions, which would be more beneficial than adopting systems-wide planning.

Local

From a Partnership perspective, it is important to recognise that "National Health and Social Care Workforce Planning" should take into account the needs of all Partnerships colleagues, recognising the interdependencies that already exist within these organisations and the differences in governance arrangements.

Local roles as outlined in the Discussion Document appear suitable, and there is some recognition that organisations will continue to maintain responsibilities for workforce planning that falls out with the remit of IJBs (for example, Children's Services).

There also needs to be sensitivity shown to the need to avoid the development/ establishment of a "top down" approach in the functioning of these systems; active encouragement of a "bottom up" approach would encourage local innovation and creativity in terms of workforce planning, whilst maximising local accountability and responsiveness to local communities and service users.

Workforce Planning Roles: Question 2 - How can organisational and individual collaborative working be improved, and barriers removed, so that workforce planning can be effectively coordinated to ensure people get the care they need where and when they need it:

All of the organisations involved in the delivery of health and social care services are, and should remain, aware of the implications of "Silo" approaches.

Within "front end" or "customer facing" services it has been shown that co-location, joint training, shared vision and values in conjunction with clear, robust and shared policies and procedures (for example, information-sharing protocols) significantly improve outcomes for people.

Such approaches to service delivery generally tend to focus on choice and control for service users while providing scope to join up care in ways that work for individual service users. Wherever possible and practical, similar approaches need to be adopted within workforce planning.

It can be argued that protection and personalisation are two sides of the same coin (but have often developed separately). The Plan needs to ensure that protection and personalisation are at the centre of workforce planning, thereby ensuring positive and safe outcomes for those who require health and social care services.

Workforce planning must focus on the key deliverables of each Partnership, to ensure the Partnership can achieve these. Function-specific cross-regional interest groups may be a mechanism to support this.

Partnerships are already working on the gaps, issues and risks identifiable from their workforce data.

Workforce Data: Question 3 - How should workforce data be best collated and used to undertake workforce planning in an integrated context based on current approaches of a nationally-led NHS system and a locally-led care system?

It would be helpful to if there was some consideration given to ITC systems and procedures at national, regional and local levels: are they compatible; are they fit for purpose; are they secure? If not, what changes are required to make them so?

There is a need to share workforce data; however, there are information sharing implications arising from this. Consideration needs to be given to the data sets in use across organisations: again, are they compatible; fit for purpose; accurate? Is it feasible to harmonise or standardise these data sets across organisations?

Recruiting and Retaining staff: Question 4a) - How might employers and other relevant interests in the Health and Social Care sector work, jointly and individually, to identify and tackle recruitment and retention issues, ensuring priority gaps are identified and addressed:

It may be possible for employers and other interested parties to consider, where appropriate and practical, joint recruitment campaigns or approaches where vacancies in all of the organisations can be publicised jointly and where consideration could be given to joint recruitment processes.

Councils, for example, already have a shared recruitment system (myjobscotland), and this is being further developed to promote and encourage returners to teaching jobs, for which there is a shortage. A similar approach could be taken for professions within health and social care.

There is also a need to better “professionalise” the roles available within the social care sector in order to promote the roles as worthwhile career opportunities. Within this context, there is a need to be aware that different pay and conditions exist amongst the different organisations who provide health and social care services.

Question 4b). Are there any process or structural changes that would support collaborative working on recruitment?
See comments on Question 4a, first paragraph, above.

Clear and consistent Guidance: Question 5 - Based on what is said above, would it be helpful at national level to have an overarching process (or principles, or framework) for workforce planning across the Health and Social Care sectors?

It may be helpful to develop a unified or harmonised set of principles or a framework for workforce planning across the Health and Social Care sectors. The language and terminology of any set of principles or framework should be neutral.

The Scottish Government discussion document recognises and references: a) the six step methodology in use within NHS, b) the eight stage guidelines offered by SSSC and c) the four stage process used within the third sector. It should be feasible to develop a hybrid of these three approaches that may prove useful across the sector as a whole.

This, however, must be flexible enough to accommodate the needs of the different employers. For example, in Councils, Audit Scotland requires Councils to take the same approach to workforce planning for their whole workforce, including those employees in-scope for integration.

Student Intakes: Question 6a) - How can a more coordinated and collaborative approach be taken to assessing student intake requirements across all relevant professions, and what other issues should be addressed to remove barriers to successful workforce planning?

As with other areas discussed in this response, a “cross organisation” approach to assessing student intake requirements is critical to ensure the right students are recruited in the right numbers in the right areas to fulfil current and future needs.

It is essential, therefore, to ensure that a fit-for-purpose IT infrastructure is in place to enable health and social care partners to share accurate and up-to-date information about all aspects of recruitment and student intake requirements.

Perhaps a reasonably quick win would be to consider introducing National Apprenticeship schemes, particularly in gap areas where there are urgent recruitment needs.

Question 6b). What other issues should be addressed to remove barriers to successful workforce planning in both health and social care?

Certainly, physical barriers (for example, being in different locations) and systems barrier (such as the inability for different Partners’ IT systems to “talk” to each other) are critical.