Agenda Item 8

Falkirk Health and Social Care Partnership Update

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Falkirk Council

Title	**Falkirk Health and Social Care Partnership Update**
Meeting	**Scrutiny Committee (External Organisations)**
Date:	**4 October 2018**
Submitted By:	**Chief Officer, Falkirk Health & Social Care Partnership**

1. PURPOSE OF REPORT

1.1. The purpose of this report is to provide a summary of the progress made by the Falkirk Health and Social Care Partnership HSCP to implement the Integrated Strategic Plan. This reports progress with performance since the last update to the Scrutiny Committee on 17 May 2018.

2. RECOMMENDATIONS

2.1. It is recommended that the Committee considers the performance of the Health and Social Care Partnership, and select a course of action from the following options:

- Approve the report and acknowledge progress by the HSCP in meeting its priorities under the Joint Strategic Plan;
- Request further information on specific aspects of the performance of the HSCP;
- Request a follow up report for future Scrutiny Committee consideration.

3. BACKGROUND

3.1. The Falkirk Integration Joint Board (IJB) is responsible for overseeing the planning, management and delivery of all relevant functions within scope of health and social care integration. This involves the delegation of functions and services by Falkirk Council and NHS Forth Valley and these services are delivered through the Falkirk Health and Social Care Partnership (HSCP).

3.2. The Board has 6 voting members – 3 Falkirk Council Elected Members; Councillors Black (who is vice-chair), Collie and Meiklejohn and 3 NHS Forth Valley non-executive Board members. The membership also includes senior officer representation from health, social work and wider

stakeholders including service users, carers, Third sector and staff representatives.

3.3. The IJB controls an annual budget of approximately £208m, and the Board decides how resources are used to achieve the objectives of the Falkirk Integrated Strategic Plan 2016-19.

3.4. This plan describes how the Partnership will continue to make changes and improvements to health and social care services for all adults. It identifies five specific local outcomes which align with the Scottish Government national health and wellbeing outcomes, the National Health and Social Care Delivery Plan and the Falkirk Community Planning Partnership Strategic Outcomes and Local Delivery (SOLD) Plan.The plan details how the Partnership will prioritise services in response to the key issues for the Falkirk area and is supported by a Joint Strategic Needs Assessments (JSNA).

3.5. Work has started to review the Strategic Plan, with reports considered by the IJB and Strategic Planning Group. A refreshed plan will be produced for the period 2019-2022.

3.6. The IJB has a responsibility for the effective monitoring and reporting on the delivery of services and relevant targets and measures. The management of performance is critical to managing the overall IJB budget by providing a sound basis from which to make decisions regarding services, redesign and disinvestment. The Board does this is a number of ways:

- Annual Performance Report
- performance reports are presented to each of its meetings, and these are accessible online
- reports on a range of subjects, including the Chief Officer report
- IJB Audit Committee is responsible for the promotion of best practice in the areas of risk management, financial procedures, internal controls, development of continuous improvement and review of External Audit issues
- IJB Clinical and Care Governance Committee will provide assurance to the Board on the systems for delivery of safe, effective, person-centred care in line with the IJB's statutory duty for the quality of health and care services.

4. FALKIRK HSCP UPDATE

4.1 The report to Scrutiny Committee will focus on recent information contained in the Integration Joint Board reports; the Annual Performance Report and the Performance Report presented to the IJB on 1 June 2018. Future reports to Scrutiny Committee will provide updates from the IJB Audit Committee and Clinical and Care Governance Committee.

Progress with integration

4.2. On 1 April 2016 the operational responsibility for Adult Social Care services transferred to the IJB and all decisions relating to those services have been taken by the IJB, or it's Chief Officer, via the IJB's Leadership Team.

4.3. In February 2017 the operational responsibility for the Integrated Mental Health team and Integrated Learning Disability team transferred to the IJB. There is ongoing commitment by NHS Forth Valley to integration and to further implement operational arrangements to the HSCP.

4.4. At the December 2017 meeting of the IJB, the Chief Executives of Falkirk Council and NHS Forth Valley were asked to submit a joint paper detailing the plans for further integration. This was to reassure the IJB regarding the pace of change.

4.5. At subsequent meetings, the IJB has received reports setting out progress to achieve further integration. However there are diverging views on the following areas:

- role of the Chief Officer
- governance of in-scope services
- management structures
- hosted services.

4.6. At the Special IJB meeting held on 25 June 2018, the Board received two reports from the Chief Executives, setting out respective partner positions. It was considered important to set this out in separate reports to ensure that the IJB was properly informed of the discussions that have taken place and why agreement has not been reached on the plans for further integration.

4.7. The areas set out at section 4.5 need to be clear and agreed in order to mitigate the substantial risks associated with the transfer of services. It was the Council's expressed view that until these areas are clarified the opportunities and benefits associated with integration cannot be recognised and the pace of transformation will continue to be slow. This will continue to pose a risk to the reputation of the Forth Valley NHS Board, the Council and the IJB.

4.8. Since then, the Chief Executive, NHS Forth Valley, has continued to chair meetings with the two HSCP's to progress these areas. A development session with the Board took place on 7 September and a report will be presented to the IJB at its meeting on 5 October.

Home Care Inspection Report

4.9. The Homecare service is a registered care service with the Care Inspectorate and an annual inspection took place during May 2018. The

inspection process took into account a range of evidence, including a self-evaluation, information and intelligence received on performance from 66 questionnaires by people who use the service, conversations with staff, and direct observation of support being provided in peoples' homes. The inspection report noted that no complaints had been upheld since the last inspection. The report also found that no requirements or recommendations made at the last inspection remained outstanding at the time of the current inspection.

4.10. The report recognised that the service was working towards improving the consistency of the service and noted a slight increase in the levels of consistent staffing experienced by people. This slight increase in the levels of consistent staffing notwithstanding, the inspection team found 24 out of the 66 questionnaires returned raised concern about the amount of different staff who were providing their service. The inspection team made a requirement that the service must improve on consistency and reliability in who is giving the care. The findings on consistency and reliability are counterbalanced in the report by positive observations about people's overall experience of care. The inspection team reported that people told them they were happy with the care they received from staff providing their care and support. Overwhelmingly people told the inspection team that staff treated them with dignity and respect. It was noted that staff were said by people to be skilled, kind and caring.

4.11. The inspection team made a second requirement that the service must develop and implement internal auditing systems that deliver effective oversight and monitoring of all aspects of the service. This requirement reflected the findings of the inspection team that there was insufficient monitoring of the service. In regards staffing the report made a range of positive observations. They found for example that training available for staff was comprehensive and responsive and that there were good links with health colleagues, meaning training could be organised where service users had new or complex health conditions. On quality of staffing the report pointed to improvement opportunities regards making some areas of good practice more consistent across the whole service.

4.12. The Care Inspectorate report was published on 31 July 2018. The grades awarded to services at inspection describe how well those services are performing against Care Inspectorate quality themes and statements. The grades have fallen again this year in all three of the inspected areas, namely Care and Support, Management and Leadership and Staffing and are:

- Care and support 2 – Poor
- Management and Leadership 2 – Poor
- Staffing 3 - Adequate
- Environment - not assessed.

The implementation of new, outcomes based national health and social care standards forms part of the context for the inspection.

4.13. The service has submitted an Improvement Plan to the Care Inspectorate and will take forward the necessary actions. This will be overseen by the Homecare Review Group, chaired by the Chief Officer. The actions which are being taken to address the issues raised in the Care Inspectorate's report include:

- improving staff working patterns and rotas to increase staff availability at the times when people want to have service provided
- redesign of our scheduling, better aligning staff resource to localities
- moving towards all our staff becoming personal carers, increasing the availability of personal care
- improve continuity through better use of information from our electronic scheduling system.
- improving communication with service users around changes to their service which may prove necessary.

4.14. In all of the above improvement work we are implementing progress through close partnership working with staff and their Trade Unions and with our colleagues in the Care Inspectorate.

Falkirk HSCP Annual Performance Report

4.15. The Partnership published an Annual Performance Report 2017-18 in line with statutory requirements on 31 July 2018. It reports on performance against the Partnership's local outcomes as required by the legislation, and highlights achievements throughout the year, with some case studies included. Partnerships are expected and encouraged to include relevant information beyond the minimum required, to build as full and accurate an assessment as possible as to how the integration of health and social care is delivering for people and communities. This is attached at Appendix 1 for information.

4.16. The report provides an opportunity to describe service developments and redesigns, that are currently demonstrating benefits to people and that over time should have a positive impact on Partnership performance. Many of the developments have previously been reported to Scrutiny Committee.

5. IJB PERFORMANCE REPORT

5.1 The IJB Performance Report presented to the Board in June 2018 is attached at Appendix 2 for information. This report presents performance in relation to unscheduled care and the local performance indicators for the period April 2017 to March 2018 against the baseline year 2015/16.

5.2 The Performance Report contains a Strategy Map. This has been created to ensure there is a direct link with the strategic vision and local outcomes

to the national health and well-being outcomes against which performance on integration is audited at a Scotland wide level.

5.3 The structure of the performance report has recently been reviewed and a new format developed. The layout is:

- **Table of Contents** to help readers navigate through the content more easily.
- **Section 1** provides a summary of key performance issues
- **Section 2** of the report provides an 'at a glance performance summary of local indicators' with RAG status and direction of travel, as appropriate. Current performance is shown beside the baseline 2015/16.
- **Section 3** presents a summary of linked performance issues, providing additional detail about the indicators described within the Strategic Plan, as well as detail in respect of a number of other linked indicators relating to Unscheduled Care.
- **Appendix 1** – The Strategy Map
- **Appendix 2** – A glossary has been provided to give explanation and context to abbreviations and areas contained within this report.

5.4 The social care IJB indicators are presented using the traffic lights system (red, amber, or green) plus some data only indicators. The distribution of these indicators is shown in Table 1 below.

Table 1: Social Care IJB Performance indicators

Green	Amber	Red	Data Only	Total
14	1	5	10	30

5.5 Fourteen indicators show positive performance. These include the home care measures (Indicators 69-77) showing the number of people receiving the service, the volume and rate per 1000 home care hours, the number of people receiving more than 10 hours per week, the proportion receiving personal care, and the percentage of crisis care service users retained in the community when service ends. Only one home care indicator shows red and this reflects an area of service where changes have been made to the operation of the service during 2017-18 (see section 5.7 below). The number of people with community alarms, telecare and who received a community care assessment (Indicators 48, 78 and 79) reduced a little but numbers are being broadly maintained, The service users' and carers' experience measures (Indicators 49, and 60 to 63) also show high levels of satisfaction on the part of service users and carers ranging between 90 - 98%.

5.6 One indicator is shown as amber, as the number of carers' assessments completed has declined in recent years. However, carers' support and

assessment is also undertaken by the Carer's Centre in Falkirk. The Carers (Scotland) Act 2016 will bring new focus to this area of work as the Scottish Government is developing a range of new data on carers. This includes the activities of the Carer's Centre and this will inform the development of new indicators on carers. Progress with these will be reported to the IJB in due course.

5.7 For five indicators performance is shown as red and not performing to required levels. These include complaints to social work (Indicators 64/65); sickness absence to the end of quarter 3 in Social Work Adult Services (Indicator 66); and overdue OT assessments (Indicator 81). In all three of these areas performance has improved in the latest reporting period, but requires further improvement. Finally, the percentage of Rehab at home service users who attained independence after 6 weeks declined significantly in 2017-18 compared to the previous year. As noted above, this is a result of operational changes made to this service during the year to reflect the reduced capacity of service users that were being referred to the service in 2017-18. Further changes are being made to improve this area of service, so a new more meaningful indicator will be developed to reflect this changing area of service.

5.8 A further ten indicators are defined as data only indicators as these provide factual information about the relevant service areas. Two indicators on respite are included in this category as the 2017-18 data is not yet available. However, it is important to note that data only indicators such as the number of Adult Support & Protection (ASP) referrals, investigations and support plans (Indicators 45-47) have been increasing in 2017-18 and these high priority ASP services can affect performance in other areas of service, such as completing outstanding pending OT assessments. Similarly, the indicators on Self Directed Support (SDS Indicators 37-41) provide a summary of the distribution of SDS choices made by service users but also show the steadily declining proportion of people who have not yet chosen SDS support options.

6. CONSULTATION

There was no requirement to consult in the preparation of this report.

7. IMPLICATIONS

Financial
There are no financial requirements arising from this report.

Resources
There are no resource requirements arising from this report.

Legal
There are no legal implications arising from this report.

Risk
There are no risk implications arising from this report.

Equalities
An equality and poverty impact assessment is not required for this report.

Sustainability/Environmental Impact
This was not required for this report.

8. CONCLUSIONS

The integration of Health and Social Care remains at an early stage in its development at the national level, and in particular at a local level. This report summarises performance information covering a range of measures of key areas of service activity. The Partnership continues to make good progress across a range of service areas. This is within a context of growing demand, an ageing population, people living with more complex health conditions and financial constraints.

The Scrutiny Committee is invited to consider recommendations at paragraph 2.1 of this report presented by the Falkirk HSCP.

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Chief Officer, Health and Social Care Partnership

Author: Suzanne Thomson, Programme Manager, Falkirk Health and Social Care Partnership

Date: 29 August 2018

Appendices:

Appendix 1: Falkirk HSCP Annual Performance Report 2017 - 18
Appendix 2: Performance Report presented to IJB on 1 June 2018

List of Background Papers:
None

Falkirk
Health and Social Care
Partnership

Falkirk Health and Social Care Partnership

Annual Performance Report 2017 – 2018

Introduction

Welcome from the Integration Joint Board (IJB) Chair

Welcome to the second Annual Performance Report for the Falkirk Health and Social Care Partnership. Our report highlights some of the work of the Partnership over the reporting year – 1 April 2017 to 31 March 2018. If you'd like to know more about our work, you can find information on our Board reports and webpages.

This has been another busy year for the Board, and I would like to acknowledge the contribution of all Board members, those whose terms of office ended in the year, and to our new members joining us. We have taken the time to reflect as a Board on our responsibilities to increase the pace of change required to put integration into practice as we remain in a transitional phase. We will continue to take important steps together, guided by a Board development plan.

Collectively, and individually, we are committed to making a positive difference to people who need our services, their carers and our communities. We will continue to make sure our systems deliver high quality, safe, effective and person-centered care. The work ahead of us this coming year is challenging. However, we have significant changes planned that will allow us to put the benefits and opportunities that integrated services bring into practice.

In the coming year we will be reviewing the Strategic Plan. This plan will set out how the IJB will plan and deliver services over 3 years from 2019 – 2022, using the integrated budgets under our control. We are working with the Strategic Planning Group to prepare the new plan. This means that the plan will reflect the views of a wide range of service users, carers and partner organisations that work in the Falkirk area. Working in partnership with members of the Strategic Planning Group helps the Integration Joint Board to understand the needs of communities through locally based services.

I hope you find this report interesting.

Julia Swan
Falkirk IJB Chair

Welcome from the IJB Chief Officer

Throughout the year we have continued to develop our engagement with service users, partners and staff to explore how we can work together to shape our Health and Social Care Partnership (HSCP) and transform how we meet local need.

During the extreme weather in March, we saw how committed and responsive our communities, partners and staff are to maintain essential services and support our vulnerable service users. Individuals, communities and businesses made tremendous efforts including: the school dinner ladies stepping in to cook the meals in our residential homes; staff walking miles in the snow to provide care; neighbours clearing paths and roads to allow ambulance access and; numerous small acts of kindness within our communities. Our challenge is to harness this community spirit and collaboration to develop more community based supports "to enable people to live full and positive lives within supportive communities."

During the year we have embarked on an ambitious change programme to reshape the way we support adults in our communities and developing how our integrated health and social care services will be delivered on a locality basis. Work has progressed to support the delivery of our five priority outcomes. This ranges from the implementation of the new commissioning contract for care at home to the recent introduction of 'Living Well Falkirk' a web based tool to improve access to information, support and advice to support health and wellbeing. Our work to improve supported discharges from hospital and reablement is now embedded in our service.

While we are still working with our NHS colleagues to develop integrated teams, we are learning from other HSCP's who have been able to realise the benefits of collaboration. The Partnership is not unique in the challenges that we face. By building on our strong track record of partnership working, and sharing learning through our networks, we can deliver innovative services that will respond to people's needs and expectations.

The IJB recognises that the pace of change needs to improve and that integrated services must be operational to ensure delivery of the outcomes set out in the Strategic Plan. Plans are underway to transfer operational management of in-scope health services to the Chief Officer. This will facilitate the delivery of locality planning structures as a priority. As the Partnership moves through this period of transition, we are committed to continuing to engage with our service users, carers, communities, workforce and partners.

By working together we can improve the outcomes for our communities.

Patricia Cassidy
Chief Officer

Our Partnership

Strategic Plan

The Falkirk Integrated Strategic Plan 2016 – 2019 describes how the Falkirk Health and Social Care Partnership (HSCP) will continue to make changes and improvements to health and social care services for all adults. The plan details how the partnership will prioritise services in response to the key issues for the Falkirk area and is supported by a Joint Strategic Needs Assessment (JSNA). Integration will focus on health and social care services with third and independent sectors providing a valuable contribution.

The IJB approved its Strategic Plan to deliver the vision for Falkirk:

"to enable people to live full and positive lives within supportive communities"

The Strategic Plan identifies five specific local outcomes which align with the Scottish Government's national health and wellbeing outcomes, the National Health and Social Care Delivery Plan and the Falkirk Community Planning Partnership Strategic Outcomes and Local Delivery (SOLD) Plan.

The Local Outcomes were created to address the key challenges highlighted in the Joint Strategic Needs Assessment with the outcomes consistent with the views of service users, carers and local communities.

The Five Local Outcomes are:

Figure 1: Five Local Outcomes

The following section of this Annual Report will explain in more detail what these local outcomes mean for people and communities and what we are doing to help achieve these outcomes.

To complement these outcomes, under-pinning principles for the Falkirk Health and Social Care Partnership were also agreed:

- putting individuals, their carers and families at the centre of their own care by prioritising the provision of support which meets the personal outcomes they have identified as most important to them
- recognising the importance of encouraging independence by focusing on reablement, rehabilitation and recovery
- providing timely access to services, based on assessed need and best use of available resources
- providing joined up services to improve quality of lives
- reducing avoidable admissions to hospital by ensuring that priority is given to strengthening community based supports
- sharing information appropriately to ensure a safe transition between all services
- encouraging continuous improvement by supporting and developing our workforce
- identifying and addressing inequalities
- building on the strengths of our communities
- planning and delivering health and social care in partnership with community planning partners
- working in partnership with organisations across all sectors e.g. Third sector and independent sector
- communicating in a way which is clear, accessible and understandable and ensures a two way conversation.

The Scottish Government has set out nine national health and wellbeing outcomes to improve the quality and consistency of services for individuals, carers and their families, and those who work within health and social care. Figure 2 below highlights these national outcomes.

Figure 2: National health and wellbeing outcomes

The Scottish Government has also identified 9 key national priorities areas for all IJB's to address. These are to:

- reduce occupied hospital bed days associated with avoidable admissions and delayed discharges
- increase provision of good quality, appropriate palliative and end of life care
- enhance primary care provision
- reflect delivery of the new Mental Health Strategy
- where children's services are integrated, continue to invest in prevention and early intervention
- support delivery of agreed service levels for Alcohol and Drugs Partnerships' work
- ensure provision of the living wage to adult care workers and plan for sustainability of social care provision
- continue implementation of Self Directed Support
- prepare for commencement of the Carers (Scotland) Act 2016 on 1 April 2018.

Locality Planning

The development of localities lies at the heart of the integration legislation – the Public Bodies (Joint Working) (Scotland) Act 2014. It is also reflected in the Community Empowerment Act.

The Partnership has identified its locality areas for service planning purposes. There will be three localities within the Falkirk Council area, which are illustrated in Figure 3 and are:

1. Central – Falkirk central
2. East – Braes, Grangemouth and Bo'ness
3. West – Denny, Bonnybridge, Larbert and Stenhousemuir

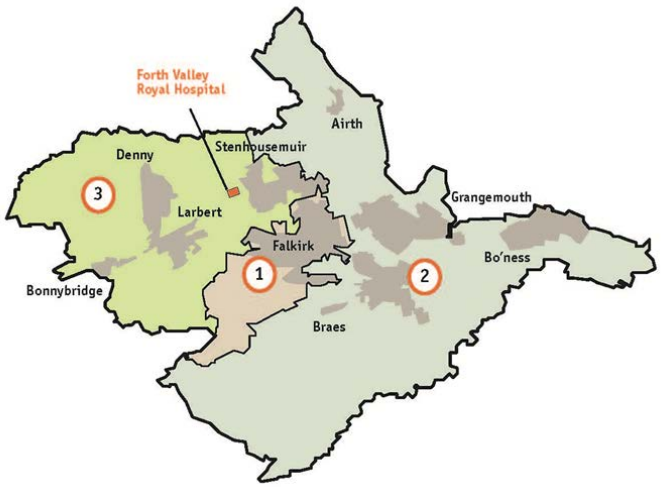


Figure 3: Falkirk H

The following table summarises information on each of the locality areas.

	Central Locality	East Locality	West Locality	Falkirk HSCP
Total Population	44,500	67,136	47,477	159,380
Percentage over 65 years	18.9%	18.6%	17.3%	18.3%
EQUALITY	(per 1,000 population)			
Ethnicity(ethnic minority population)	5.1%	3.3%	3.3%	3.6%
Physical Disability	74.9	70	64.3	69.7
Learning Disability	5.3	3.9	5.6	4.8
CIRCUMSTANCES LIFESTYLE & RISK	(per 100,000 population)			
Population Income Deprived	14.3%	10.8%	10.1%	11.6%
Drug-related hospital stays	158.5	73.4	83	100.8
Alcohol related hospital stays	673.3	476.1	468.2	528.1
MENTAL HEALTH	(QAF rate; per 1,000 population)			
Dementia	360	460	361	1,181
Mental Health	11	7.7	6.2	8.1
Psychiatric Hospitalisation	389.1	248.4	281.1	297.6

Table 1: Locality Information, extracted from the HSCP Locality Profile produced in 2018

Locality working provides the opportunity for the partnership to design integrated services and realign resources to deliver the Strategic Plan. This will also include working alongside our partner's key plans including the Community Planning Partnership (CPP) SOLD Plan. In developing our locality structures we will align with the work being led by the CPP to:

- co-produce locality plans
- design integrated and localised services, including health improvement and prevention support
- build community capacity to improve health and wellbeing outcomes, and address health inequalities.

The Partnership will build on work that has been taken forward by front line locality based managers between October 2017 and March 2018. This work consisted of 12 development sessions across the 3 locality areas. The sessions were attended by staff from Community Care Teams, Community Nursing, GP locality co- coordinators, home care; CVS Falkirk, Carers Centre, NHS Allied Health Professional leads; Housing and Community psychiatric nursing (older people).

The sessions focused on identifying areas of practice where there is already evidence of high quality integrated working and also identified opportunities for more mainstreamed working with less duplication. This work continues in each locality and we will identify resources to assure the continued momentum of this work.

How we are making a difference

Our Strategic Plan sets out the Partnership's vision, outcomes and priorities for people who live in the Falkirk area. In this section of the report we set out what our 5 local outcomes will mean for people and communities and what we have achieved over the first year of the Falkirk HSCP.

Local Outcome 1: Self-Management

Individuals, carers and families are enabled to manage their own health, care and wellbeing

What will this mean for people?

People, their carers and families will be at the centre of their own care by prioritising the provision of support which meets the personal outcomes they have identified as most important to them. Services will encourage independence by focusing on reablement, rehabilitation and recovery.

People are able to access services quickly via a single point of contact. Information that enables people to manage their condition is accessible and presented in a consistent way. This will include a range of information on services and community based supports.

In addition, services are responsive and available consistently throughout the year, on a 24/7 basis, if appropriate.

What will this mean for our communities?

Communities will feel they are involved in decisions that affect them. Their views are gathered and they are listened to. They know what services we are able to provide and have confidence in them.

Examples of work progressed during 2017/2018

1. Living Well Falkirk
2. Reablement Pathway and establishment of the Reablement Project Team
3. Discharge to Assess
4. Intermediate Care
5. Delayed Discharge and Unscheduled Care
6. Enhanced Dementia Team

1. Living Well Falkirk

In partnership with ADL Smartcare and the University of Newcastle, Falkirk HSCP has implemented *Living Well Falkirk.* This is an online tool for people who live in the Falkirk area and who want information, support or help with everyday living. The tool gives people choice and control by sharing a wide range of information about local and national health and social care services.

Living Well Falkirk allows people to connect in to local groups and services and so helps them to live independently and do the things that they want to do. There is information about local fitness classes, local charities supporting a range of physical and mental health conditions, as well as how to access equipment privately or through the Joint Loan Equipment Store. People can also use it on behalf of someone they live with or who they help care for. If assistance is needed in using the tool, staff at local libraries are able to help.

The Living Well Falkirk website is now live www.falkirk.gov.uk/livingwell and over 200 employees across all agencies have been trained in its uses and are equipped to direct people to the online self assessment and in some cases guide them through it. This initiative will support a reduction in waiting times for some interventions, for example assessments leading to equipment provision, as people are enabled directly to access simple solutions.

2. Reablement Pathway and establishment of the Reablement Project Team

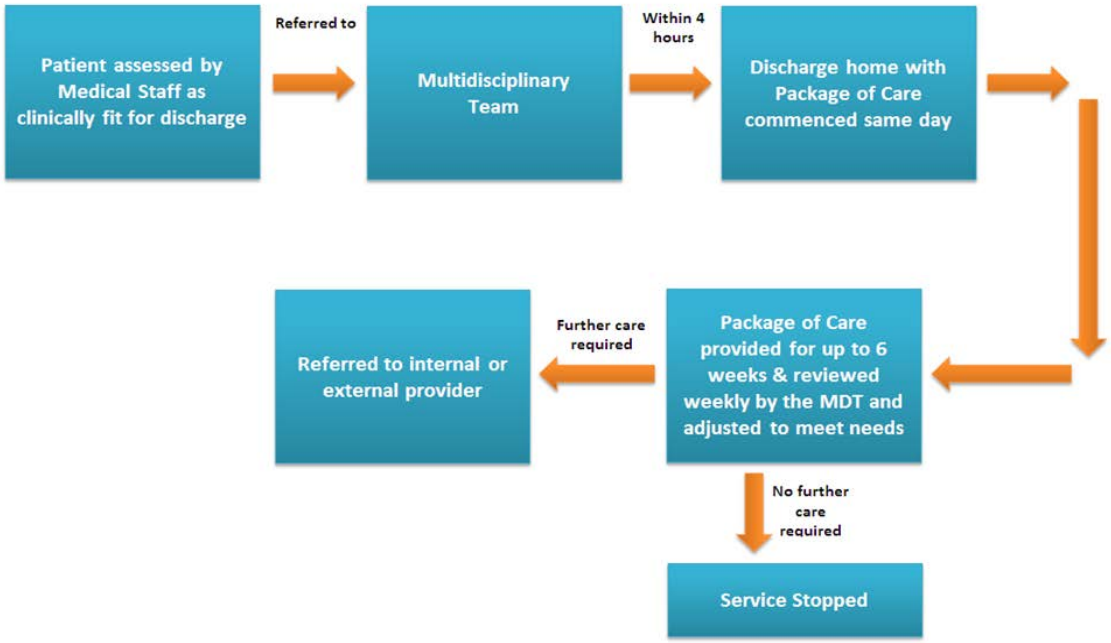
Considerable work has been undertaken on the implementation of a reablement approach across the Partnership. An integrated, Reablement Leadership Group has developed a high level integrated pathway for service delivery across the HSCP. The Reablement Leadership Group will continue to work to implement the changes required to deliver reablement to all service users who would benefit from this approach. This will not only support people to remain as independent as possible for as long as possible, but will potentially deliver savings by avoiding some people using formal health and social care services.

A Reablement Project Team (RPT) was developed in Social Work Adult Services Assessment and Planning service in January 2017 to test out various reablement approaches and processes. The team consists of Occupational Therapists (with Community Care worker background) and Social Care Officers. Various strands of work have been completed over the past year including undertaking reviews from both the Community Care Teams and Home Care services where there is external home care provided. The reviews are being completed using a reablement and outcomes focussed perspective. Early indications suggest a significant impact of this work, with purchasing of care from external home care providers reducing by £200,000.

3. Discharge to Assess

Discharge to Assess (D2A) is a new approach to identify people in hospital who can be discharged to their own home as soon as they are clinically fit. This can reduce the time a person may spend in hospital. Avoiding unnecessary delays in a person's discharge from hospital is imperative to avoid deterioration in an individual's health and consequent loss of independence.

The following diagram describes the Discharge to Assess pathway.



Figu

The D2A pilot started in December 2016 and continues as part of the Partnership's Integrated Reablement Service. The pilot initially worked with an external provider partner and is now delivered by the in house home care service. The approach identifies appropriate discharge pathways for people including those who can be discharged and assessed in their own home. Following discharge home, support with a reablement focus is provided for up to six weeks. Regular reviews are completed and an outcome focussed assessment involving the individual will identify any ongoing support required.

Case Study

Ethel lived at home and did not receive home care. She was admitted to hospital following a fall. The Ageing and Health ward placed her onto the community hospital list for rehabilitation and discharge planning. Following discussion with ward and family, Ethel was discharged direct from the acute hospital to home. The ward assessed that an ongoing care package of 4 daily visits would be required. Ethel was discharged within a day of her placement on the community hospital waiting list.

Ethel was keen to regain her pre-hospital admission independence and was supported to do so by the D2A model. Ethel regained full independence within 6 weeks of discharge and achieved her personal goal. The daily care packaged of 4 visits was no longer required. Family were at first concerned that there was no ongoing care, but accepted it was not required following the 6 weeks of reablement support.

Service users report satisfaction in regaining their independence. The reablement approach also makes available a substantial number of staff support hours that can be allocated to people who have a need for ongoing support.

The service was evaluated in late 2017 and determined to have contributed to successes in some key areas:

Referral to discharge time: The average time between the care provider receiving a referral and the patient being discharged from hospital was one day.

Patient experience: Although there is evidence of some areas for improvement the patient survey produced evidence that the patient experience was positive. Positive findings include 92% of patients feeling their care plan reflected their views and 95% of patients received a consistent group of carers.

Success of reablement approach: 67% of patients with an IoRN (Indicator of Relative Need) score recorded at the start and end of their D2A journey, experienced an improvement in their score. 33% of patients (regardless of potential for reablement) saw a reduction in home care hours.

Reduction on package of care delays and community hospital bed days

There has been a substantial reduction in delayed discharges due to delays in sourcing a package of care (see figure 5 below) and there has been a reduction in community hospital bed days. It would be inaccurate to say that these improvements are solely a result of D2A, but it is likely to have made a significant contribution.

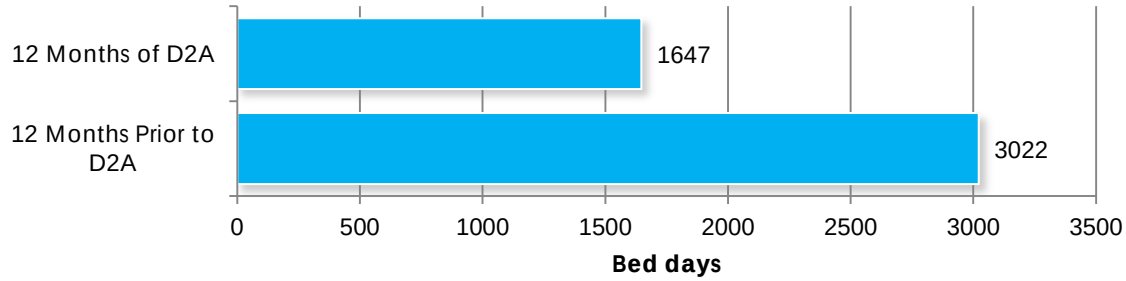


Figure 5: Bed days lost to POC delays before and after the introduction of Discharge to Assess

4. Intermediate Care

Bed based intermediate care where time limited episodes of care are provided in Summerford Care Home or Tygetshaugh Housing with Care. This care provides an opportunity for further assessment and reablement following discharge from hospital or as an alternative to hospital admission.

Summerford was refurbished in 2017/2018 and capacity increased to 20 beds and Tygetshaugh provides 5 beds. Both resources receive Allied Health Professional (AHP) support from the ReACH. Further support is also provided by the Enhanced Care Team

for people who may be unwell. A specialist psychiatric nurse input provides education and support to staff and individuals.

Summerford and Tygetshaugh both offer the opportunity for people to leave hospital as soon as they are clinically fit. This avoids unnecessary delays in a persons discharge from hospital and using a reablement approach, ensures as many people as possible move back to their own homes to live as independently as possible.

Various strands of work to support Summerford's expansion has occurred in 2017/2018 including the implementation of a new referral criteria and pathway. This involves the multi-disciplinary team which is also involved in the Discharge to Assess pathway and the Reablement Project Team.

5. Delayed Discharge and Unscheduled Care

The partnership continues to have a focussed approach to prevent unplanned admissions to hospital as well as identifying the reasons for people being delayed in their discharge home. This work is led by the Delayed Discharge Steering Group which oversees the delivery of an improvement plan that ensures there is a collective ownership of the targets and improvement action plan.

Throughout 2017/2018 the action plan has been reviewed and ongoing work strands include the Choice Policy Improvement Action Plan. This has resulted in the recent implementation of a standardised letter about Interim Care Home Offer and revised Moving to Care Home flow chart which will provide clarity on expectations in relation to the Choice Policy. A delayed discharge micro-management group has been introduced within mental health wards resulting in decreases in delayed discharges within this area.

To address the issue of high numbers of people delayed in their discharge from hospital as a result of the Guardianship process a number of work strands are presently ongoing:

- implementation of dedicated Mental Health Officer time to monitor private Guardianship applications, support families and improve peoples pathways
- standardised information regarding Adults with Incapacity (AWI) process to be distributed to individuals and families prior to AWI meetings
- development of a simplified process for solicitors /applicants to obtain timeous medical reports from Consultants to support Guardianship applications
- AWI flowchart with target timescales to be completed including recommendation about convening AWI meetings for all situations where use of AWI Act being considered. This flowchart to be shared with local solicitors in order to convey Partnership expectations.
- standardised letter to be issued, should progress with Guardianship application not be demonstrated, advising of Falkirk Council's intention to progress application
- education for community care workers through induction, briefings, supervision and training opportunities will focus on supportive decision making and risk management and ensure least restrictive options are being used wherever possible
- POA to be promoted more widely and consider inclusion on Living Well Falkirk website.

Following the national delayed discharge system called Edison being decommissioned, each health board was required to formulate their own replacement. In May 2018 EDS, an electronic reporting database, was successfully introduced as a replacement for EDISON system. Following training of staff within the Partnership the system is being used to provide daily, weekly and monthly census reports both locally and to ISD and contributes positively to performance management.

The Unscheduled Care Programme Board oversee system wide activities, initiatives, actions and performance around unscheduled care.

6. Enhanced Dementia Team

The national Dementia Strategy underlines the importance of timely, accessible and person-centred care for people with dementia to enable them to achieve their personal goals. The strategy estimates that by 2020 there will be approximately 20,000 new cases of dementia each year in Scotland.

Dementia is a progressive illness which results in physical and mental changes for the person. At times these changes can be sudden and this can be attributed to a range of factors which require careful consideration and management. This can happen at any time during the illness, create a crisis and this can have an impact on carers. Services for people with dementia must therefore be integrated, seamless and readily accessible irrespective of the stage of illness. The illustration below (figure 6) highlights the spectrum of support that should be available.

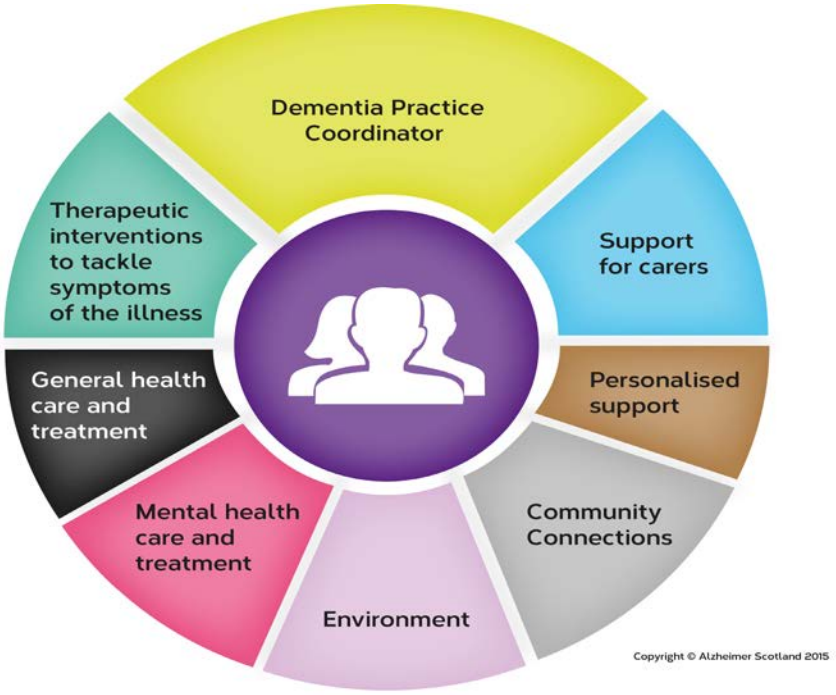


Figure 6: Spectrum of Support for Dementia Patients

During 2017/18, work has progressed to consider how services could be developed and improved.

- an engagement event was attended by over 60 delegates, including services users and carers. Key priorities and improvement actions were identified
- an amended, multi-agency governance structure has been developed and implemented, providing Forth Valley wide oversight, with operational developments being progressed at locality level
- partners have worked together to map current and future provision and proposals about future service design have been approved by the Leadership Group and IJB
- Transformation Funds have been allocated via the Primary Care Transformation Funds and Partnership Funding to enhance provision and progress change
- Post Diagnostic Support (PDS) support has been extended and revised to ensure that it is appropriate for people regardless of the level of their illness at the point of diagnosis.

Next Steps - Future Service

Through analysis of performance information, mapping exercises and the engagement process, it was recognised that whilst current support for dementia is effective, service demand outweighs current provision and there is a need for improved joint working between agencies.

During the course of 2018/2019, it has been agreed that an enhanced, multi-agency dementia team, incorporating current Post Diagnostic Support, Dementia Outreach Team (DOT) (which currently provides short term crisis support) and dedicated Social Work capacity, be developed.

The co-located team will ensure that a resource is available to support the shared assessment, information sharing and therefore improved support for people with dementia and their carers. This team will have nursing staff from the DOT, with supervision from a Consultant Psychiatrist, Alzheimer's PDS Link Workers and Social Workers who have strong links with the localities. The already improved governance structure will enable greater operational and delegated authority within the locality structures as well as strategic oversight.

Local Outcome 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	
What will this mean for people? Health education and information is accessible and readily available to people, their carers and families, which allows them to make informed choices and manage their own health and wellbeing. Person-centred care is reinforced, acknowledging family/carer views. Care and support is underpinned by informed choices and decision making throughout life.	**What will this mean for our communities?** Communities are enabled to continue to develop and manage a variety of good quality local services to meet community need.
Examples of work progressed during 2017/2018 1. Redesign of day services for younger adults 2. Anticipatory Care Plans 3. Palliative and End of Life Care	

1. Redesign of day services for younger adults

The IJB agreed to a programme of redesign of day services for younger adults. This is in line with the outcome of consultation and engagement work with people who use services, their carers and staff. The redesign work reflects Self-Directed Support principles to empower and enable service users to have choice and control over the design of their own support and develop alternative community based services.

Case Study 1
Miss L has attended the day service three days a week for a number of years. She was picked up and dropped off by centre transport.

Some of her friends had left the day service and were part of a group that met up one afternoon a week for a coffee, chat and a game of bowling. She was keen to maintain her friendships, so joined the group.

With her support worker, she checked what was available in the same area that would fill her morning. She was interested in an art group at the local adult education centre, and was welcomed by the tutor and group. This has given her confidence to take part in the group and look at other options and hopes to build on her interests over the coming months.

Her support worker helped her to write letters to various charity shops, offering to do some voluntary work. Miss L now volunteers one day a week within a charity shop and is enjoying giving something back to her community.

With the encouragement from her mum, sister and brother, and assistance from the support worker, Miss L is trying out other interests. She is now travelling using public transport with minimal support.

Case Study 2
Mr P lives in his own flat with support from his family, and attended the day service three days a week. He left in May to pursue other activities that he wished to do.

He is part of a group of friends who meet up one morning a week to play pool as this is a shared interest for them all. They have lunch together and make plans for the following week. In the afternoon they go to the bowling where other friends join them.

Mr P travels to a local community centre by bus independently to play five aside football. This group was initially set up with the aid of a support worker, who still comes along to introduce others to join in.

Through trying different activities, he found he really likes to keep fit to music. He now attends a Zumba class and a line dancing group without any support. Mr P attended a Dates and Mates ceilidh event in Glasgow along with others, which he absolutely loved and is looking forward to the next one.

This now fills the three days that he previously attended a day service, doing a range of different activities within his community. Mr P is so proud at how far he has come.

2. Anticipatory Care Plans

The Partnership is working with people, particularly those at risk of hospital admission, to have an Anticipatory Care Plan (ACP) in place. These plans have a focus on prevention, anticipation and supported self management with the person at the centre of all decisions regarding their care.

When a patient has particular health care needs that may make them more vulnerable to readmission, the ACP forms an important part of the delivery of consistent care. This will support clear communication between hospital and community teams. Through work carried out by ACP nursing teams, the service aims to:

- prevent patients being readmitted to hospital, and if
- in the case of a hospital stay, the length of time spent there is shorter. This is because home care needs are addressed on an ongoing basis and are not a reason for delays in discharge.

From September 2017 the ACP Team have been working with the Advice Line for You (ALFY). The combined service now proactively contacts patients within a few days of discharge. This is to check how patients and their carers are coping at home with the services arranged for them. If further support is required, a referral for an ACP assessment is made. On assessment, necessary interventions are determined and initiated to ensure the best care plan can be delivered outwith the hospital setting where appropriate.

The multi professional Forth Valley Anticipatory Care Planning Group promotes a whole system model for anticipatory care planning built on existing good practice and improvement work locally and nationally. The group have developed robust evaluation and reporting arrangements.

3. Palliative and End of Life Care

Palliative care is the care given to a person who has an advanced life threatening illness that can't be cured. It helps to improve a person's quality of life as much as possible by managing social, physical and psychological symptoms. End of life care (EOLC) is the care given to people who are in the last few months, weeks or days of their life to allow dignity until they die.

When people are asked, about 70% wish to die at home. However it is thought the actual numbers who achieve this is nearer 25%. This means that people are dying in places such as hospitals, which may not be what a person or family wants or appropriate for the needs of a person. Much of palliative and EOLC can be delivered within the community with the support of trained health and social care professionals.

Anticipatory Care Planning (ACP) is a "thinking ahead" approach which allows an individual to think about their future care, wishes and needs. By encouraging social and health care professionals to have conversations around these issues, it is hoped that people will receive the right care for them in the right place when this care is needed.

The Partnership is working to deliver a model of care for people with palliative and end-of life care needs. This will provide high quality, effective, integrated and person centred care. The model can be achieved by a skilled workforce with an increasing focus on providing care in community settings as close to home as possible.

This work is being led by the Forth Valley Palliative and End-of-life Care Network and a Forth Valley Strategic Group. The main areas of progress over the year have included:

- the Forth Valley Planning Ahead Anticipatory Care Planning Project are working to ensure people have an ACP, and that Key Information Summaries (a summary that can be accessed centrally) are updated. This will enable the person to be at the centre of their care and that the team supporting them are aware of their needs. The ability for professionals, both in and out of hours, to access important information regarding an individual is vital to ensure the correct decision about their care is made.

- improving communications and encouraging earlier conversations. Conversations about palliative and end of life care can be difficult for families, patients and professionals. By having a trained team, these issues can be discussed in a timely, efficient and sensitive way.
- staff education: the Network runs with an education sub-group. There are numerous and varied education opportunities within Forth Valley aimed at those with different roles and responsibilities. Highly skilled staff will be able to deliver quality care.
- care homes: A new education facilitator is working closely with care homes. The facilitator is working on areas such as better communication with primary care, recognising dying and documentation about EOLC. Care home staff are vital in enabling quality palliative and EOLC for their residents and training in these areas ensures their competence.
- EOL care planning education to support changes in practice. New documents and processes are developed all the time for this area of health care. (eg My ACP, ReSPECT). By supporting practices through education events and visits, they are encouraged to use the most up-to-date and relevant resources.
- EOL care planning**:** Staff education is being supported by a nurse to provide peer support in Community Hospitals. This nurse supports staff to undertake the most up to date processes for EOLC and collating data around what is actually occurring. This allows identification of further training needs for staff.
- developing Advanced Nurse Practitioner (ANP) role to support teams in the provision of care for people with cancer and/or palliative or end of life care needs. Over recent years there have been increasing challenges around recruitment in primary care. This has resulted in the need to develop new ways of working with a different skill mix of health care professionals. The ANP role is one way NHS Forth Valley has responded to this challenge. The uniqueness of this particular role is that the person involved is an ANP for 2 days and the Cancer and Palliative Care Facilitator for 3 days – what is evolving is a new blended model which is proving to be very beneficial for patients and the organisation.
- the Quality Improvement Team are supporting measurement of this work so we may evidence the value of the ANP role.
- one of the key performance indicators will be in reducing the risk of admission to hospital inappropriately in the last 6 months of life therefore reducing the number of hospital bed days. This ensures that this area is kept as a priority for NHS Forth Valley and encourages regular analysis.
- EoLC in the community. All these initiatives have resulted in an improvement in care for people at the end of their lives within their local community. This is demonstrated through individual patient stories along with ongoing larger scale audits or quality improvement work. However, this is an ongoing development and requires an ongoing commitment.

To date the emerging priorities from the work are as follows:

- develop a revised future model to meet the national goal to ensure that everyone in NHS Forth Valley area who needs palliative care and/or end of life care will have access to it by 2021
- improve communication, coordination and care planning for those with palliative and end of life care needs
- develop a balanced workforce with the right capacity, knowledge and skills.

Some of the key themes within these emerging priorities are outline in the diagram below

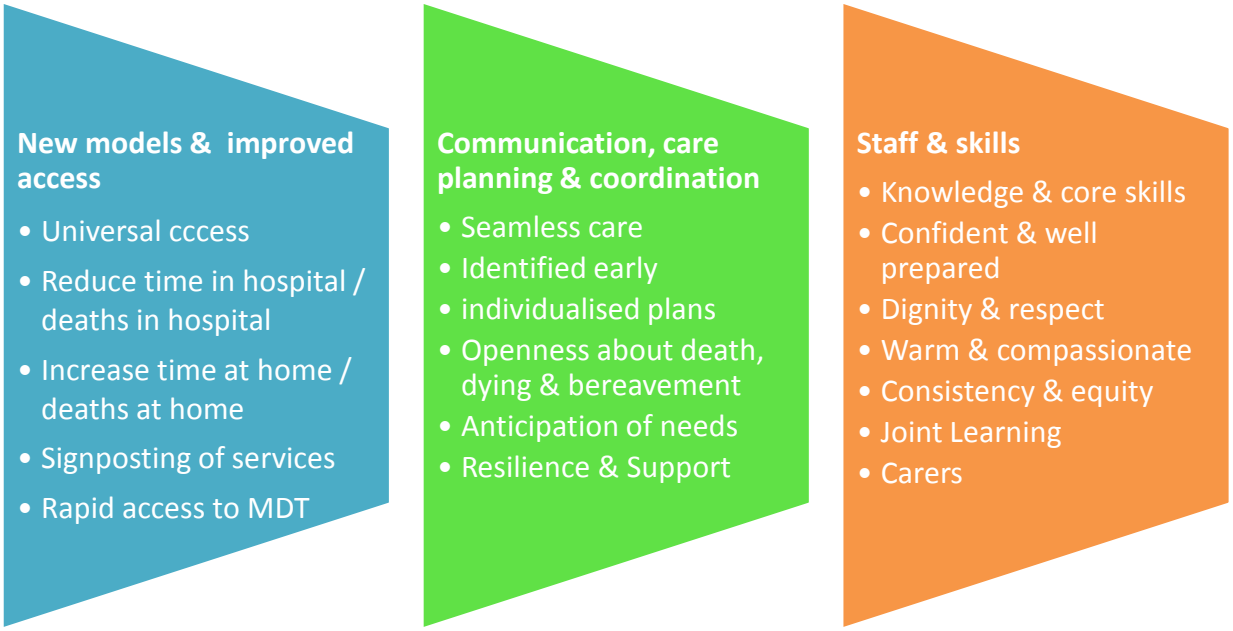


Figure 7: Key themes

After some further scoping work, it is envisaged that these broad areas will see significant levels of improvement activity over the next 3 years.

Local Outcome 3: Safe

Health and social care support systems are in place, to help keep people safe and live well for longer	
What will this mean for people? People will be supported to live safely in their homes and communities. People will be involved and consulted on decisions about their care, treatment and support. People will have timely access to services, based on assessed need. Services will improve quality of lives and be joined up to make best use of available resources.	**What will this mean for our communities?** Communities are confident that systems are in place for the identification, reporting, and prevention of harm.
Examples of work progressed during 2017/2018 1. Closer to Home: Enhanced Community Team 2. Uninjured faller pathway with the Scottish Ambulance Services 3. Pharmacy Support	

1. Closer to Home: Enhanced Community Team

The Closer to Home model is part of a broader portfolio of health and social care services. The Enhanced Community Team (ECT) is a dedicated nursing team with GP Fellows and Allied Health Professional (AHP) input. The team aim to support people to remain more resilient at home at a time of escalating need or 'crisis' due to acute illness.

This can help avoid hospital admission by providing immediate and urgent advice and /or treatment. It can also provide an enhanced supported discharge 'step-down' model.

The service operates 24 hours a day, 7 days a week. Since the service started in December 2015 there have been 586 admissions to the service from Falkirk. When a patient is admitted to the team a Medical Anticipatory Care Plan is carried out, so should the person's condition decline, there is a clear plan to indicate whether they wish to be admitted to hospital or remain at home. Approximately 25% of patients are either admitted or die fully supported by the team at home. Of the remaining people who were cared for by the service, all patients were given the choice to give feedback. We collect feedback in a number of ways; patient stories, NHS FV feedback cards, thank you cards and video interview feedback. There have been no complaints received about this service. All feedback has been positive.

2. Uninjured faller pathway with the Scottish Ambulance Service (SAS)

A Forth Valley multi-agency group, including SAS, is taking forward work to develop pathways and local services. This will avoid unnecessary transportation to hospital for fallers who are uninjured or uninjured and medically unwell. They will refer this latter group to the Enhanced Community Team for services. The group also receive support from the Improvement Adviser from the national Active and Independent Living Programme to facilitate learning and sharing of good practice.

The following diagram describes the new uninjured faller pathway being used.

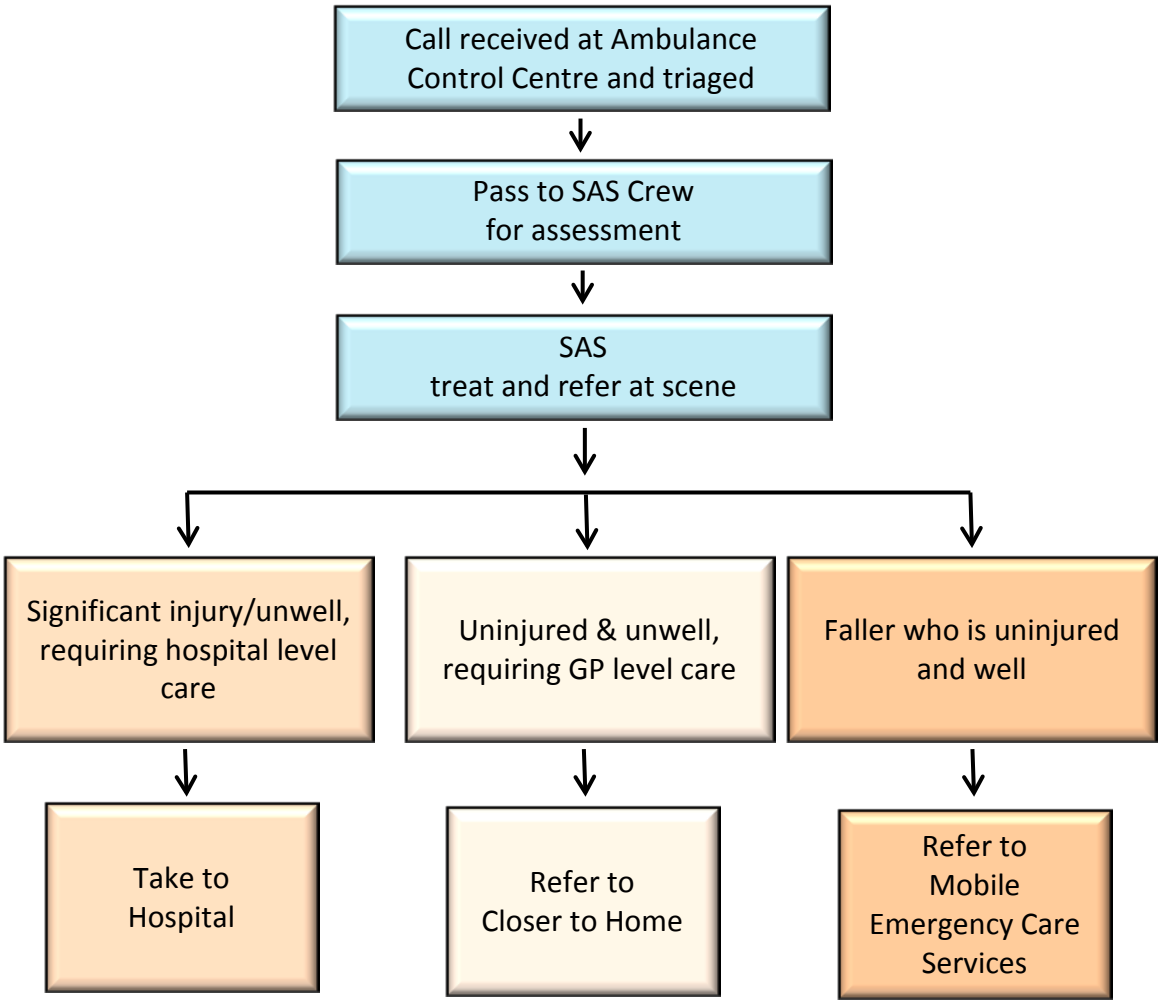


Figure 8: Uninjured faller pathway

3. Pharmacy Support

Practitioners within Community Pharmacy, Care at Home and GP practices worked together to develop a 2 year pilot service to provide additional pharmacy support within Community Hospitals, Care at Home and Care Homes. The pilot will test the impact of having Pharmacist Prescribers and Technicians working across these three community settings. The intended outcomes are that there will be a reduced demand on the GP workforce, reduce medicines related hospital admissions and improved patient safety through polypharmacy review and liaison with the health and social care teams.

The new service is intended to provide polypharmacy support within 2 Community Hospitals and 23 Care Homes. Support will also be provided across Care at Home Services, which provide care for approximately 4,000 services users across the Falkirk area. Care at home visits typically include over 5,000 medication prompts per week.

Pharmacy Technicians will review people's ability to manage their medicines independently or with home care support. This will enable prompt discharge from hospital settings and encourage self management, thereby enabling people to remain at home longer. Home Care staff will also be trained and supported to administer some medicines, where appropriate. This follows recommendations made by the Care Inspectorate that resulted in changes in local policy to allow staff to administer some medications.

Expected benefits include:

- updated education and training of care staff and carers in medicines management
- service users will receive an improved service where they have been identified as requiring medication support and it is anticipated that this will reduce delays in sourcing care packages for hospital discharge
- savings on medical resource by releasing GP workforce capacity as part of Primary Care Transformation
- improving patient safety during transition between services e.g discharge from Community Hospital to Home
- reduction in readmission rates
- improving medicines optimisation by providing poly pharmacy review (estimated at £140 each year for every care home resident)
- efficiency savings in medicine expenditure (Estimated at 8% saving)
- reduction in medicines wastage, particularly in the community.

Local Outcome 4: Service User Experience

People have a fair and positive experience of health and social care	
What will this mean for people? People feel services are responsive to their needs and are available to them before reaching a point of crisis. These services are joined up and improve quality of lives. People are engaged and involved across the HSCI Partnership. People will receive feedback and understand what their contribution has influenced.	**What will this mean for our communities?** Communities will have the opportunity to be engaged and involved in service redesign and delivery within their local areas. This will be based on a clear understanding of local needs and available resources.
Examples of work progressed during 2017/2018 1. Carer's Act Implementation 2. Frailty at the Front Door Collaborative 3. National Health and Social Care Standards 4. Duty of Candour 5. Eligibility Criteria	

1. Carer's Act Implementation

From 1 April 2018, the Carer's (Scotland) Act 2016 extends and enhances the rights of unpaid carers. The Act aims to ensure that carers are supported more consistently, so they can continue to care if they wish, and are able to do so in good health and with a life alongside their caring responsibilities.

The IJB and Partnership, has over the course of 2017/2018 overseen and directed the preparations for the implementation of the Carers Act. A Carers Act Implementation Group was established. This has membership from across the HSCP, Falkirk Council and importantly carers and carers' representative groups. Through effective engagement and co-production the group ensured that the requirements of the Act and its introduction have been realised. A work programme to meet the additional ongoing requirements of the Act for 2018/2019 has been developed.

2. Frailty at the Front Door Collaborative

The Partnership and NHS Forth Valley are one of five partnerships participating in the national Frailty at the Front Door Collaborative, facilitated by the iHub Acute Care Team.

The aims of the project are to improve outcomes and experience for older people and their carers living with frailty and presenting to acute services by:

- rapidly and reliably identifying frailty at the front door
- delivering early Comprehensive Geriatric Assessment (CGA)
- ensuring the person experiences well coordinated care and support attuned to their needs with the focus on support at home or a homely setting where possible
- improving interface and collaborative working between health and social care.

This work is being taken forward by an integrated Frailty at the Front Door Project Team with representation from acute, health and social care staff.

3. National Health and Social Care Standards

Work has taken place in the Partnership to implement new human rights based National Health and Social Care Standards from 1 April 2018. The objectives of the new standards are to drive improvement, promote flexibility and encourage innovation in how people are supported and cared for. Each Standard is underpinned by five principles: dignity and respect, compassion, be included, responsive care and support and wellbeing. These principles are not standards or outcomes but rather reflect the way that everyone should expect to be treated. All services and support organisations, whether registered or not, should use the Standards as a guideline for how to achieve high quality care.

4. Duty of Candour

The Partnership has prepared for the implementation of the Duty of Candour, which came into effect on 1 April 2018.

The overall purpose of the new duty is to ensure that organisations are open, honest and supportive when there has been an unexpected event or incident that has resulted in death or harm that is not related to the course of the condition for which the person is receiving care. This requires organisations to follow a procedure which will include notifying the person affected, apologising and offering a meeting to give an account of what happened. The procedure will also require the organisation to review each incident and offer support to those affected (people who deliver and receive care).

The IJB Clinical and Care Governance Committee will be the lead for implementation planning, monitoring and review.

5. Eligibility Criteria

The Adult Eligibility Criteria for social care was revised with a new version being approved by the IJB for implementation from October 2017. The new Criteria seeks to:

- identify the skills and abilities of individuals in managing their own support
- the informal support networks available to them (family, friends, neighbours, community) and
- consequently to outline the role of formal services, if required, in supporting individuals with care and support needs.

In this way support can be designed around identified personal outcomes with support plans being agreed, including how formal support will be delivered alongside informal support arrangements, using self-directed support values and principles.

Local Outcome 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	
What will this mean for people? People are more confident, reliant and able to access local services and support to improve and maintain their health and well-being and be more independent. There will be a focus on early intervention and prevention.	**What will this mean for our communities?** Communities are informed, involved and supported to work cohesively to develop and manage community based supports**.**

Examples of work progressed during 2017/2018

1. Primary Care Transformation Programme
2. Hope House: Specialist Low Secure Female Unit
3. Home Care Review
4. Falkirk HSCP Community Grants Scheme
5. FUSE Group
6. Community Capacity Building in Falkirk
7. Changing Places Toilet Facilities

1. Primary Care Transformation Programme

Primary Care Transformation is set within the context of the new GP contract and a background of general practice sustainability challenges. These challenges include an aging General Practitioner workforce, rising workload and a lack of doctors training to be GPs. Moving forward Primary Care Transformation will be driven by a Primary Care Improvement Plan which is currently under development. This will outline the implementation of the six priority areas for implementing the new GP contract. These largely focus on augmenting primary care capacity and capability through multidisciplinary supports such as pharmacists, Advanced Nurse Practitioners, mental health practitioners and physiotherapists, supporting GPs to focus on complex and undifferentiated care.

There are 3 strands to the Transformation Programme in place in Forth Valley focusing on the following:

Urgent Primary Care (GP) Out of Hours Transformation: A plan has been developed to deliver on the aim of creating a safe and sustainable multidisciplinary approach to Urgent Out of Hours Care in Forth Valley.

This new model will be delivered by significantly increasing the capacity for Advance Nurse Practitioners to work safely with fewer GPs, supported by Mental Health Nurses, Paramedic Specialists and improved integration with other over night supports. Five advanced nurse practitioner training posts have been filled to support the new model.

Primary Care Transformation: Aims to encourage GP practices to work together in clusters, taking a multi-disciplinary approach to care within practice and the community. This involves developing the role of health professionals such as pharmacists, physiotherapists, mental health professionals and advanced nurse practitioners in delivering aspects of patient care – freeing up GPs to focus on more complex cases and provide clinical leadership.

The key focus, to date, has been on improving access to GP services for mild to moderate mental health issues within the Falkirk West Locality. Four mental health primary care nurses and additional pharmacy sessions each week will provide an additional 300 triage and face to face mental health appointments within 8 GP practices. Baseline data has been collected with 10% of GP appointments found to be for mental health support alone. A further 10% of consultations include a mental health component presented alongside other complaints.

Mental Health in Primary Care: The investment for mental health services aims to improve access for people with mental health needs to the most appropriate support as quickly as possible, in the most appropriate setting. This aligns with the new Mental Health Strategy for Scotland 2017-2027.
The Primary Care Transformation Fund (PCTF) is supporting the development of a more efficient and integrated model which will bring Alzheimer Support Workers, the Dementia Outreach Team and a PCTF funded social care dementia resource together to improve the matching of support to the needs of users.

Aligning with the Autism Strategy recommendations, we are also developing an area wide resource to support the diagnostic pathway and post diagnostic support for people with autism spectrum disorders and their families.

2. Hope House: Specialist Low Secure Female Unit

The IJB approved a proposal in 2017 to establish a six bedded low secure female unit on the Bellsdyke site. The unit has been open since August 2017.

Hope House is a specially designed resource for women of adult age who have complex needs requiring treatment in a low secure care setting. In the design of Hope House there was significant consideration given to the therapeutic setting of the environment and staff training was designed to support a homely model of care which is trauma-informed and highly risk-managed.

Hope House has allowed us to repatriate women who were cared for in private resources out-with the Forth Valley area, reducing the travel burden for families and

providing care closer to home with the opportunity for appropriate community engagement and integration making discharge planning much smoother.
The remaining beds have been utilised for NHS Forth Valley patients who were either in medium secure inpatient facilities or in the local mental health service. This prevented expenditure on out of sector treatment and care and embraced the principles of a least restrictive alternative without compromising on risk management.

Since opening the Mental Welfare Commission have visited the unit and reviewed the care and treatment. The findings of the Commission were very positive and in particular the model of care and therapeutic alliance with patients was identified as a real strength in the service.

3. Home Care Review

The Home Care Service is undergoing a review to ensure the service continues to meet the outcomes of people who use the services. At the same time there is redesign work ongoing towards a whole service reablement focus and ensuring availability of services to support people with complex and challenging care needs.

In reviewing the service, the use of data from the real time monitoring system (CM2000) is providing robust information about the needs of service users. This information enables demand and capacity to be mapped in real time, providing evidence to design how staff are deployed to deliver care at the right time and in the right place. The roll-out of the CM2000 system across all of in-house provision was completed in November 2017.

The in-house home care service has focused on service review and improvements informed by findings from the CM2000 scheduling system and through engagement events targeted at the home care workforce. The objective in 2018 is to improve the service and make sure it can respond in the future when the service user base is likely to be older, frailer and have multiple disabilities. Initiatives currently being progressed include:

- achieving efficiencies in scheduling
- embedding reablement and outcomes based approaches
- upskilling and mobilising the workforce
- steering the service towards delivery based on a locality model.

4. Falkirk HSCP Community Grants Scheme

Falkirk HSCP Community Grants Scheme was launched in April 2017. It offers small grants of up to £2,000, to groups and organisations operating across the Falkirk Council area. The scheme will fund groups to start up or extend activities within communities that help people stay well or improve their health and wellbeing. During 2017/2018, 14 grants were made during 2017/2018. Applications are welcomed from both new and existing groups.

The main criteria for award are that the activities of the group have a positive impact on the health or wellbeing of local adults. This may be an additional benefit rather than the main aim of the group. Groups must be open to new people to join in with their activities.

The HSCP would like to support a broad range of activities, however key areas of work will be:

- support the reablement of people following an episode of ill health, to allow them to live for as long as possible back in their own homes and communities with accessible social interaction and activities.
- advocate and support preventative activity with people who have not yet entered the health and care system to help minimise or postpone the need for formal health or care services.
- develop the role that local organisations play in health and social care, including participation in the design of future services.

Examples of grants that have been awarded:

Grangemouth Stroke Club: Support was provided towards their annual programme of weekly meetings and activities, including local outings and Otago exercises. The organisations members have varying disabilities and this offers them a day out and a social opportunity for both them and their carers.

The Tuesday Club: grant awarded towards the running costs of the group, which supports people with dementia and their carers. The group provides hot food and company to help tackle the disadvantages of poor nutrition and isolation that older, vulnerable people sometimes experience. Members pay a small fee which contributes towards their lunch and running costs. The organisation receives referrals from Alzheimer's Scotland, GPs, Social Work and directly from older people and their families.

Make it Happen Falkirk District Forum: The organisation is open to anyone over the age of 50 and/or those that are interested in the well-being of those over 50. The grant supports the running costs of the group.

TocH Denny: The group is for adults with a disability. Members are supported by carers and volunteers to participate in a range of activities safely, and without restriction. Funds were awarded to the group to support a range of activities throughout the year.

5. FUSE Group

Staff within Bellsdyke and Community Mental Health services have worked in collaboration with Stenhousemuir Football Club to establish the F.U.S.E. Group. This is an integrated football team who have participated in the mental health and wellbeing events, organised through the Scottish Football Association. The team's hard work paid off when they won the national Championship League in November 2017. This service

demonstrates that through collaborative approaches and working in partnership, innovative services can be developed.

6. Community Capacity Building in Falkirk

The aim of the project is to work with individuals and communities to help build capacity within their community and empower them to continue initiatives when the project funding comes to an end. This will enable communities to create solutions that are desired to address the needs of individuals living there.

All activities undertaken will focus on facilitation and sustainability, enabling the community to flourish in the future. Outcomes are to:

- create co-produced community action plans
- reduce inequalities
- support community champions
- facilitate engagement with Community Planning partners and the HSCP via third sector forums.

The Health and Wellbeing Officer will work with community groups and individuals to facilitate their plans for development and expansion, which will include a range of activity based groups as well as sports clubs and community sports hubs, however it is recognised that not all health and well being activities are sports related.

CVS Falkirk staff work jointly with the Community Learning and Development team and Falkirk Community Trust. This work is also integrated with the SOLD delivery groups and HSCP locality planning groups. To date we have worked with communities to:

- map community assets and existing groups
- jointly with service providers identify gaps in provision
- identify possible opportunities for Community Asset transfer.

7. Changing Places Toilet Facilities

Within the Falkirk Partnership area we are making progress towards having on Changing Places Toilets [CPT] available at a range of locations. A stakeholder group, chaired by the Head of Social Work Adult Services, has brought together family carers, Occupational Therapy, Falkirk Delivers and the Community Trust to take this forward.

The provision of CPT facilities has been identified as a gap, which leads to denial of dignity. People are feeling compelled to abandon planned time away from their homes, having no choice but to return there to attend to their personal care needs. Alternatively they and their carers are required to deal with personal care needs in non adapted facilities.

The group has made good progress over the year, including:

- the Community Trust has completed work on installation of a facility at the Mariner Centre
- a facility at Grangemouth Sports Complex is nearing completion
- Forth Valley College have agreed to open their facilities for use by the wider community
- the Social Work Service is taking steps to open some facilities, for example at Oswald Avenue Day Service, for use by the wider public
- the Council's Locality Hubs are being designed with the need for CPT included as standard
- engaging with the private retail sector to make available CPT facilities.

By empowering people who have higher levels of personal care need to be involved in their communities, new provision will support the Partnership outcomes of self management, fair and positive experience, and access to community support. The proposal supports the objectives of the Review of Day Services for Younger People which can only deliver the shift towards more community based support if the necessary physical infrastructure is in place.

How we are enabling change

Understanding our local needs

The Partnership's Joint Strategic Need Assessment (JSNA) has helped us to understand and demonstrate the needs which exist and to inform the development of the Strategic Plan.

The JSNA brings together available data that allows us to understand the current supply of services and gaps between need and supply. Understanding need and service provision across the Partnership will be key to future success.

Over 2017-2018 the Partnership has published locality profiles and a Carers Needs Assessment. Further work will be done in 2018/2019 to develop more detailed needs assessment and these will support the preparation of a new Strategic Plan for 2019 -2022.

Health Inequalities

The National Health and Wellbeing Outcomes describe what health and social care partnerships must achieve through integration. These are set out in the *Our Partnership* section of this report. Outcome 5 states that health and social care partners will work with local communities to "…contribute to reducing health inequalities."

Life expectancy is one of the key indicators of health inequalities and the charts below show the difference in life expectancy at birth for the 15% most deprived areas of Falkirk (and Scotland) against the remaining 85%.

Addressing health inequalities is not just about providing quality health and social care services. It involves working with local partners such as Housing, Employment and the Falkirk Community Planning Partnership to create a better physical, social and economic environment for all.

It also involves delivering services to those who have the greatest need. The evaluation of the Discharge to assess service highlighted that 55% of the recipients of the service were from the most deprived areas in Falkirk, while only 19% of service users were from the least deprived areas.

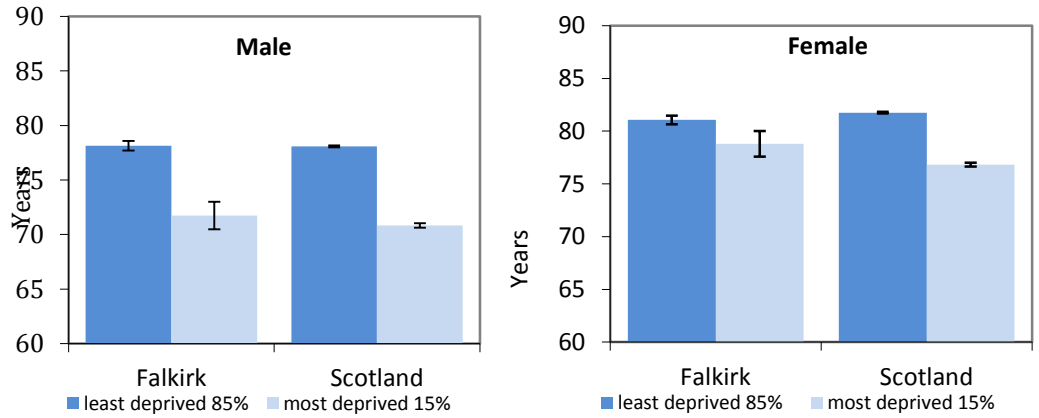


Figure 9: Expectation of Life at Birth for Falkirk & Scotland, by Sex, split by level of deprivation for the period 2011-2015

Source - National Records of Scotland (NRS)

Note on Input data *- Small Area Population Estimates for 2011-2015 and death counts at the data zone level (obtained from NRS Vital Events) were used as input data. The population and death data was aggregated over a five year period (as opposed to the three year period used for other life expectancy statistics published by NRS) to ensure a higher level of statistical robustness.*
Error bars signify 95% confidence intervals. Please note that the 'Years' axis does not begin at zero.

Key points on the charts above:

1. Male and female life expectancy at birth is broadly similar for Falkirk and Scotland.
2. The difference between male life expectancy at birth for the most deprived 15% and the least deprived 85% is much greater than for females.
3. Estimates suggest that males born in one of Falkirk's least deprived 85% areas will live on average **6.4 years** more than males born in the least deprived 15%.
4. For females in Falkirk, there is only **2.3 years** difference in life expectancy at birth between the 15% most deprived and 85% least deprived.

Palliative and end-of-life care

In Forth Valley there are approximately 3,000 deaths each year, of which approximately 75% could be anticipated or planned for (estimated by Information Service Division (ISD)). This number is projected to increase by 22% from 2013 to 2035. Our current models of health and social care delivery need to develop to meet this demographic challenge.

We also know that in Forth Valley:

- when asked up to 70% express a desire to die in their own home if possible
- 26% of deaths occur at home
- 42% of deaths occur in an acute hospital
- 8% of deaths in a community hospital
- 17% in a care home
- 7% in a hospice
- 30% of acute bed days are used by people in their last year of life
- 24% of people who are dying do not have access to the palliative care that they need.

Use of Data and Intelligence

The Partnership has been working collaboratively with the Local Intelligence Support Team (LIST) to promote and further the use of data and intelligence.

A visual and interactive dashboard has been developed that aims to assist managers understand performance and variation. The dashboard is updated on a weekly basis and provides managers with a near real-time picture of the current number of delays with an added emphasis on identifying patterns in numbers of delays.

The dashboard has been used by managers to monitor the drive to reduce delays due to sourcing packages of care. The snapshot below (Figure 10) shows how numbers of package of care delays have improved considerably since the inception of the dashboard:

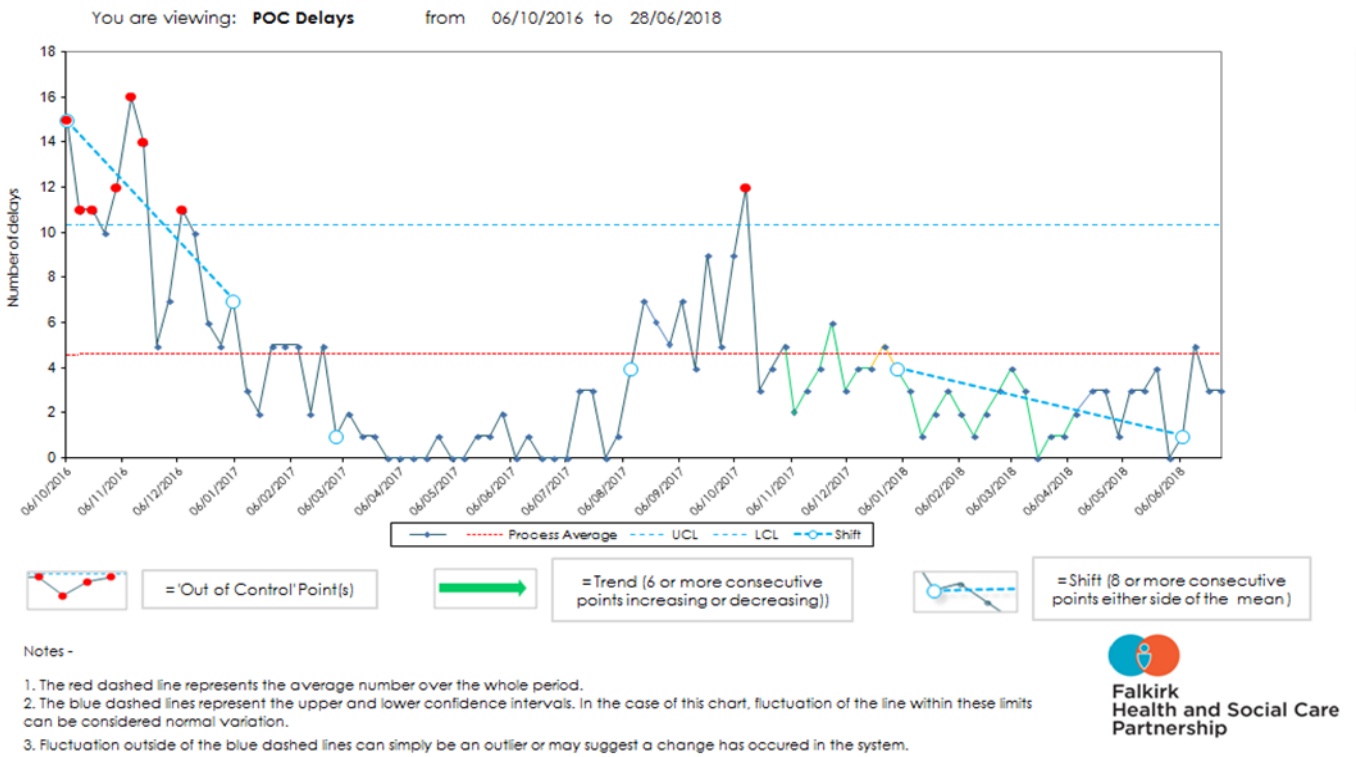


Figure 10: Delayed Discharge Dashboard

How we are collaborating to improve

The Partnership is working with organisations such as Healthcare Improvement Scotland and Improvement Hub (iHub) to ensure that health and care services continue to improve and evolve so that they meet the changing needs of people that use them. The "How we are making a difference" section of this report provided some examples of the range of work being completed. In addition, we are working with Glasgow Caledonian University to develop a Priority Setting Framework for the Falkirk Partnership.

Funding was secured the Chief Scientist Office[1] for a three year research project to develop, implement and evaluate a framework for priority setting based on principles and processes from economics, decision science, ethics and law. Falkirk is the main site working closely with the lead researcher.

The framework is being applied to Homecare Services in Falkirk. There is an established Home Care Review Group looking at the provision of Home Care services. This is supported by a recently established Home Care Performance Reporting Group. The framework is building on this existing work.

[1] The ~~project team includes: Professor Cam~~ Donaldson, Professor Rachel Baker, Marissa Collins, and Dr Micaela Mazzei Glasgow Caledonian University; Dr Lucy Frith, University of Liverpool; Professor Alec Morton, University of Strathclyde; Keith Svrett. University of Bristol: Paul Leak. Scottish Government

The process will focus on the balance of the delivery of Homecare services and is looking to answer the question

> ***"what balance of internal and external provision would deliver a responsive, efficient and sustainable Home Care provision that addresses quality, personal outcomes and reablement?"***

Using this area as the focus for priority setting will allow for a short, medium and long term analysis for the service.

Workshops have been held with the IJB, the Homecare Review and Performance groups alongside Home Care managers and the Strategic Planning Group to outline and clarify how this is being applied to the Home Care service and to begin to develop criteria to aid decision making. Data on the current resource use for both internal and external Home Care services is being collated. A research team has been set up to lead and facilitate the process.

How we involve people

Falkirk HSCP Participation and Engagement Strategy sets out our commitment to effective and meaningful engagement with service users, carers, communities, staff and partners. Importantly, it also provides information about how people can participate and why participation is important.

The table below shows some activity undertaken by the Partnership during 2017-2018.

	Who was involved?				
Activity	**Service Users**	**Carers**	**Comm-unity**	**Staff**	**Partners**
Representation on the IJB and Strategic Planning Group	✓	✓		✓	✓
Recruitment process completed for the service user, carer and Third sector positions on the IJB	✓	✓	✓	✓	✓
Held 6 staff engagement sessions for a range of staff across the HSCP, including Third and Independent Sector. The emerging themes and opportunities for better integrated working were developed.				✓	✓
Held 8 Homecare engagement sessions for frontline workers and support staff at the end of 2017 and January 2018. The events were attended by 42% of frontline staff. The staff feedback provided has helped inform a number of key priorities for the service being progressed during the course of 2018.				✓	
Implemented Living Well Falkirk. The website was demonstrated to MECS users, the local Scottish Health Council rep, CVS Falkirk, Action on Hearing Loss at the Sensory Centre and the Public	✓	✓	✓	✓	✓

	Who was involved?				
Activity	**Service Users**	**Carers**	**Comm-unity**	**Staff**	**Partners**
Partnership Forum. Feedback is very positive and any areas for improvement have been fedback to the Steering Group and ADL Smartcare.					
Redesign of day services for younger adults	✓	✓		✓	
Conducted a public consultation on local Eligibility Criteria for the Carers Act. This consisted of 2 public events, an online and paper survey, information in the local press, Facebook and Twitter.	✓	✓	✓	✓	✓
Worked collaboratively to develop the Support at Home (Home Support and Supported Living) contract	✓	✓		✓	✓
Involved in work with service users, the three Councils and NHS Forth Valley to put in place a Forth Valley contract for Advocacy Services. This was led by Stirling Council.	✓			✓	✓
Local networks in place e.g. Carers Forum, Public Partnership Forum, Joint Staff Forum, Providers Forum and Community Care and Health Forum	✓	✓	✓	✓	✓
Held a Third sector commissioning event to help co-design how Falkirk HSCP take forward strategic commissioning			✓		✓
Participation in Forth Valley wide Third Sector Conference, facilitation support within 2 workshops about Strategic Commissioning			✓		✓
Completed integrated locality development work with health and social care teams and the Third sector				✓	✓
Celebrated Older People's Day - CVS Falkirk led the organisation of an Older People's Day 2017 drop-in event for the Partnership	✓	✓	✓	✓	✓
Held a multi-agency Forth Valley planning event to raise awareness of the new national Mental Health Strategy. Fifty one participants from across a range of statutory agencies and third sector organisations working with adults, children, educational and criminal justice services attended this event				✓	✓
Held a multi-agency event following the launch of the Dementia Strategy. Delegates were engaged in determining the current position in achievement of each of these commitments, where the gaps were, who should lead on closing the gaps and how we		✓	✓	✓	✓

Activity	Who was involved?				
	Service Users	Carers	Comm-unity	Staff	Partners
could measure success. This was followed up by engagement with the Carers' Centres to ensure wide stakeholder participation. These outputs have informed the redesign of specialist dementia services detailed below and started the conversation of how communities and organisations can work together to achieve the commitments in the strategy					
Published articles in the local press, Falkirk Council newsletter, and delivered presentations to local groups	✓	✓	✓	✓	
Consultation with young people and their families in the Partnership area about how we can improve the way we support young people with additional support needs as they move from children's to adult services	✓	✓			
Held a FV wide stakeholder workshop to review the future priorities for palliative and end-of-life care and to help shape the key actions required to deliver transformational change. The outputs were used to refine the priorities and P&EOLC action plan				✓	✓
Reviewed the Social Work Adult Services Transport Policy - a questionnaire, the draft policy and a covering letter and were sent in hard copy to all 150 service users currently receiving assistance with transport in early December 2017. This group includes users of the buses for day services as well as those for whom taxis or volunteer drivers provide transport. Three drop in sessions were held in January 2018. 83 people completed the questionnaire and approximately 30 people attended the drop in sessions. Most respondents were people or the carers of people who currently use day services.	✓	✓		✓	✓

Table 2: Partnership engagement activity 2017-18

How we support our workforce

The Partnership remain committed to ensure our workforce, and that of partners, is responsive and skilled and is able to provide care and support that is local, and of a high quality, consistent with our ambitions. Our workforce is the single most important resource in delivering high quality services and the transformation required to ensure the delivery of health and social care integration.

We ensure our workforce has a voice in the work of the partnership through the Joint Staff Forum which involves senior officers and staff side/Trade Union representatives. We aim to work in partnership with our workforce through this Forum to ensure the local knowledge of our workforce is considered when improving our services. We have always contributed to the Forth Valley Forum but have now set up a Falkirk specific Joint Staff Forum to ensure we are focused on important local issues.

We are working with Forth Valley College and the independent sector to ensure the availability of a flexible responsive workforce with the right skills, in the right place and at the right time to ensure that our service users get the right level of support early enough. A development workshop was held in Spring 2017 with care providers and stakeholders from Falkirk Council and Third sector to consider working together to improve the quality of vocational training in Falkirk. The overall aim of the workshop was to '*ensure that potential partners and stakeholders consider and help draft the design and initial function of a potential Training Consortium in Falkirk*'.

During the workshop several exercises and discussions were completed to identify the key areas for the consortium to consider and develop. The overall aim for the proposed training consortium is to *'enhance the quality and cost effectiveness of health and social care vocational training in Falkirk.'* Following the workshop work discussions have continued with the aim of establishing a collaborative approach to training and workforce development as reflected in Part 2 of the National Health and Social Care Workforce Plan.

The section above (How we involve people) also describes some of the work that involved and engaged our workforce.

How we are working with Falkirk Community Planning Partnership

The Health and Social Care Partnership is a strategic partner within the Falkirk Community Planning Partnership and makes a significant contribution to the CPP's Strategic Outcomes and Local Delivery (SOLD) Plan in a leading capacity, as follows:

- People live full and positive lives within supportive communities
- Improving mental health and wellbeing.

The Partnership also makes a distinct contribution to a number of other priorities and outcomes within the SOLD plan.

In relation to mental health and wellbeing, the Chief Officer chairs a multi-agency Mental Health and Wellbeing group, who have developed an area wide action plan, which all partners are accountable for delivering. This is currently being reviewed following the publication of the national Mental Health Strategy.

How we are working with Children's Services

Good Transitions – Improving Transitions Planning:

Young people with additional support needs and their families told us how we can improve the way we support them as they move from children's to adult services. The work found optimism about the future and enthusiasm around how good transitions can be achieved and a realistic appraisal of the work that will be required.
For young people with additional support to do this successfully they need the right support to make the transition into young adulthood. Good transition planning is of central importance to the achievement of their personal outcomes. This involves coordination within and across services including education, children's social work, the Health and Social Care Partnership, health, housing, employment services and the third sector.
The Partnership has adopted the Principles for Good Transitions to guide service delivery and practice and signal our commitment to excellence in transition planning. The Partnership has agreed to identify resources to create a strategic role to co-ordinate transition planning, implement the improvement actions and to create a Transitions Steering Group, including the terms of reference for this group.

Safe and Together

November 2017 saw the launch of the Safe and Together approach in Falkirk. This initiative is jointly supported by the Partnership and Falkirk Child Protection Committee and is focussed on addressing the harmful impact of domestic abuse on children, young people and families and communities.

The approach provides a means of assessing and describing the impact of domestic abuse on family functioning and children's wellbeing and development. It supports a move away from a broad recognition of how domestic abuse tends to impact on individuals and children as a group, to an understanding of how the specific abuse within that particular family has impacted on the individual child's wellbeing.

Safe and Together is an approach to intervene successfully with domestic abuse victims (survivors) to:

- create non-blaming partnership
- recognise the victim's strengths and parenting capacity
- strengthen the relationship between the non-abusing parent and child.

An approach to intervene successfully with perpetrators of domestic abuse to:

- assess risk
- assess impact on children's wellbeing
- assess capacity to change
- hold them to a high standard of parenting

- ensure they are visible within Child Protection processes and the Child's Plan, including safety planning.

The approach supports the need to change the way we view domestic abuse; to think differently about how we currently respond and what we do in practice. As the approach is being embedded across services in Falkirk this is helping to inform and achieve culture, systems and practice change.

Partnership Funding was used to bring and launch the *Safe and Together* approach to Falkirk and this includes evaluation of the impact of using the approach on practitioners, managers and families. Practitioners who attended 4 days multi-agency core training in the approach act in the role of mentor to support wider awareness raising, use of shared language and embedding practice based on key principles. There is already a growing body of evidence in relation to culture, systems and practice change across services.

How we are working with Housing

The Falkirk Housing Contribution Statement provides an essential link between the Falkirk HSCP Strategic Plan and the Local Housing Strategy (LHS) with the key priority linking both plans being "providing housing and support to vulnerable groups".

The SCP Housing Contribution Group continues to progress actions from the LHS and the Housing Contribution Statement and has representation from Falkirk Council Housing Services, Falkirk HSCP and Registered Social Landlords(RSL). Three sub groups have been set up to move these actions forward.

A report written for the group highlighted that there is an uneven geographic spread of older people's housing with less high end care/support and specialist housing in East locality. There are also numerically greater numbers of older people in the East Locality. The group have discussed using affordable housing grant to build specialist housing for older people in the East Locality and looked at incorporating dementia friendly design features into Council new build properties.

The group are reviewing the existing model of older people's housing in order to assess if it is fit for purpose. They are exploring if it could be used for Extra Care Housing or if it can be reconfigured to address the current difficulties with the stock.

Visits have taken place with officers from Falkirk Council Housing Services, Falkirk HSCP and Registered Social Landlord Managers to RSL developments for older people. These visits considered communal facilities, housing support and social activities and how they can increase their usage and involve members of the local community. Over 2018/2019 we will continue to work with RSLs to explore opportunities to use of their facilities to develop community based supports.

How we are working with Falkirk Alcohol and Drugs Partnership

The Falkirk Alcohol and Drug Partnership is a multi-agency partnership that aims to reduce the harm caused by the use and misuse of substances within our communities. The ADP oversees a broad range of activity to support individuals and communities, including:

- adopt a Whole Population Approach - the team has widely distributed resources which are designed to increase awareness of local services available to support individuals and families affected by alcohol and/or drug use. This ranges from leaflets to radio and plasma screen campaigns. The topics covered range from safe drinking advice through to the dangers and legalities associated with buying alcohol for those under the age of 18. It is thought that such work contributes, in part, to self-referral being one of the most common referral routes locally. Future plans include an alcohol campaign targeted at older adults.

- Forth Valley Recovery Community (FVRC) – this is a geographically based community of people who are committed to making recovery from substance misuse a reality. It is a community that hosts weekly events and regular activities that support people in various stages of recovery from substance misuse. FVRC is open to anyone who is affected by substance misuse with recovery activity now available 7 days of the week. The FVRC is establishing strong links with other community groups across Falkirk and is critical to making recovery visible within the area and to delivering a clear message of hope and support to those contemplating or beginning their recovery journey.

- continue to build a Recovery Oriented System of Care (ROSC), where treatment and aftercare are integrated and priority is given to empowering people to sustain their recovery. Features of a ROSC also link and contribute to the work of the IJB.

- continue to operate a Critical Incident group which reviews all local drug related deaths for learning points and relevant service developments. Wider Council services are invited to reviews including Social Work services and Housing. Drug related deaths continue to be a cause of significant concern across Scotland, with 2017 seeing the largest ever number recorded (934).

- Adult addiction services working across Falkirk continue to exceed the Scottish Government LDP Standard in relation to waiting times. At the end of the last published quarter (October – December 2017), Forth Valley exceeded the national target. During this quarter, 100% of people referred for drug and/or alcohol treatment, were seen within 3 weeks. This includes those in prison within Forth Valley. More rapid access to treatment reduces risk not only to individuals but also to families and communities.

How we are working with Community Justice Partnership

The IJB is a Community Justice partner, and as such is required to engage in the planning and delivery of services. The Chief Officer represents the IJB on the Falkirk Community Justice Partnership (CJP), which sits within the Community Planning Partnership structure. People with lived experience of Community Justice Services often have a range of needs. These will require partnership working between the IJB and CJP to ensure people access and make use of relevant services to address areas of need such as physical and mental health, housing, social welfare, education and employment.

In 2017/2018, the Falkirk Community Justice Partnership was successful in funding bids for:

Aspiring Communities Fund: Led by Cyrenians, in partnership with CVS Falkirk, the Prepare, Support and Sustain (PSS) project aims to scope out what the needs, skills, assets and deficits are across Falkirk for people coming to the end of their involvement with the criminal justice system who wish to access volunteering or work opportunities.

Employability, Innovation and Integration Fund: The Tackling Inequalities and Improving Outcomes project aims to reduce health inequalities and improve the health and wellbeing of people in the criminal justice system in order to improve their ability to engage in employment and training. The project aims to work with people to improve their mental health, deliver anticipatory care through keep well assessments, liaise with other health professionals over compliance and changes to medication, liaise with psychiatry and psychology and work with criminal justice and employability services to jointly plan supported pathways to employment.

How we are working with the Third Sector

In August 2017, the partnership hosted a Third sector commissioning event. This provided around 60 Third Sector Partners with information and the opportunity to help co-design how Falkirk HSCP take forward strategic commissioning in a way that develops a robust and sustainable partnership with Third Sector organisations, in order to deliver local services. The event was jointly facilitated by ALLIANCE Scotland, CVS Falkirk and HSCP representatives.

In February 2018, at a Forth Valley wide Third Sector Conference, 2 workshops were jointly facilitated by representatives from Procurement and Commissioning Units within Falkirk and Stirling Councils. The workshops focussed on strategic commissioning with a particular focus on health and social care. A representative from the HSCP supported the facilitation of both workshops.

How we are working with providers

Meetings	Approach
Care Homes for Older People	During 2017 Care Home Managers meetings were held in January, March and October. So far in 2018 meetings have been held in January and April (meetings now held quarterly). These meetings provide the opportunity to discuss prudent information with the managers as a group. To build greater collaboration, the Care Home Managers are encouraged to set the agenda to ensure discussion points that are important to them are raised. There are often guest speakers e.g. Care Home Education Facilitator, the Care Inspectorate and ASP Lead Officer.
Care Homes for Adults (LD, MH, PD & Complex Care)	The first Care Home Managers meeting (for 2017) was held in June and then a further meeting in November. For 2018 there has been one meeting which was held in March 2018. It is the providers meetings and managers are asked to add items to the agenda. It is a meeting aimed at partnership working whereby the providers share good practice, engage in reflective practice and discuss lessons learned. Guest speakers are also invited to the meetings and also staff from Social Work Adult Services. To date we have had the Care Inspectorate attend, ASP lead from Adults services and Service Manager from Adult Services. OTs have been invited along to discuss the provision of equipment in Care Homes. Information is shared with the group in terms of forthcoming changes i.e. Care Inspectorate (CI) reorganisation, Duty of Candour, GDPR and new care standards. Adult services and CI shared good practice guidance with group such as SSSC guidance on supervision, etc. The feedback from participants has been very positive and the group are working really well together. It has been a good demonstration of joint working with providers and other organisations to deliver better outcomes.
Support at Home	The engagement that we have had with Providers and others throughout 17/18 in relation to Support at Home: On 23 March 2017 and 20 October 2017 we held provider consultation events. These were a continuation of a series of provider workshops that commenced in Dec 2016. The whole process was aimed at ensuring that we consulted with and involved providers in the development of the new Support at Home framework which commenced in April 2018. A total of 35 contract mobilisation meetings were held with providers by Procurement and Commissioning staff and colleagues from Falkirk HSCP. Meetings were held to give an opportunity for providers and colleagues to share information around the work of the HSCP and operation of the

	framework. The meetings also gave an opportunity to understand the work of organisations within the framework and what they can offer those in need of support living within the Falkirk area. In September 2017 a survey of carers was undertaken in partnership with Falkirk Carers Centre. The aim of the survey was to engage with carers and gain their views on what elements of home support were of importance to them when receiving this service. Now that the Support at Home Framework has been established, we intend to work alongside colleagues in the HSCP to develop Provider Forums and aiming for the first one to be later in the year. The purpose of these forums is to give an opportunity for providers and staff from HSCP and Procurement and Commissioning to meet and share practice, talk about innovation within the sector, any challenges and how these may be overcome and also any changes to legislation within the sector. We expect these meetings will develop organically and that, through time, providers will take much more of a role in leading on the agenda rather than these being led by Procurement & Commissioning staff and the HSCP.

How we are enabling information and data sharing

There has been a significant level of work undertaken by the Data Sharing Partnership (DSP) and IT colleagues across councils and health. This work supports a number of integration strategic strands with a focus on enabling information sharing and access across the care settings.

This has resulted in established infrastructure links now being in place between the main health and council settings. In practice this means that access to both key health and social care core systems (MIDIS, SWIFT, SWISS, Care Partners and TOPAS) can be undertaken at the main health and council settings across the area.

There has also been work around developing a Health and Social Care Information Sharing Portal to support clinical services.

How Partnership Funding is supporting transformational change and redesign

During 2015-2018, the Scottish Government has provided funding in the form of Integrated Care Funding (ICF) and Delayed Discharge (DD) Funds. These two resources are collectively known as Partnership Funding. A single governance and monitoring process has been implemented in relation to Partnership Funding. This ensures that the collective resource has the potential to enable transformational change and improvement to health and social care provision, across the whole system.

The four local investment priorities are:

- Avoiding unplanned admissions
- Health and wellbeing in communities
- Support for unpaid carers
- Infrastructure.

2017/2018 was the final year of the current Partnership Funding Investment Programme. The Scottish Government have confirmed that Partnership Funding will continue to be allocated to Integration Authorities, however funds will be issued via the NHS baseline budget as opposed to a centrally monitored, ring-fenced allocation. The Scottish Government are keen that partnerships continue to use ICF and DD Funds to support the progression of local health and social care outcomes.

Activity and Progress during 2017/2018

This information provides an overview of how Partnership Funding has been used during the period 2017/2018.

Partnership Funding Spend 2017-18	
Total Spend	£3,059,000
ICF Spend	£2,661,000
Delayed Discharge Spend	£398,000
Projects Supported	40

Table 3

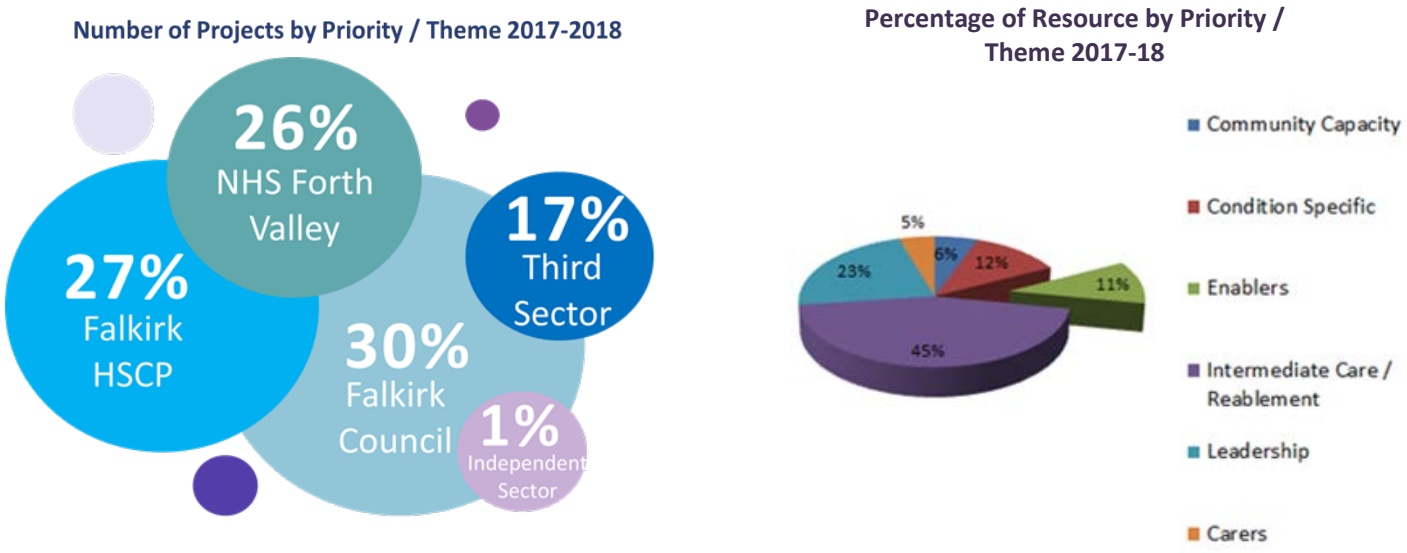


Figure 11: Overview of Partnership Funding

Programme Learning, Challenges and Changes

Areas of learning and proposed improvement actions were provided within the 2016/2017 Annual Report. The table below (table 3) provides an update on progress against programme improvement actions during 2017/2018. Further improvement actions are also highlighted.

Learning Point	Proposed Improvement Actions	Progress during 2017/2018
Initiative Sustainability	Moving forward a proactive approach to commissioning will be adopted with the Partnership working with partners to clearly define what services are required, based on evidence of local need and linkage with the whole system. Evaluation process will also continue, with consideration being given to sustainability and service redesign. This work should sit within the context of longer-term local strategies and planning processes across the Partnership.	Three year Partnership Funding Investment Plan approved by IJB in March 2018. The plan sets direction for investment in key areas for the period 2018 – 2021. Investment is subject to governance process. Evaluation continues to inform continuous improvement and development within initiatives and also between initiatives. Programme links with Primary Care Transformation Programme, Unscheduled Care Board and Frailty Collaborative.
Performance Management	Continue to work with project leads to embed performance frameworks and encourage the use of this information to drive service development and improvement. Ensure that performance information is established at the point of initiative design.	Performance management has improved, however leads continue to require some support. **Action**: Maintain support and assert escalation process consistently for non-compliance.
Commission-ing Approach	A more pro-active commissioning approach should be adopted to enable service development in line with evidence based need. This model of commissioning should link with work being undertaken regarding strategic commissioning. In relation to current initiatives, work will continue to evaluate and streamline provision. This will include on-going discussion via the Reablement Leadership Group and commissioning sessions for Third sector providers, focussing on Partnership priorities and collaborative service development.	Three year investment plan approved. Wider commissioning work has progressed, with focus on: • Mental Health • Support for Carers • Care and Support at Home • Reablement **Action**: Develop single contract between Partnership and organisation incorporating all funding strands to enable effective service planning, collective oversight of impact and sustainability.
Financial Management	Principles regarding financial governance have been developed. These principles have been applied to all initiatives to help inform how variance in actual expenditure to approved allocation is treated. The implementation of the principles will ensure consistency of practice and clear accountability.	Financial principles and an initiative 'Change Request' process are in place and provide consistent and effective approach to programme management.

Table 4

Strategic Commissioning

Falkirk Council and NHS Forth Valley support a wide range of services delivered through external providers. The transfer of budgetary authority to the IJB, has provided an opportunity to consider how existing funding arrangements support the delivery of the HSCP Strategic Plan and achieve best value, whilst also adequately supporting local providers to develop and improve services in line with need and demand within localities.

In March 2017, the IJB requested that the Leadership Group progress with work to develop a robust approach to the way that services across Falkirk HSCP are put in place, particularly within the Third Sector. Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Central to the implementation of effective strategic commissioning process is outcomes for people. Therefore, partner, services user and carer involvement is critical. The commissioning cycle is shown within figure 12, below.

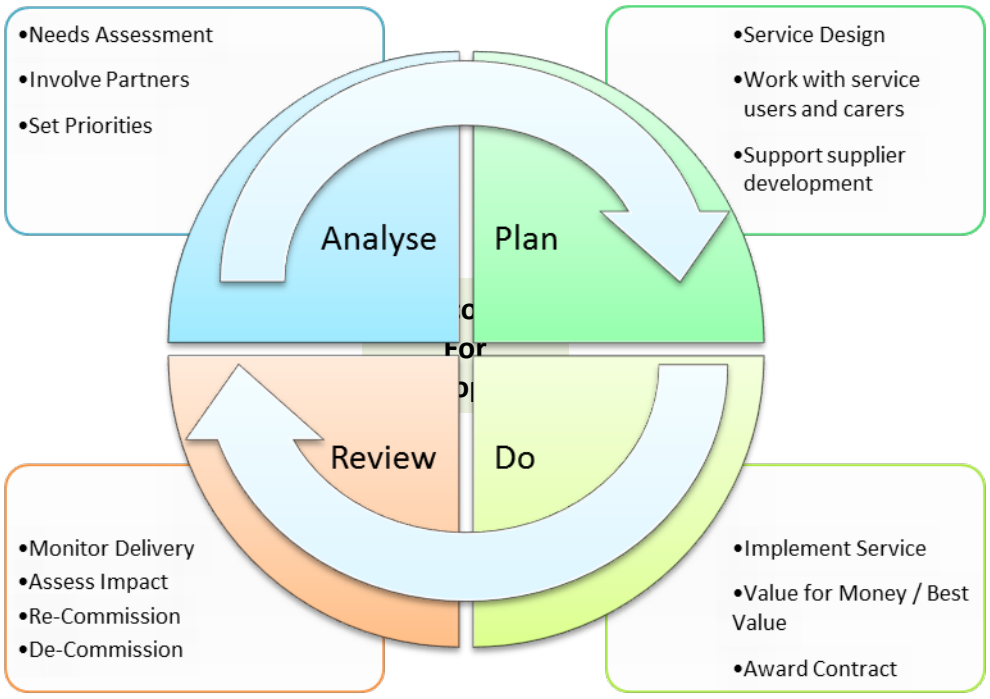


Figure 12: Commissioning Cycle

The IJB agreed that a whole-scale review should consider:

- clear alignment of investment with HSCP priorities and potential de-commissioning of some services which no longer meet with HSCP priorities
- how best to engage with Partners, Services Users and Carers in the evaluation and design of services
- development of contracts which enable sustainability for organisation, including the ability to plan ahead and better develop and retain their workforce
- development of collaborative approaches to service delivery, encouraging providers to work together to support provision

- maintenance of services supported through short-term funding, in line with service specific commissioning strategy and priority e.g. development of the Mental Health and Wellbeing priority of the SOLD Plan
- the introduction of new legislation, which may change current statutory responsibility.

In order to progress the implementation of a Partnership approach to strategic commissioning, it was agreed that a phased approach should be taken. On this basis, due to high level of need identified, the complex nature of funding, new legislation and priority status within the Community Planning Partnership's SOLD plan, initial work has focussed on the following services:

- support for unpaid carers
- community based Mental Health
- reablement
- Home Care provision.

A multi-agency group has oversight of the strategic commissioning work, with sub-groups of thematic experts taking forward activity.

Mental Health

Strategic Commissioning work in relation to community based mental health services, is intended to ensure appropriate pathways are in place to enable people experiencing mental health related illness to be supported within communities. In August 2017, an initial Strategic Commissioning Event was held for Third Sector agencies. The feedback and key learning from the event has informed the work of the Mental Health Strategic Commissioning Working Group. This group was tasked with progressing a plan for commissioning mental health services that have traditionally been delivered within the third sector.

Several Third Sector organisations are commissioned to provide services for improving, promoting or supporting the mental health and well being of the Falkirk population; however the process of commissioning these services has been fragmented with numerous funding streams created separately by Health and from Social Work. Fragmenting the funding and commissioning process has created challenges for planning and service delivery in both the statutory and third sector organisations across the HSCP.

The publication of the Scottish Government's Mental Health Strategy (2017-2027) in March 2017, the priority status allocated to Mental Health within local strategy such as the Community Planning Partnership's Strategic Outcomes and Local Delivery Plan (SOLD) and the requirement for Integration Authorities to discharge duties in line with local, regularly reviewed Strategic Plans, mean that the development of a commissioning plan specific to community based Mental Health Services is timely and critical.

The team agreed that in order to meet the needs of the population it would be important to commission services based on need. This would include adult and older adult services with

no distinction made, wherever possible, on the age group the intended intervention is for. Child and Adolescent specific services were excluded as these services are not within the scope of integration, however consideration was given to transition points. In addition, specialist alcohol and drugs services are commissioned through a separate process, which is led via the Alcohol and Drug Partnership and therefore specific alcohol and drugs services were not directly a remit of this group. However, owing to the incidence of co-morbid substance misuse within the group being considered it is essential that addictions services are considered within the overall context of need and provision.

Early meetings of the group focussed on learning how the current commissioning arrangements were working and what could be improved on in terms of process. An exercise was also undertaken to gather information about existing service provision, including internal provision, service funded by the NHS Forth Valley and/or Falkirk Council and independent provision. The group has also reviewed interventions employed, the consistency of performance information and data available from services and also communication across services as a network.

Following this initial work, the group has now established opportunities to engage with GPs and other colleagues within Primary Care and with providers, potential providers and partners working with Mental Health Services.

Support for Carers

Similar to the process undertaken by the Mental Health group, the Carers Strategic Commissioning Group initially gathered information about existing provision for carers as well as national and local data. This information formed a baseline for the group to then progress the identification of needs gaps between existing service and future service delivery.

The Carers Act (Scotland) became operational on 1 April 2018. A considerable amount of work has been undertaken to understand the current and projected need for provision within the Falkirk Council area. The pace and complexity of the implementation requirements from the Act, for example, eligibility criteria and the waving of charges have been significant.

Support for Carers is currently in place, consistent with previous years. To date, additional commissioning has related to supporting the implementation of the Act and undertaking Carers Support Plans. Performance information is being gathered to enable the group to establish and identify emerging service need. This will then inform ongoing commissioning.

Our Performance

IJB Governance and Decision Making

Falkirk Integration Joint Board (IJB) has had responsibility for the health and social care functions that were formally delegated to the Board since 1 April 2016. This means the IJB takes responsibility for the strategic planning and commissioning of delegated functions. They are also responsible for ensuring the delivery of its functions, through the locally agreed operational arrangements of:

- Social Work Adult Services
- Community and Family Health Services relating to in-scope functions
- Large hospital services planning, with partners who will continue to manage and deliver the services as part of the pan Forth Valley structures.

NHS Forth Valley and Falkirk Council delegate budgets to the IJB, which decides how resources are used to achieve the objectives of their Strategic Plan. The IJB then directs the partners, through the Health and Social Care Partnership, to deliver services in line with this plan. The IJB controls an annual budget of approximately £213m, and is responsible for providing health and social services for the Falkirk area population.

A governance framework is in place which covers areas including the Integration Scheme, IJB Standing Orders, Risk Management and Clinical and Care Governance. This framework covers the rules and practices by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The IJB has legal responsibilities and obligations to its stakeholders, staff and residents of the Falkirk Council area.

Membership of the Integration Joint Board is set out in legislation and is made up of 19 members. The Board has 6 voting members – 3 Falkirk Council Elected Members and 3 NHS Forth Valley non-executive Board members. The membership must also include senior officer representation from health, social work and wider stakeholders including service users, carers, Third Sector and staff representatives.

The range of Board members has enabled insightful contributions from different perspectives, and informed decisions. The voice of service users and carers in particular, has been of importance and value to the Board.

The diagram (figure 13) provides an overview of the key activities of Falkirk IJB during 2017/2018.

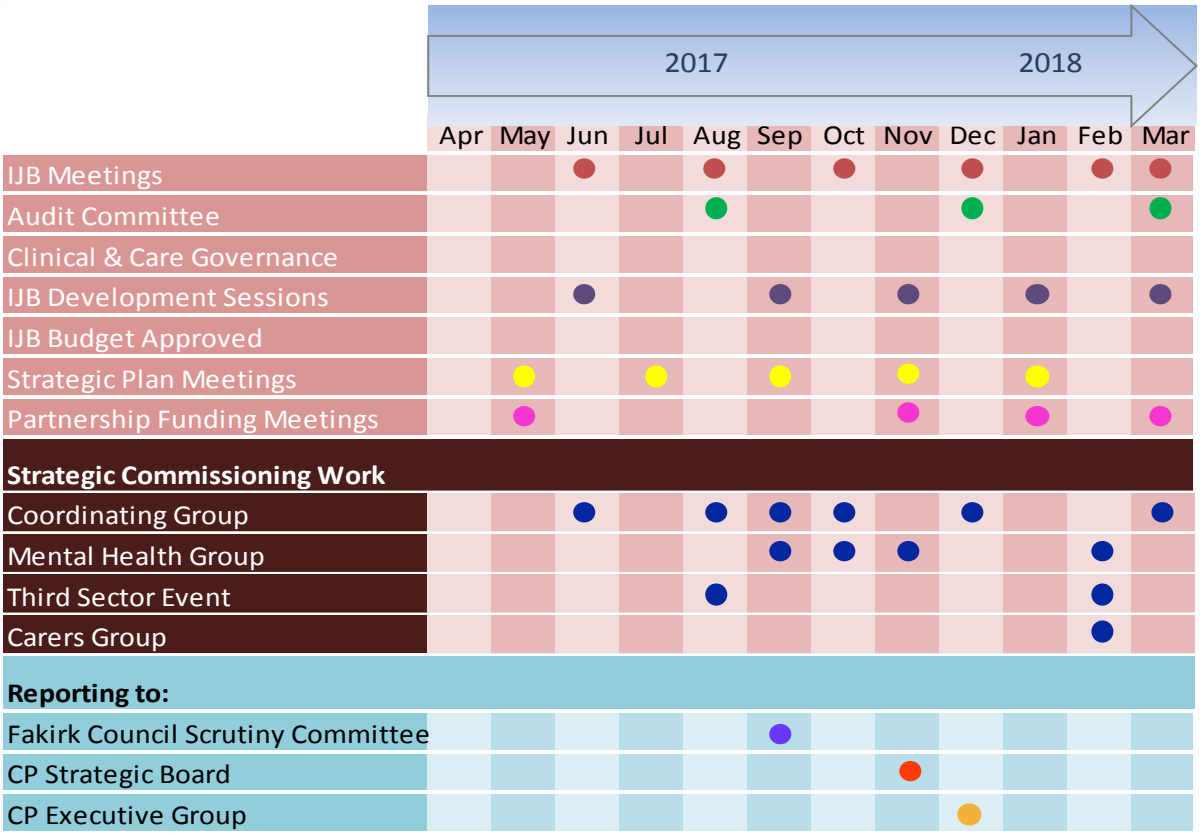


Figure 13: Key Activities of the Falkirk IJB 2017/18

Financial Performance

The IJB Annual Accounts 2017-2018 report the financial performance of the IJB. Their main purpose is to demonstrate the stewardship of the public funds which have been entrusted to the IJB for the delivery of the IJB's vision and its core outcomes as expressed within the Strategic Plan. This section summarises the information contained in the Annual Accounts 2017 – 18.

The funding available to the Integration Joint Board to support the delivery of the Strategic Plan comes from contributions from the constituent authorities (Falkirk Council and NHS Forth Valley) and funding allocated from Scottish Government. This funding includes the Integrated Care Fund, Delayed Discharge Funds and the Primary Care and Mental Health Transformation Funds. The combined funding is used by the IJB to support the delivery of the Strategic Plan.

The IJB issues directions to the constituent authorities to utilise the funding available to deliver and/or commission services across the partnership on its behalf to deliver the priorities of the Strategic Plan.

A financial report to the June 2017 meeting of the IJB highlighted that in 2017/2018 the Partnership faced a financial risk in respect of in scope NHS budgets of c£1.490m. This was due to a number of factors including recurring pressures carried forward from the

2016/2017 budget and a number of savings options included in the 2017/2018 budget which were rated as high risk for deliverability.

Despite efforts to address the financial risk, including the creation of a financial recovery group which met regularly, the risk did not reduce, albeit some of the pressures on the Partnership changed during the year. The most significant pressure facing the Partnership in 2017/2018 was prescribing costs, due in part to higher drug costs for a number of reasons, including short supply of some medications. This pressure was reflected nationally.

A risk sharing agreement was reached between the IJB, Falkirk Council and NHS Forth Valley for 2017/2018. The agreement sets out that each Partner will take responsibility for their overspend if applicable. It was also agreed that general reserves carried forward from 2016/2017 of £0.213m would be applied to the overspend.

The impact of the risk sharing agreement was as follows at Table 5:

	£m
Overspend on budget delegated to NHS Forth Valley	1.593
Transfer from General Reserves	(0.213)
Net Position	**1.380**
Additional funding received from NHS Forth Valley	(1.380)
Final Net Position	**-**
Underspend on budgets delegated to Falkirk Council	(0.297)
Transfer to General Reserves	**0.297**

Table 5

A summary of the 2017/2018 financial position for the IJB is shown below at Table 6:

	£m
Total Resources Available	212.847
Total Expenditure	(211.198)
Total Comprehensive Income & Expenditure	**1.649**

Table 6

The £1.649m shown in the table above represents an underspend against funds earmarked for specific funding. This unused funding has therefore been carried forward for use in 2018-2019.

The IJB adopted a reserves policy and strategy in March 2017. The reserves of the IJB have increased from £4.841m as at 31 March 2017 to £6.490m as at 31 March 2018. Of the £6.490m, £0.297m is a general reserve (effectively a contingency fund) and £6.193m is made up of a number of earmarked reserves, where funds have been ring fenced for a specific purpose.

The Set Aside budget covers the in-scope integration functions of the NHS that are carried out in a large hospital setting – in the case of the Falkirk Partnership, this is Forth Valley Royal Hospital - and this covers areas such as geriatric medicine, palliative care and mental health inpatient services. The distinction is that such settings will usually provide services to the population of more than one local authority.

NHS Forth Valley meets the pressures associated with the set aside budget and therefore the financial risk does not currently lie with the IJB. In 2017-2018, expenditure on Set Aside services was £26.300m against a budget of £25.207m. NHS Forth Valley met the additional £1.093m of costs.

To help address financial challenges, the IJB is committed to developing a medium term financial plan. Work will progress on this during the summer 2018 with a report back to the IJB in the autumn. Part of this work will include identifying sustainable budget savings through service change and efficiency.

Financial Reporting on Localities

The 2017/2018 financial information is not split into localities. Work is underway to allow the Partnership to report financial information at locality level. This work forms part of the overall locality planning arrangements.

Best Value

The governance framework is the rules, policies and procedures by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The Board has legal responsibilities and obligations to its stakeholders, staff and residents of the Falkirk area.
Falkirk IJB ensures proper administration of its financial affairs by having a Chief Finance Officer (section 95 of the Local Government (Scotland) Act 1973).

As part of the governance arrangements the Chief Officer chairs the HSCP Leadership Team. The partnership considers that key performance indicators, measureable progress in delivering the priorities of the Strategic Plan and financial performance form the basis of demonstrating Best Value. Therefore the evidence of Best Value can be observed through:

- The Performance Management Framework and Performance Reports
- Financial Reporting; and
- Reporting on Strategic Plan delivery through both the Chief Officer's reports to the IJB and topic specific reports.

This approach is visually demonstrated in Figure 14 Best Value diagram below

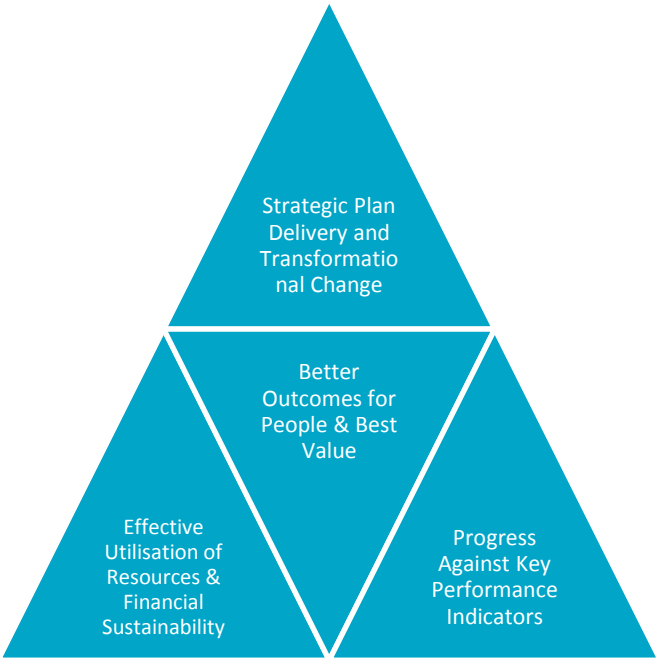


Figure 14:

Audit Arrangements

The IJB Audit Committee is responsible for the promotion of best practice in the areas of risk management, financial procedures, internal controls, development of continuous improvement and review of both Internal and External Audit recommendations. The Committee approved the Internal Audit plan for 2017/2018 in September 2017, which was based on an assessment of the risks facing the IJB. Their review will cover Corporate, Staff, Care, Financial and Information Governance.

The Audit Committee will consider an Internal Audit progress report and the Annual Internal Audit Report for 2017/2018 which will provide the Chief Internal Auditor's opinion on the IJB's internal control framework.

Ernst & Young is the external auditor of the IJB for the five year period from 2016/2017 to 2020/2021. They prepare an Annual Audit Plan, for the benefit of IJB management and the Audit Committee that sets out their proposed audit approach for the audit of the financial year ahead.

These reports will be available from September 2018 and can be found through the link.

Performance Management

The IJB fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services, relevant targets, and measures which are set out in the Strategic Plan and integration functions.

The Partnership reports progress against the suite of national integration indicators. This enables us to understand how well our services are meeting the needs of people who use our services and communities.

Our performance for 2017/2018 is set out in the following table:

National Indicators

	NI	Title	Falkirk Partnership 2015/16	Falkirk Partnership 2017/18	Comparator Average 2017/18	Scotland 2017/18
Outcome Indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	93%	92%	93%	93%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	85%	83%	81%	81%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	80%	76%	75%	76%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	79%	72%	77%	74%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	81%	81%	81%	80%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	84%	81%	83%	83%
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	84%	78%	82%	80%
	NI - 8	Total combined % carers who feel supported to continue in their caring role	43%	37%	37%	37%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	85%	84%	84%	83%
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	NA

Note: Figures are not available for 2016/17 for indicators 1-10 as the Health and Care Experience Survey (HACE) is completed every two years. Additionally for these indicators, a different weighting methodology was used in the most recent Scottish Government publication in May, and the previous years were recalculated. As a consequence, figures in this year's annual report may not align with last year's annual report.

	NI	Title	Falkirk Partnership			Comparator Average	Scotland
			2015/16	2016/17	2017/18	2017/18	2017/18
Data Indicators	NI - 11	Premature mortality rate per 100,000 persons	440	466	427	416	425
	NI - 12	Emergency admission rate (per 100,000 population)	11,524	11,768	12,362	13,067	11,959
	NI - 13	Emergency bed day rate (per 100,000 population)	136,656	144,727	133,709	123,786	115,518
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	112	121	117	100	97
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	86%	87%	88%	88%
	NI - 16	Falls rate per 1,000 population aged 65+	20	20	22	21	22
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	84%	86%	88%	88%	85%
	NI - 18	Percentage of adults with intensive care needs receiving care at home	64%	63%	NA	63%	61%
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	864	1,023	921	724	772
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	25%	26%	25%	23%	23%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	NA
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	NA
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	NA

Source: ISD Scotland
Note: NA indicates where data is not available yet.
Comparators: Include members of Family Group 3: Dumfries and Galloway; Fife; South Ayrshire; West Lothian; South Lanarkshire; Renfrewshire and Clackmannanshire.
http://www.improvementservice.org.uk/benchmarking/how-do-we-compare-councils.html

Table 7: National Indicators

Local Indicators

The following section provides an 'at a glance performance summary of local indicators' for 2017/2018 where this data is available. The tables also provide "a direction of travel" compared to 2016/2017 performance, where this can be compared.

The Partnership has produced a Strategy Map which details the Partnership's vision, local outcomes, and maps these against the national Health and Wellbeing Outcomes, National Core Indicators, MSG integration indicators and local Partnership indicators.

1. Local Outcome: Self-management

		2016/2017	2017/2018	*
25	Emergency department 4 hour wait Falkirk	92.9%	87.3%	▼

2. Local Outcome: Autonomy and Decision Making

		2016/2017	2017/2018	*
29	Emergency admission rate per 100,000 Falkirk population	1,036	985.82	▲
31	Acute emergency bed days per 1000 Falkirk population	592	861.08	▼
33	Number of patients with an Anticipatory Care Plan in Falkirk	n/a	6,685	—
35	Key Information Summary as a percentage of the Board area list size Falkirk	n/a	4.2%	—

Self Directed Support (SDS) options selected: People choosing		March 2017	March 2018	*
37	SDS Option 1: Direct payments (data only)	32 (1.2%)	26 (0.9%)	
38	SDS Option 2: Directing the available resource (data only)	83 (3.1%)	99 (3.6%)	
39	SDS Option 3: Local Authority arranged (data only)	1,749 (66.3%)	1,980 (71.3%)	
40	SDS Option 4: Mix of options, 1,2 (data only)	45 (1.7%)	56 (2.0%)	
41	No recorded SDS Option (data only)	730 (27.7%)	617 (22.2%)	▲

3. Local Outcome: Safe

		2016/2017	2017/2018	*
43	Readmission rate within 28 days per 1000 Falkirk population	1.37	0.73	▲
44	Readmission rate within 28 days per 1000 Falkirk population 75+	1.26	1.28	▼
45	Number of Adult Protection Referrals (data only)	540	706	
46	Number of Adult Protection Investigations (data only)	47	81	

47	Number of Adult Protection Support Plans (data only)	10	24	*
48	The total number of people with community alarms at end of the period	4,481	4,469	▼
49	Percentage of community care service users feeling safe	91%	90%	▼

4. Local Outcome: Service User Experience

		2016/2017	2017/2018	*
54	Standard delayed discharges	29	23	▲
55	Delayed discharges over 2 weeks	14	19	▼
56	Bed days occupied by delayed discharges	631	786	▼
57	Number of code 9 delays	9	25	▼
58	Number of code 100 delays	5	4	▲
59	Delays - including Code 9 and Guardianship	38	48	▼
60	Percentage of service users satisfied with their involvement in the design of their care package	98%	98%	◀▶
61	Percentage of service users satisfied with opportunities for social interaction	93%	93%	◀▶
62	Percentage of carers satisfied with their involvement in the design of care package	93%	91%	▼
63	Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	90%	91%	▲

		2016/2017	2017/2018	
			Stage 1	Stage 2
64	The number of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	62	70	7
	The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	57.4%	63.6%	58.3%

			2016/2017		20172018	
			S1	S2	S1	S2
65	Proportion of Social Work Adult Services complaints upheld	% upheld	n/a		36.4	33.3
		% partially upheld			26.4	41.7
		% not upheld			37.2	25.0

5. Local Outcome: Community Based Support

		2016/2017 Annual Indicator	2017/2018
67	The total respite weeks provided to older people aged 65+	1,527	Annual indicator data not available
68	The total respite weeks provided to older people aged 18-64	578	

		2016/2017	2017/2018	*
69	Number of people aged 65+ receiving homecare *	1,807	1,642 (Q3)	
70	Number of homecare hours for people aged 65+ *	13,949	13,938 (Q3)	
71	Rate of homecare hours per 1000 population aged 65+ *	489	478 (Q3)	
72	Number receiving 10+ hrs of home care *	401	458 (Q3)	
73	The proportion of Home Care service users aged 65+ receiving personal care *	92.4%	90.7% (Q3)	
76	Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	92.3%	66.7%	▼
77	Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%)	75.2%	74.4%	▼
78	Number of new Telecare service users 65+ (data only)	75	132	
79	The number of people who had a community care assessment or review completed	8,932	9,213	▲
80	The number of Carers' Assessments carried out	1,624	1,656	▲
81	The number of overdue 'OT' pending assessments at end of the period	316	285	▲

		2016/2017	2017/2018	
82	Proportion of last six months of life spent at home	86%		
83	Number of days by setting during the last six months of life: Community	241,236		

* Direction of travel relates to previously reported position	
▲	Improvement in period
◀▶	Position maintained
▼	Deterioration in period
—	No comparative data

Inspection of Falkirk HSCP Registered Services

The Care Inspectorate is responsible for the regulation of care standards and assess quality under 4 themes:

- care and support
- environment
- staffing and management
- leadership.

Throughout 2018/2019 we will continue to work with providers to strengthen relationships and develop systems to effectively monitor all registered and commissioned services being delivered across the Falkirk Council area.

Residential Care Homes (Older People)

Falkirk HSCP area has 941 care home beds between 21 residential and nursing care homes. Five of these residential care homes are owned by Falkirk Council and 16 care homes owned by the independent sector care homes.

At the end of the 2017/2018 financial year the percentage scores from all homes in the Falkirk Council area were as follows:

	Good Very Good Excellent	Unsatisfactory Weak Adequate
Care & Support	87%	13%
Environment	83%	17%
Staffing	91%	9%
Leadership & Management	78%	22%

Over 2017/2018, Care Inspectorate grades for Care Homes improved. The general position continues to be held across the sector with 85% of providers scoring excellent, very good or good across all 4 Care Inspectorate themes. By comparison last year, 70% of providers scored excellent, very good or good. The area of focus in 2018/2019 will be to eliminate any weak and unsatisfactory grades, particularly in the theme of Care and Support.

Residential Care Homes (Adults)

Falkirk HSCP area has 11 adults residential care homes in the area with a capacity of 141 beds. Ten of the care homes are owned by the independent sector and one is owned by NHS Forth Valley.

At the end of the 2017/2018 financial year the percentage scores from all Adult Care homes in the Falkirk Council area were as follows: -

	Good Very Good Excellent	Unsatisfactory Weak Adequate
Care & Support	64%	36%
Environment	73%	27%
Staffing	73%	27%
Leadership & Management	64%	36%

Over 2017/2018, Care Inspectorate grades for Adult Care Homes improved. The general position continues to be held across the sector with 69% of providers scoring excellent, very good or good across all 4 Care Inspectorate themes. By comparison to last year, 64% of providers scored excellent, very good or good. The area of focus in 2018/2019 will be to eliminate any weak and unsatisfactory grades, particularly in the theme of Care and Support. As at 31 March 2018, none of the adult care homes scored a weak Care Inspectorate grade.

Care at Home and Housing Support Services

Falkirk HSCP area has 38 organisations engaged in the delivery of Care at Home and Housing Support Services, supporting in excess of 1000 people to remain living in their own homes in their local communities.

The Care Inspectorate is responsible for the registration, regulation and inspection of all care at home and housing support providers carrying out inspections under 3 themes:

- care and support
- staffing
- management and leadership.

At the end of the 2017/2018 financial year the percentage scores from all Care at Home and Housing Support providers engaged in service delivery in the Falkirk Council area were as follows:

	Good Very Good Excellent	Unsatisfactory Weak Adequate
Care & Support	97.4%	2.6%
Staffing	55.3%	2.6%
Leadership & Management	60.5%	5.3%

Due to changes to the way in which services are inspected not all organisations are inspected under all themes at each inspection which accounts for the lower percentage of providers graded under the themes of Staffing and Management and Leadership.

The following key themes emerged during the financial year 2017/2018:

- 97.4% of providers attained grades of excellent, very good or good in the theme of Care and Support an increase of 5.9% from the previous year

- annual spend increased by over £2.5M due to increased demand for services and due to the continuing financial investment to support the payment of the Scottish Living Wage throughout the social care sector
- providers were engaged in a number of workshop sessions seeking their input to the development of a new framework agreement. Following a successful tender exercise carried out in late 2017 a framework agreement was established for a period of 2 years from 1 April 2018.

Inpatient Mental Health and Learning Disability Services

The Mental Welfare Commission (MWC) undertakes a rolling programme of visits to mental health and learning disability inpatient services. Some are planned visits (announced) and others are unannounced or are part of a national themed approach by the Commission.

Reports from all visits are published on the MWC website and services are asked to provide an action plan within 3 months of a Report being published. Reports cover areas of good practice as well as areas where the Commission would like to see improvements.

There have been seven reports published in Forth Valley in recent months covering inpatient facilities at FVRH, Bellsdyke and Lochview (Learning Disability).

A detailed report is being prepared for discussion at the next meetings of both the Health Board Clinical Governance and IJB Clinical and Care Governance Committee. Some of the highlighted by the Commission include:

- the need to ensure, through audit, that care plans are person centered and outcome focused
- the need to review and improve provision of meaningful activity within inpatient settings
- more priority needs to be given to providing a more comfortable therapeutic environment, particularly in acute admission wards.

Good practice examples were also highlighted in reports including the improved focus on physical care in the acute admissions wards with the establishment of the National Early Warning Score (NEWS) system; positive feedback on the innovative and positive ethos developed in Hope House and the quality of leadership and care observed in Trystview, Russell Park and Lochview in particular.

Action Plans to address the recommendations arising from visits have now been submitted to the Mental Welfare Commission and will be discussed at the Forth Valley MWC End of Year Review meeting to be held November 2018. There are some consistent themes and there is ongoing action in the following areas:

- Person Centred Care Planning: Ongoing work is required to ensure there is consistency in the quantity of care plans across all inpatient areas with clear evidence of person specific interventions and patient involvement. This is being

achieved through a process of audit with additional teaching and training of staff as required, and re-inforcement through staff supervision.

- Meaningful Activity: Plans are in place to introduce 3 Activity Co-ordinators into the Mental Health Unit who will have protected time to ensure activity programmes are available consistently. These posts will be introduced over the summer as part of a wider review of the nursing workforce across the Unit.

- Ward Environment: Ward staff continue to take action to improve the ward environment and there has been recent investment in more comfortable furniture in the Inpatient Units. Artlink resources are also being prioritised to support work in the Inpatient Unit. Upgrading of showers in Trystview have been approved together with other improvements to the infrastructure of the ward.

Looking forward

The Annual Performance Report highlights our work in the past year, some of which will continue into the year ahead.

Further areas of work that will take place in 2018/2019 include:

- develop our Strategic Plan 2019 – 2022, working with the Strategic Planning Group
- continue work to further delegate services from NHS Forth Valley into an integrated health and social care structure
- work with Primary Care to implement the Primary Care Improvement Plan
- work with the West of Scotland Regional Planning Group to prepare a regional delivery plan to implement the Health and Social Care Delivery Plan. The development and delivery of the regional plan requires ongoing engagement with partners across the region with the aim of continuous improvement in wellbeing and care of the population.
- continue to implement the Carer's Act, including the production of the Short Breaks Services Statement; monitor the uptake of Adult Carer Support Plans and the outcomes to carers and implement our commissioning approach for carer support
- develop our approach to the national Digital Health and Care Strategy, including replacement of technology from analogue to digital platforms
- deliver a comprehensive workforce development programme that is responsive to the needs of the workforce now and in the future. This will make best use of all available learning platforms, including modern and digital technology. We will continue to actively promote Health and Social Care as a positive career destination.

List of terms used in the Annual Performance Report

A&E	Accident and Emergency Department (casualty)
Activities of daily living	Tasks that people carry out to look after their home, themselves and when taking part in work, social and leisure activities
Admitted (to hospital)	Being taken into hospital
Adult support and protection	Things we can do to identify, support and protect adults who may be at risk of harm or neglect and who may not be able to protect themselves
Alcohol and Drug Partnership	ADPs are multi agency partnerships established to implement and respond to the national strategies on alcohol, drugs, tobacco and volatile substances across the whole population. ADPs also have a responsibility to develop a local substance strategy which addresses prevention. This must ensure that the range of treatment options that are required to promote recovery from substance use problems are provided for and available at point of need.
Anticipatory Care Plans (ACPs)	A plan prepared by a person with health/care needs along with a professional. The plan lays out what the person would prefer if/when their condition changes.
Assessment	Process used to identify the needs of a person so that appropriate services can be planned for them
Balance of care	How much care is given in the community compared to how much is given in hospitals etc
Bed based services	Those services such as inpatient wards in a hospital where people are cared for overnight
Bed days	The number of days that beds in hospital are occupied by someone
Carer	A carer is a person, of any age, who looks after family, partners or friends in need of help, because they are ill, frail or have a disability and need support to live independently. This care is unpaid however the carer may be in receipt of carers allowance but this is not considered to be payment.
Adult Carers Support Plan	An assessment to find out what a carer (unpaid, informal carer) needs (such as respite, short breaks etc) and how services can support them better

Clinical and Care Governance	Clinical and care governance is a systematic approach to maintain and improve care in a health and social care system. This will provide assurance to the IJB on the systems for delivery of safe, effective, person-centred care in line with the IJB's statutory duty for the quality of health and care services.
Commission (a service)	Buying a service from another to meet the needs of a population
Community assets	The building and other resources owned by a community
Community Planning Partnership	Where public agencies work together with the community to plan and deliver better services which make a difference to people's lives
Delayed discharge	Where someone is unable to leave hospital because the appropriate care and/or support is not yet available for them at home
Delegated function	A service that the new partnership will be responsible for
Delivering (a service)	Carrying out a service
Demographic challenges	Changes in population (e.g. more older people) that mean we have to change how we provide our services
Direct payments	Means-tested payments made to service users in place of services they have been assessed as needing. This allows people to have greater choice in their care
Early intervention	Giving support, care and/or treatment as early as possible
End of Life Care	Addresses the medical, social, emotional, spiritual and accommodation needs of people thought to have less than one year to live. It includes a range of health and social services and disease specific interventions as well as palliative and hospice car for those with advanced conditions who are nearing the end of life.
Engagement	Having meaningful contact with communities e.g. involving them in decisions that affect them

Facilitate/facilitator/facilitation	Making a process easy or easier
Front line staff	Staff who work directly with users of a service
Governance	The way that an organisation is run
Health inequalities	The gap that exists between the health of different population groups such as the well-off compared to poorer communities or people with different ethnic backgrounds
Independent sector	This includes voluntary, not for profit, and private profit making organisations. It also includes housing associations
Integrated care	The aim is to enable better co-ordinated, joined-up and more continuous care, resulting in improved patient experience while achieving greater efficiency and value from health and social care systems
Integration	The term used to describe the partnership working between health and social care services as outlined in the Public Bodies (Joint Working) (Scotland) Act 2014
Integration Joint Board (IJB)	The IJB is responsible for running the partnership and has members from Falkirk Council and NHS Forth Valley, staff representatives, the Third Sector and the public
Integration Scheme	The detail of our model of integration is laid out within our Integration Scheme. This scheme sets out a robust and transparent framework for the governance and operation of the Falkirk Health and Social Care Partnership. This includes detail such a financial arrangements, governance arrangements, data sharing, liability and dispute resolution.
Joint working	Different teams and organisations working together
Locality	One of the three areas Falkirk will be divided into for planning purposes
Locality-based	Situated in a locality
Long term conditions (LTC)	Conditions that last for a year or longer and may need ongoing care and support (such as epilepsy, diabetes etc)
Multi-agency	Where several different organisations work together in the interests of service users and carers
Multidisciplinary	Where several different professionals work together in the interests of service users and carers

Multi-professional	Where several different professionals work together in the interests of service users and carers
National Health and Social Care Standards	Scottish Ministers developed the National Health and Social Care Standards to ensure everyone in Scotland receives the same high quality of care no matter where they live
Outcomes	See “Personal outcomes”
Palliative care	Is an approach that improves the quality of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
Partnership	see Falkirk Health and Social Care Partnership
Personal outcomes	The changes or improvements that have taken place during the time someone has been receiving support
Person centred	Putting the needs and aspirations of the individual service user at the centre of our work
Priorities	Things we think are important to do
Proactive	Creating or controlling a situation rather than just responding once it’s happened
Readmission	Being taken back into hospital shortly after having been discharged
Recruitment and retention	Being able to recruit and keep staff
Reablement service	Reablement service will begin at the point of assessment and have a focus on independence through the delivery of a short-term person centred approach by a multidisciplinary team of well-trained staff working with patients, carers and their families
Resilience	Being able to cope with and recover from difficult situations
Risk management	The process of identifying, quantifying, and managing the risks that an organisation faces
Self management	Where people take responsibility for and manage their own care. Encouraging people with health and social care needs to stay well, learn about their condition and remain in control of their own health

Self directed support	When the person who needs services directs their own care and has choice when it comes to their support
Social Care	Any form of support or help given to someone to help them take their place in society
Strategic Plan	The plan that describes what the partnership aims to do and the local and national outcomes used to measure our progress
Sustainable	Can be maintained at a certain level or rate
Third sector	Voluntary and community groups, social enterprises, charities
Transformational change	A complete change in an organisation, designed to bring big improvements
Unplanned admissions	Being taken into hospital as an emergency

If you would like this information in another language, Braille, large print or audio tape please call 01324 504021 or email integration@falkirk.gov.uk

Appendix 2

Agenda Item: 8

Falkirk Health and Social Care Partnership

Title/Subject:	**Performance Report**
Meeting:	**Integration Joint Board**
Date:	**1 June 2018**
Submitted By:	**Chief Executive, NHS Forth Valley**
Action:	**For Noting**

1. INTRODUCTION

1.1 This report presents performance in relation to local performance indicators for the financial year 2017/18. This is measured against a baseline year of 2015/16, and is in line with other reporting for unscheduled care and delayed discharges.

2. RECOMMENDATION

The Integration Joint Board (IJB) is asked to:

2.1 note the content of the performance report

2.2 note the new format of the performance report

2.3 note that appropriate management actions continue to be taken to assess the issues identified through these performance reports

3. BACKGROUND

3.1 The purpose of this report is to ensure the Integration Joint Board fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services, relevant targets, and measures which are included in the Integration Functions, and as set out in the Strategic Plan.

3.2 Contents of the report are monitored on an ongoing basis and also form the basis of the reporting through other arrangements, including: Unscheduled Care Programme Board, Winter Plan and Delayed Discharge Steering Group.

4. APPROACH

4.1 The Falkirk Performance and Measurement Group has compiled the performance report and developed a new format for the report. The group are also working to develop a more structured and themed timetable for performance reporting. It was intended this would be reported to the Board in June 2018, however work is still on-going, and will be presented to the IJB in September 2018.

4.2 The Pentana performance reporting system has been used to prepare the majority of this report. Within Pentana a variance range is required to be set for indicators. This defines the acceptable or tolerable spread between the numbers in a data set and RAG statuses.

5. PERFORMANCE REPORT STRUCTURE

5.1 A new performance report template has been devised and has been used to structure this report. This is attached for information.

5.2 The content of the report mainly focuses on unscheduled care and the local performance indicators for the period April 2017 to March 2018 against the baseline year 2015/16. Delayed discharges are as the census point March 2018. The report advises the IJB on the principal reasons for delay and the actions being taken by the services to mitigate these.

5.3 The report now has a Table of Contents to help readers navigate through the content more easily.

5.4 Section 1 provides a summary of key performance issues. The areas highlighted include:

- Emergency Department (ED) performance against the 4 hour standard
- Rate of ED Attendance
- Acute emergency bed days
- Delayed Discharges.

5.5 Section 2 of the report provides an ‘at a glance performance summary of local indicators’ with RAG status and direction of travel, as appropriate. Current performance is shown beside the baseline 2015/16.

5.6 Section 3 presents a summary of linked performance issues, providing additional detail about the indicators described within the Strategic Plan, as well as detail in respect of a number of other linked indicators relating to Unscheduled Care.

5.7 Appendix 1 – The Strategy Map details the Partnership’s vision, local outcomes, and maps these against the national Health and Wellbeing Outcomes, National Core Indicators, MSG integration indicators and local Partnership indicators. A review of the Strategy Map was recently undertaken to ensure contents remain current and relevant to the Strategic Plan. The local indicators are now numbered and the frequency of reporting is indicated for each.

5.8 Appendix 2 – A glossary has been provided to give explanation and context to abbreviations and areas contained within this report.

6. CONCLUSION

6.1 The Integration Joint Board is responsible for effective monitoring and reporting on the delivery of services, relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan.

Resource Implications
The management of performance is critical to managing the overall budget of the IJB. The resource requirements to ensure effective performance management and performance reporting are under review.

Impact on IJB Outcomes and Priorities
Only by managing performance can the delivery of the IJB outcomes and priorities be truly assessed, providing a sound basis from which to make decisions regarding investment and service change.

Legal & Risk Implications
Performance management is a legal requirement as defined in the IJB's Integration Scheme.

Consultation
The approach is defined in the Performance Management Framework and further developed through the Performance and Measurement Group with all parties represented.

Equality and Human Rights Impact Assessment
This is not required for the report.

Approved for submission by: Patricia Cassidy, Chief Officer

Authors: Annette Kerr, ICF Support Officer, Philip Morgan-Klein, Performance & Information Service Manager, Vivienne Meldrum, Senior Information Analyst, Suzanne Thomson, Programme Manager

Date: 22 May 2018

List of Background Papers:

Falkirk
Health and Social Care
Partnership

Performance Report

June 2018

1. KEY PERFORMANCE ISSUES

1.1. Emergency Department Performance against the ED 4 hour Standard

Issue:

1) Analysis of 2017/18 performance against the Falkirk IJB baseline year 2015/16 reveals percentage variance in the monthly average of 6.1% down to 87.3% in 2017/18 from 93% in 2015/16.
2) The most significant drop in compliance of 10% occurring in those aged 85 year plus.
3) The reason for delay in 74% of those aged 85+ is 'Wait for a bed' and 'Wait for first assessment'.

1.2. Rate of Emergency Department (ED) Attendance

Issue:

1) The average monthly ED Attendance in Falkirk has increased by a narrow margin of 0.03% since the baseline year of 1,950 in 2015/16 to 1,954 in 2017/18.
2) The Falkirk position remains approximately 10% above the Forth Valley average at 1,774 in 2017/18.

2.3 Acute emergency bed days per 1,000

Issue:

1) The average rate per 1,000 population of unplanned bed days in Falkirk has increased by 4.8% the since 2015/16, exceeding the Forth Valley position by 8.9%.
2) The most significant percentage increase of 11% occurs in the 65-74 year age group from 1,238.61 in 2015/16 to 1,376.03 in 2017/18.

Action:

1) Unscheduled Care Programme Board (UCPB), led by the Medical Director and comprising of Chief Officers, General Managers, Unscheduled Care Teams with analytical support from Health and LIST analysts. The Board continually monitors ED performance against the MSG indicators and the six essential actions prescribed by the Scottish Government and the Day of Care Audit to ensure patients currently in a ward meet acute and community inpatient criteria.

2.4. Delayed Discharge

Issue:

1) With an average of 27 waits a month over the last financial year, Delayed Discharges of Falkirk residents from an NHS Forth Valley hospital account for 64% of the Forth Valley total
2) Standard Delays for the month of March 2018 for Falkirk are recorded as 23 out of 42 Forth Valley delays
3) Occupied bed days (OBD) attributed to delays in Falkirk equates to 786 out of 1,086 in Forth Valley OBDS. Overall this is 72% of delays within Forth Valley. However over the course of 2017/18 there has been a substantial decrease in occupied bed days attributed to delayed discharge from 816 to 472 in February 2018.

Action:

1) Additional funding has allowed the recruitment of a further 3 Discharge Coordinators
2) Extra staffing levels have resulted in 7 day coverage across all NHS sites
3) Input from team means patients are reviewed within 72 hours
4) Identify solutions and liaise with social work and community colleagues to ensure a safe discharge is achieved
5) Attend Multi Disciplinary Team (MDT) meetings to identify discharge pathways and goals
6) Support relatives and carers in arranging plans for discharge

2. AT-A-GLANCE PERFORMANCE SUMMARY OF LOCAL INDICATORS

The Partnership focus is across the local outcomes, with work ongoing to support a balanced approach to measurement and reporting. Trajectories have been set against national standards which could be applied to local outcomes, facilitating the development of local and national balanced scorecards.

The table below highlights local data for the financial year 2017/18 against the baseline 2015/16. The table also looks at a monthly breakdown of Delayed Discharges as at March 2018 census. Performance data covers adults aged 18 and over.

Key:

Direction of travel relates to previously reported position	
▲	Improvement in period
◄►	Position maintained
▼	Deterioration in period
–	No comparative data

2.3. Self Management Indicators 24 - 27

		Baseline 2015/16	2017/18	Direction of Travel
24	Emergency department 4 hour wait Forth Valley	94.5%	88.3%	▼
25	Emergency department 4 hour wait **Falkirk**	93.0%	87.3%	▼
26	Emergency department attendances per 100,000 Forth Valley Population	1,731.16	1,774.01	▼
27	Emergency department attendances per 100,000 **Falkirk**	1,949.58	1,954.58	▼

2.4. Autonomy & Decision Making Indicators 28 - 41

		Baseline 2015/16	2017/18	Direction of Travel
28.	Emergency admission rate per 100,000 Forth Valley population	1,037	969.06	▲
29	Emergency admission rate per 100,000 **Falkirk** population	1,054	985.82	▲
30.	Acute emergency bed days per 1000 Forth Valley population	766.98	784.83	▼
31	Acute emergency bed days per 1000 **Falkirk** population	821.64	861.08	▼
32	Number of patients with an Anticipatory Care Plan in Forth Valley	11,667	15,601	▲
33.	Number of patients with an Anticipatory Care Plan in **Falkirk**	N/A	6,685	–
34.	Key Information Summary as a percentage of the Board area list size Forth Valley	3.9%	4.9%	▲
35.	Key Information Summary as a percentage of the Board area list size **Falkirk**	N/A	4.2%	–

Self Directed Support (SDS) options selected: People choosing		Baseline March 2016	March 2018	Direction of Travel
37.	SDS Option 1: Direct payments (data only)	33 (1.4%)	26 (0.9%)	
38.	SDS Option 2: Directing the available resource (data only)	46 (1.9%)	99 (3.6%)	
39.	SDS Option 3: Local Authority arranged (data only)	1,505 (62.2%)	1,980 (71.3%)	
40.	SDS Option 4: Mix of options, 1,2 (data only)	30 (1.2%)	56 (2.0%)	
41.	No recorded SDS Option (data only)	805 (33.3%)	617 (22.2%)	▲

2.5. Safety -Indicators 42 - 49

		Baseline 2015/16	2017/18	Direction of Travel
42	Readmission rate within 28 days per 1000 FV population	1.84	0.61	▲
43	Readmission rate within 28 days per 1000 **Falkirk** population	2.20	0.73	▲
44.	Readmission rate within 28 days per 1000 **Falkirk** population 75+	1.53	1.28	▲
		Baseline 2015/16	**2017/18 H1**	**Direction of Travel**
45.	Number of Adult Protection Referrals (data only)	579	398	
46.	Number of Adult Protection Investigations (data only)	45	37	
47.	Number of Adult Protection Support Plans (data only)	12	16	
48.	The total number of people with community alarms at end of the period	4,526	4,469	
49.	Percentage of community care service users feeling safe	90%	90%	◄►

2.6. Service User Experience - Indicators 54 - 66

		Baseline 2015/16	2017/18	Direction of Travel
54.	Standard delayed discharges	24	23	▲
55.	Delayed discharges over 2 weeks	17	19	▼
56.	Bed days occupied by delayed discharges	809	786	▲
57.	Number of code 9 delays	7	25	▼
58.	Number of code 100 delays	1	4	▼
59.	Delays - including Code 9 and Guardianship	31	48	▼
60.	Percentage of service users satisfied with their involvement in the design of their care package	98%	98%	◄►
61.	Percentage of service users satisfied with opportunities for social interaction	93%	93%	◄►
62.	Percentage of carers satisfied with their involvement in the design of care package	92%	91%	▼
63.	Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	89%	91%	▲

		Baseline 2015/16	2017/18 All	2017/18 Stage 1	2017/18 Stage 2
64.	The number of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	113/156	77/122	70/110	7/12
	The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	73.4%*	63.1%	63.6%	58.3%
65.	Proportion of Social Work Adult Services complaints upheld *NB. 2015/16 were reported under the old complaints system	% upheld		36.4	33.3
		% partially upheld		26.4	41.7
		% not upheld		37.2	25.0

		Baseline 2015/16	2017/18 to end Q3	Direction of Travel
66.	Sickness Absence in Social Work Adult Services (target – 5.5%)	7.9%	8.2%	▼

2.7. Community Based Support - Indicators 67 - 83

		Baseline 2015/16	2017/18	Direction of Travel
67.	The total respite weeks provided to older people aged 65+. Annual indicator	1,703	Annual Indicator data not available	
68.	The total respite weeks provided to older people aged 18-64. Annual indicator	724		
* Please note that each year's Home Care data below is a snapshot of provision in a single reporting week at the end of the reporting period.		Mar 2016	Dec 2017	Direction of Travel
69.	Number of people aged 65+ receiving homecare *	1,867	1,642	▼
70.	Number of homecare hours for people aged 65+ *	14,622	13,938	▼
71.	Rate of homecare hours per 1000 population aged 65+ *	512.2	478.0	▼
72.	Number receiving 10+ hrs of home care *	406	458	▲
73.	The proportion of Home Care service users aged 65+ receiving personal care *	91.6%	90.7%	▼

		Baseline 2015/16	2017/18 to end Q3	Direction of Travel
76.	Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	77.4%	69.4%	▼
77.	Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%)	63.7%	73.8%	▲

		Baseline 2015/16	2017/18	Direction of Travel
78.	Number of new Telecare service users 65+ (data only)	142	132	
79.	The number of people who had a community care assessment or review completed	9,571	9,213	▼
80.	The number of Carers' Assessments carried out	1,936	1,656	▼

		March 2016	At 09/04/18	Direction of Travel
81.	The number of overdue 'OT' pending assessments at end of the period	352	285	▲

		2014/15	2015/16	Direction of Travel
82.	Proportion of last six months of life spent at home	86.1%	86.0%	◄►
83.	Number of days by setting during the last six months of life: Community	228,702	241,236	▲

3. SUMMARY OF LINKED PERFORMANCE ISSUES

3.1. Self Management - Falkirk Unscheduled Care Indicators 24 & 25:

Table 1 - Emergency Department Performance against ED 4 Hour Target (includes Minor Injuries Unit). This is 95% target	
Forth Valley Performance	88.3%
Falkirk HSCP Performance	87.3%

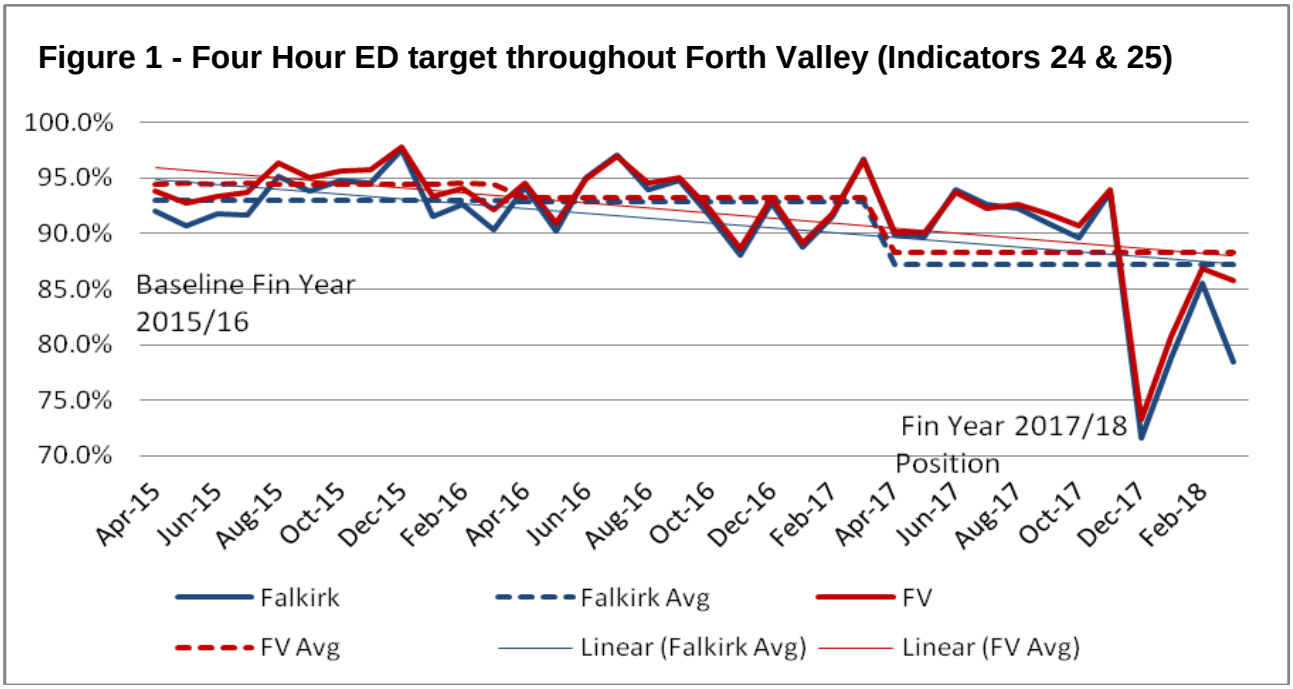
Purpose:
The national standard for A&E waiting times dictates 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.

Position:
As described in chart 1 below, performance against the 4 hour ED target throughout Forth Valley has declined since the baseline year of 2015/16 by 6.5%. This position is mirrored across the partnership with Falkirk results decreasing by 6.1%.

Analysis shows waits are longer in the 85 plus age group down 10% from 86.3% compliance in 2015/16 to 77.4% in 2017/18.

39% of wait over 4 hours are recorded as 'Wait for a bed' with 34% having the longest wait attributed to 'Wait for first assessment'. In the 18-64 age range 51% of waits in 2017/18 occur due to 'wait for first assessment'. This has increased from 45% in the baseline year.

Figure 1 - Four Hour ED target throughout Forth Valley (Indicators 24 & 25)



3.2. Self Management - Falkirk Unscheduled Care Indicators 26 & 27

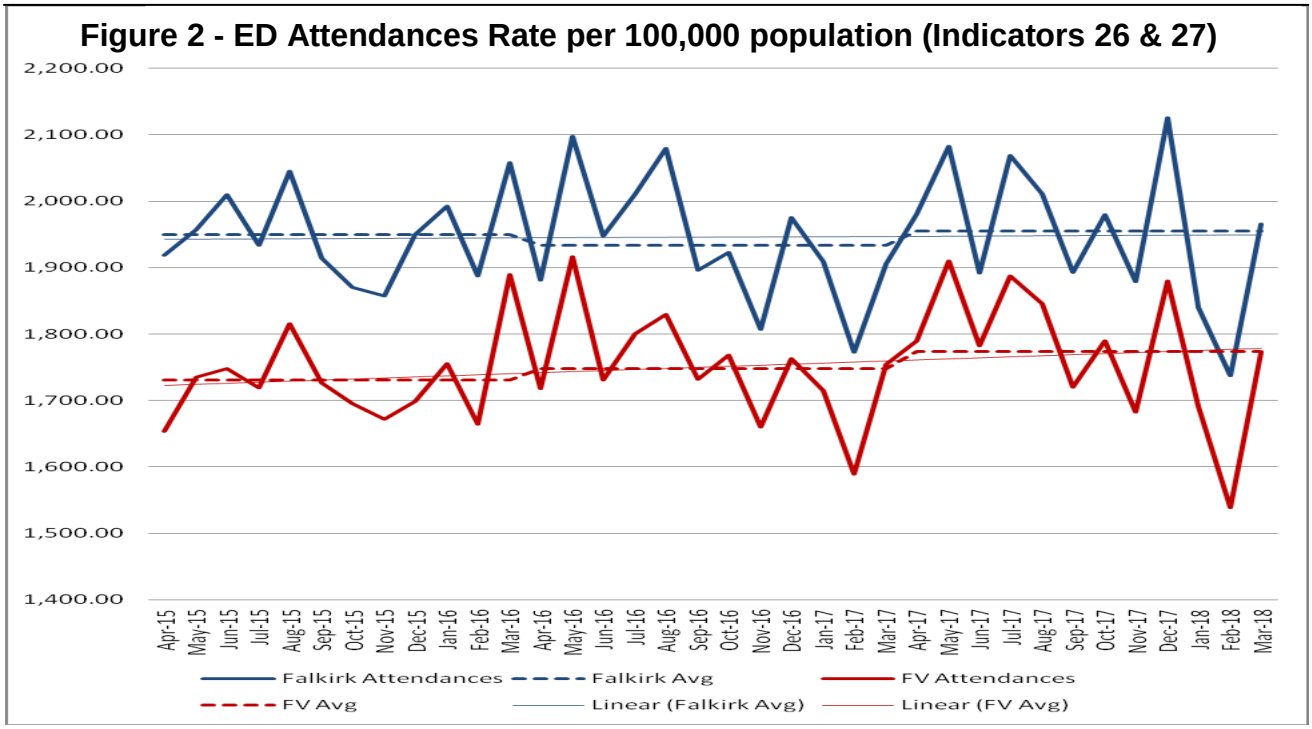
Table 2 - Emergency Department Attendance rate per 100,000 population	
Forth Valley Performance	Average monthly performance in 2017/18 1,774.01
Falkirk HSCP Performance	Average monthly performance in 2017/18 1,954.58

Purpose
It is the responsibility of the IJB to take action against increasing numbers of attendances to ED. Health and social care initiatives prevent patients presenting to ED, by signposting to more appropriate services where care needs are dealt with using an anticipatory approach. Through monitoring this activity the aim is to improve the patient experience by identifying the best use of resources and to prevent patients waiting longer than necessary in ED.

Position
The average monthly ED attendance rate in Forth Valley has increased from 1,731 per 100,000 population in 2015/1 to 1,774 per 100,000 population in 2017/18 to date. This is highlighted as a 2.5% increase.

Falkirk has seen a rise of 0.26% in 2017/18 to 1,954 per 100,000 population, from 1,949 per 100,000 population in 2015/16. Falkirk attendances remain above the Forth Valley average by 10%, although the attendance rate has remained relatively stable since the baseline year.

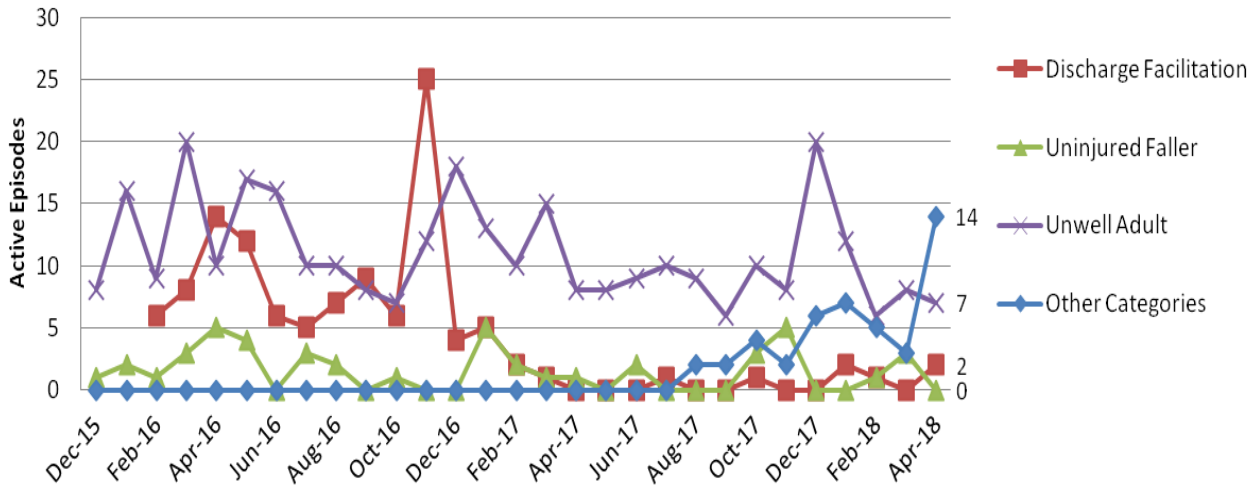
Figure 2 - ED Attendances Rate per 100,000 population (Indicators 26 & 27)



In order to reduce the number of A&E attendances and subsequent admissions to hospital, the Partnership is working to ensure that more residents receive appropriate support and treatment within the community.

The Enhanced Community Team (ECT) is working to relieve pressure on the 'front door'. The chart below shows the number of admissions (referrals to the ECT) for the Falkirk Partnership.

Figure 3 - Enhanced Care Team Admissions by Patient Categorisation April 2018



Admissions by Patient Categorisation show the most prevalent reason for admission remains to be unwell adult. However, use of the Service for Discharge Facilitation has shown a significant decrease since the baseline year. A review is underway to understand the change in the figures.

3.3. Autonomy and Decision Making – Emergency Admissions Indicators 28 & 29

Table 3 - Indicators 28 & 29	
Forth Valley Performance	Average monthly performance in 2017/18 = 969.06
Falkirk HSCP Performance	Average monthly performance in 2017/18 = 985.8

Purpose

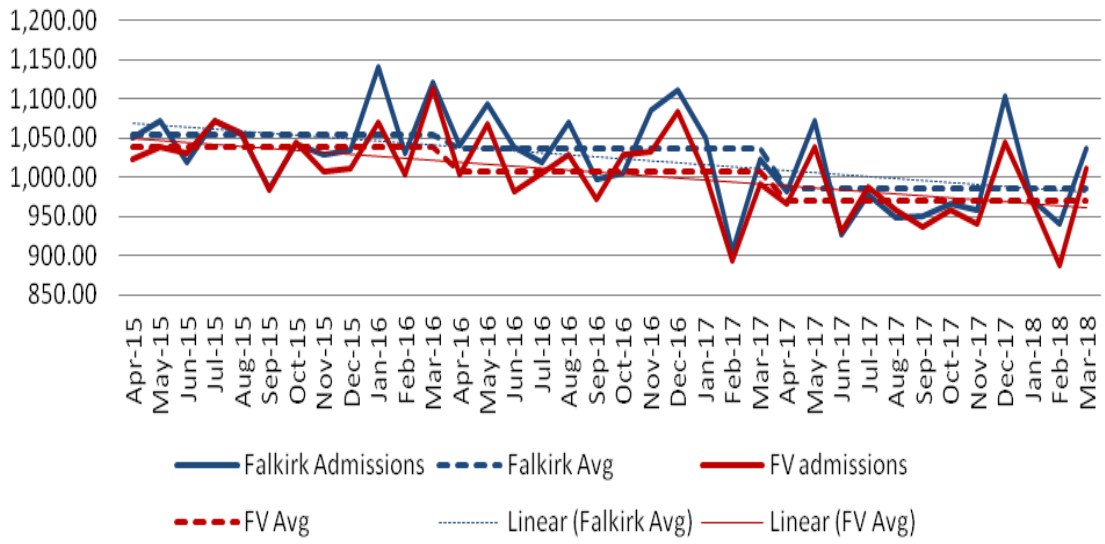
"For adults and older people, this outcome indicator should represent a shift from a reliance on hospital inpatient care towards proactive and coordinated care and support in the community. It should demonstrate the effectiveness of anticipatory care, identifying people who are at risk of emergency hospital admission, supporting people to be more confident in managing their long term conditions and providing coordinated care and support at home where safe and appropriate." *ISD*

Position

The average unplanned admission rate for both Falkirk and Forth Valley in 2017/18 has reduced. The admission rate for the financial year 2017/18 in Forth Valley is down by 6.6%, from 1,037 per 100,000 population to 969 per 100,000 population this financial year. Falkirk admissions remain above the Forth Valley average but have decreased from 1,054.1 per 100,000 population in 2015/16 to 985.8 per 100,000 population in 2017/18.

A breakdown by age range for adults shows an average decrease of approximately 6.9% across all age ranges. However the number of actual admissions for the 85 plus age group has risen by 1.9% indicative of a 2% rise in the population as per the National Records of Scotland mid year census.

Figure 4 - Unplanned Admissions Rate per 100,000 (Indicators 28 & 29)



3.4. Autonomy and Decision Making - Anticipatory Care Planning Indicators 32 & 33:

Table 4 - Indicators 32 & 33	
Forth Valley Performance	15,601 (4.9%)
Falkirk HSCP Performance	6,685 (4.2%)

Purpose

"Anticipatory Care Planning (ACP), in practical terms, are both about adopting a "thinking ahead" philosophy of care that allows practitioners and their teams to work with people and those close to them to set and achieve common goals that will ensure the right thing is being done at the right time by the right person(s) with the right outcome." *Scottish Government*

Position

ACP has been identified nationally as a priority to support the delivery of the 2020 vision and the Health and Wellbeing Outcomes linked with the Health & Social Care Integration agenda as highlighted in the recent Audit Scotland Report on Integration.

The figures above are supplied by ISD. The drop in number from circa 17,000 plans produced in 2017 is a result of ISD culling records for those patients who have since died or moved out with the area. The position of 15,548 accounts for 4.9% of Forth Valley residents and exceeds the target of 4,500 or 1.5%. 6,663 (4.2%) of the Falkirk population are in receipt of an ACP or Key Information Summary (KIS).

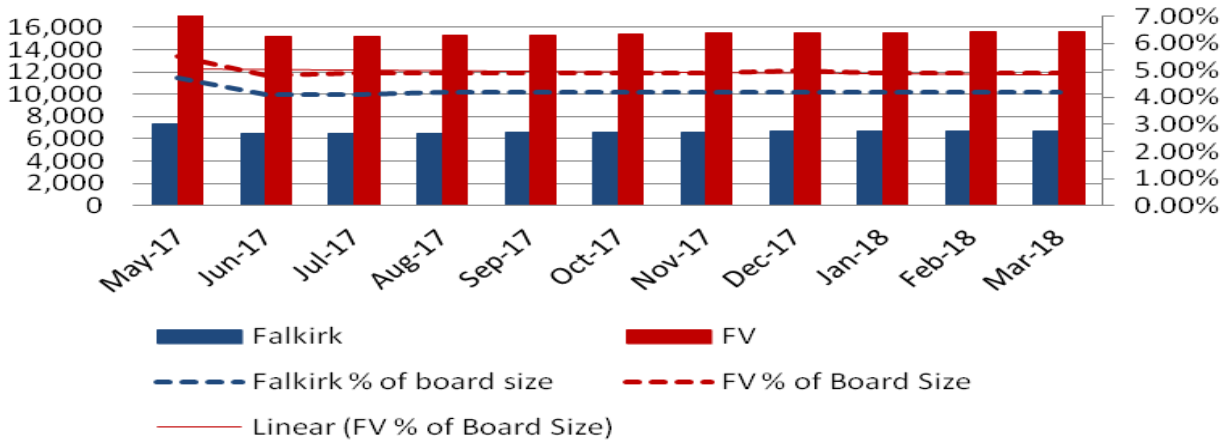
The assessment of the impact of the ACPs on patient care is ongoing. Deliberations need to be made via robust studies to assess at which stage in the patient journey referral for an ACP should be made determining the best use of current resource and identifying areas for development.

Since September 2017, the ACP and ALFY Service have gone through a period of restructuring. The Head of ACP Nursing in Clackmannanshire and Stirling is now the ALFY Manager working with community nursing and ACP Teams across both

partnerships to bring more effective communication and use of the referral processes to synchronise ALFY.

ALFY are now proactively contacting patients post discharge to gauge how well they are managing in the days following discharge from hospital and identifying those who would benefit from an ACP assessment. It is hoped this early intervention may save a further hospital admission and should admission be inevitable, by having an anticipatory care plan in situ, it is hoped this will reduce a patient's length of stay in hospital. Work is currently underway to assess the impact of this restructure. Furthermore, the impact of ALFY and other Closer to Home Services are being assessed as part of the conditions of funding from both Partnerships.

Table 5 - ACP and ACP/KIS - % of Board List 2017-18 (Indicators 32 & 33)



3.5. Autonomy and Decision Making – Acute Emergency Bed Days Indicators 30 & 31

Table 6 - Indicators 30 & 31	
Forth Valley Performance	Average monthly performance in 2017/18 = 784.8
Falkirk HSCP Performance	Average monthly performance in 2017/18 = 861.08

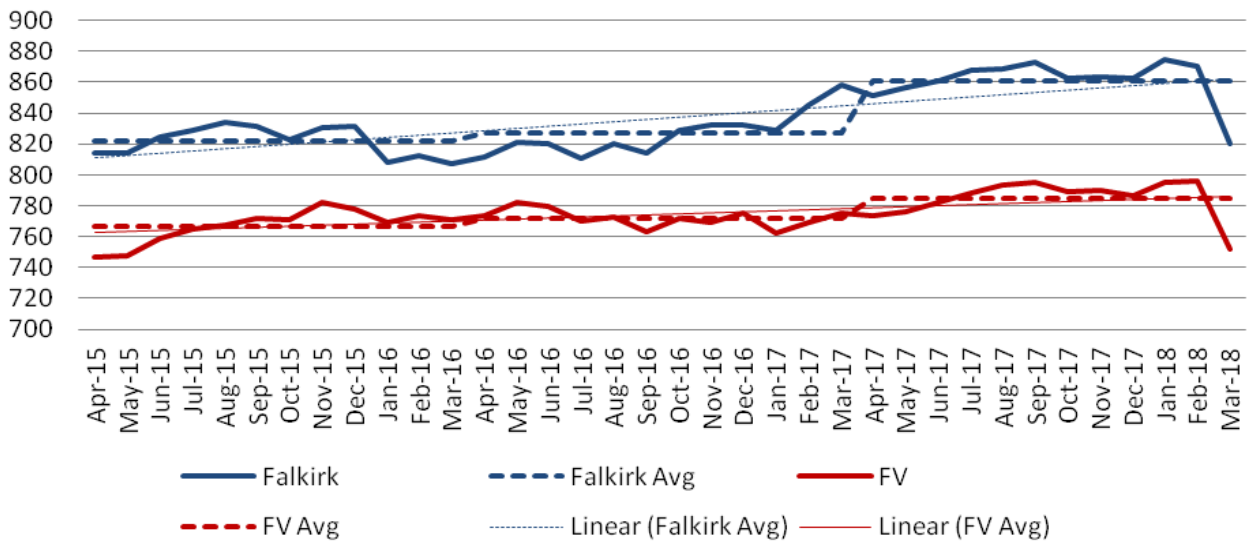
Purpose

The number of emergency bed days and emergency admissions balance each other and quality outcomes for both should be measured. A decrease over time for both emergency admissions and emergency bed days is desirable. It is possible for the rate of admissions to be decreasing with the rate of bed days increasing to as people are kept in hospital longer.

Position

In 2015/16 the average monthly rate in terms of unplanned bed days for Forth Valley was 766 per 1,000 population compared to 784 per 1,000 population in 2017/18. This represents a 2.3% increase. The rate per 1,000 of patients in the Falkirk local authority area has increased by 4.8% from 821 per 1,000 population in 2015/16 to 861 per 1,000 population in 2017/18. Further analysis shows a rise on all age groups over 65. The most significant rise occurs in the 65-74 year age range at 11.1%.

Figure 5 - Unplanned Bed Days Rate per 1,000 Population (Indicators 30 & 31)



Day of Care Survey Update as of 9 May 2018

In September 2014 an initial Day of Care survey was carried out within NHS Forth Valley which indicated that 21% of inpatients did not require ongoing care within an acute setting. A follow up survey in December 2014 showed that had risen to 31%.

Initial testing on a reliable fortnightly Day of Care survey started on 10 December 2015. The number of patients at that time who did not meet the criteria for an acute inpatient area was 26%. The latest survey (26 April 2018) has demonstrated that Forth Valley Royal Hospital (FVRH) is now at 16.2% (71 patients) not meeting acute in-patient criteria.

Within the community hospital setting there have been nine surveys so far. The first survey found that 52% of patients did not meet the inpatient criteria. The latest survey in April 2018 has demonstrated that this is now 44% (84 patients).

The current plan is to continue repeating the community hospital survey monthly in order to identify potential areas for improvement.

Next Steps

- The Day of Care survey will be carried out on a Friday afternoon instead of a Thursday morning. This will capture patients identified as not meeting in-patient criteria at the weekend and may highlight different reasons for remaining in hospital

- The community hospital Day of Care survey continues and the process now appears to be settled and embedded

- The Discharge Team, Social Work and 24/7 meet daily to discuss patients who have been identified as waiting for a community hospital bed or a package of care to allow the most appropriate patients to be moved

- The pilot of the daily dynamic discharge in the 2 community hospital wards continues with plans to roll out to the rest of the community hospitals and wards.

Figure 6 - Acute Day of Care % of patients identified as not meeting acute in-patients criteria

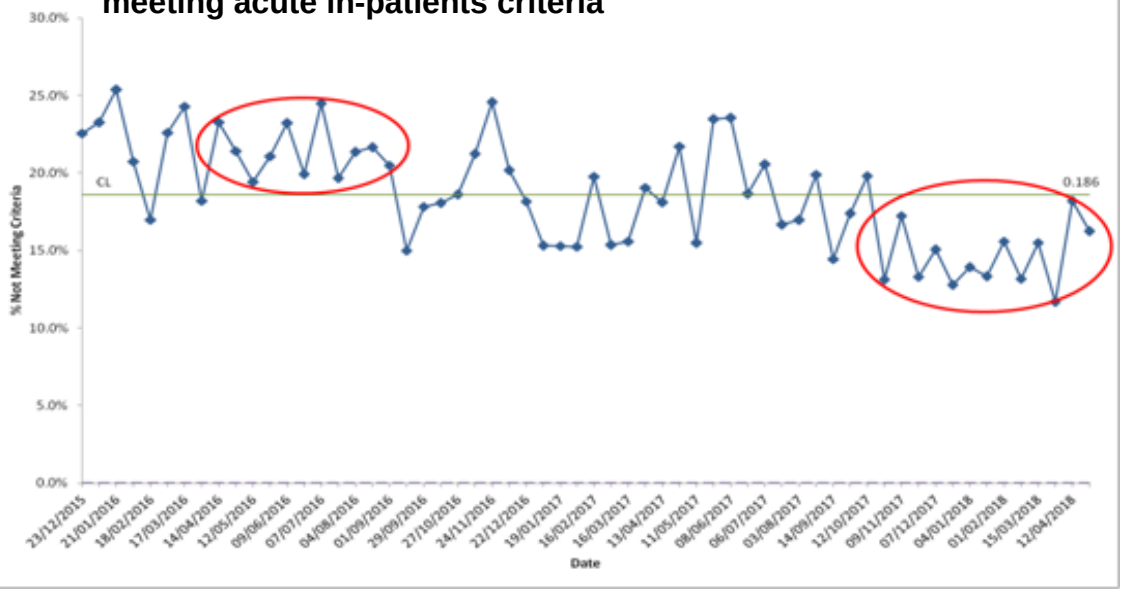
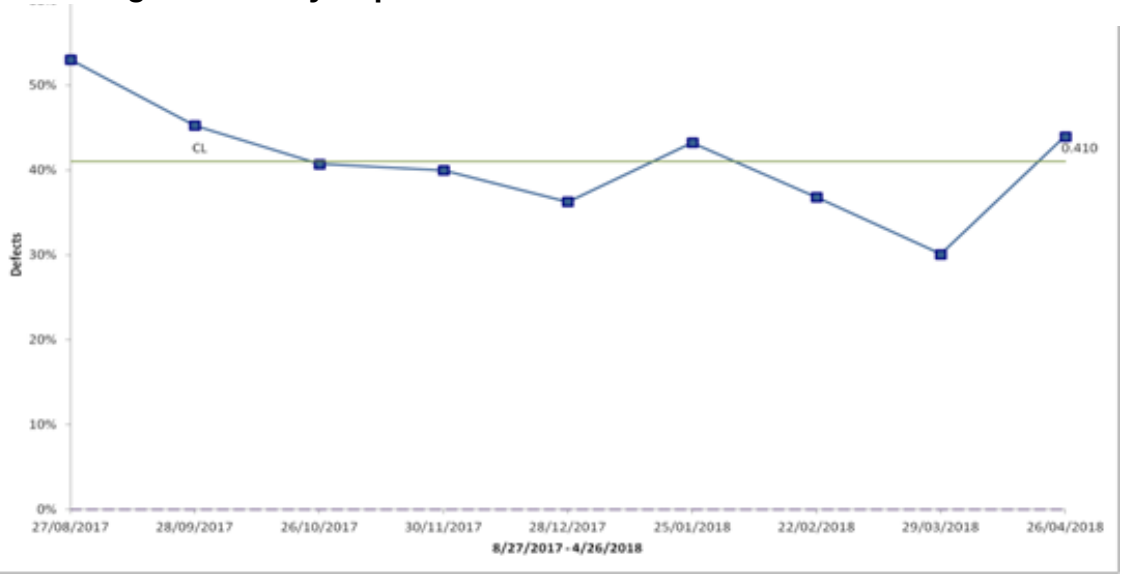


Figure 7 - Community Day of Care % of patients identified as not meeting community in-patient criteria



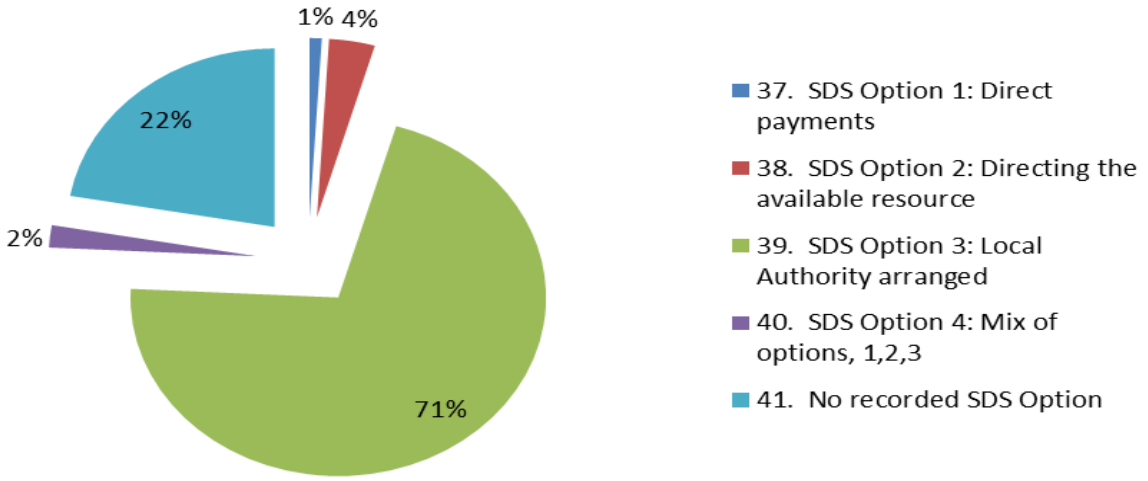
3.6. Autonomy and Decision Making – Self Directed Support (SDS) Options 1 to 4: Indicators 37 to 41

Table 7 - Indicators 37 to 41				
Self Directed Support (SDS) options selected: People choosing		**Baseline March 2016**	**March 2018**	**Direction of Travel**
37.	SDS Option 1: Direct payments	33 (1.4%)	26 (0.9%)	
38.	SDS Option 2: Directing the available resource	46 (1.9%)	99 (3.6%)	
39.	SDS Option 3: Local Authority arranged	1,505 (62.2%)	1,980 (71.3%)	
40.	SDS Option 4: Mix of options, 1,2	30 (1.2%)	56 (2.0%)	
41.	No recorded SDS Option	805 (33.3%)	617 (22.2%)	▲

Purpose
These indicators demonstrate the choices made by service users under each of the four SDS options shown. It also shows the declining number of people who have not yet made SDS choices. It also reflects an increase in the rise of people who are making choices which are recorded on SWIS.

Position
The majority of service users - 71% have chosen option 3, local authority arranged care. The other options show less than 2 percent differences over the period reported. However, the number of people who have not yet made SDS choices declined from 33.3 % in March 2016 to 22% in March 2018.

Figure 8 - Self Directed Support (SDS) options selected March 2018 (Indicators 37 to 41)



3.7. Safety – Unscheduled Care Rate of Readmissions Indicators 42 & 43

Table 8 - Indicators 42 & 43	
Forth Valley Performance	Average monthly performance in 2017/18 = 0.68
Falkirk HSCP Performance	Average monthly performance in 2017/18 = 0.73

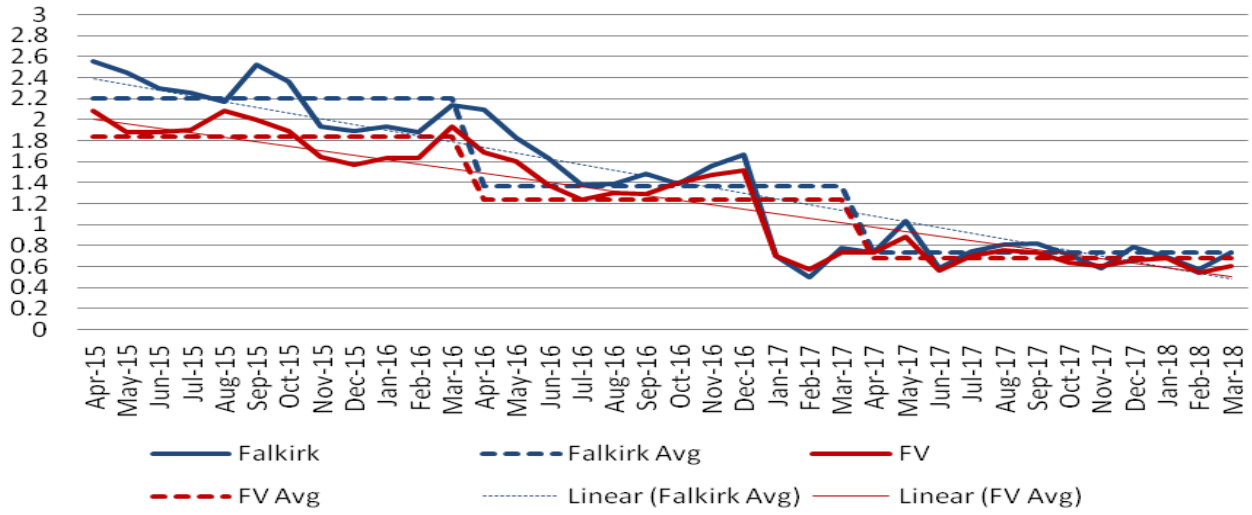
Purpose
Within Forth Valley the readmissions data are standardised by specialty and condition at readmission. This means that if a patient was admitted to a medical specialty initially with a respiratory condition and is readmitted with a broken leg, this is not categorised as a readmission as it is not relevant to the initial presentation at hospital. If however the patient is readmitted to the same specialty then this is classed as a readmission. In this way it enables targeting in areas that may require improvement.

Position
National data items relating to emergency readmissions show NHS Forth Valley in the mid range of outcomes against the Scottish position and peers. Work to identify areas for improvement is currently ongoing.

It should be noted that this differs from national publications reporting the crude rate of readmissions. This is defined as any readmission within 28 days to any specialty, within any health board regardless of the reason for readmission.

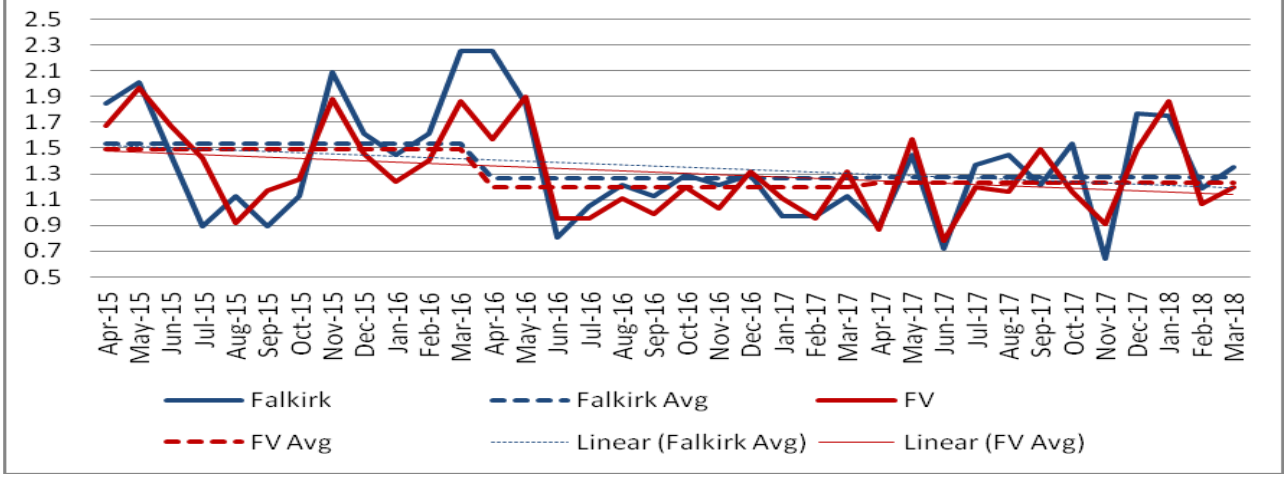
Chart 10 highlights a decrease in the rate of readmissions across Forth Valley from 1.84 per 1,000 population in 2015/16 to 0.68 per 1,000 population in 2017/18 year to date. This decreasing trend is mirrored within the Falkirk Partnership with a decrease from 2.20 per 1000 population in 2015/16 to 0.73 per 1,000 population in 2017/18 year to date.

Figure 9 - Readmissions Rate per 1,000 - 18 years plus population (Indicators 42 & 43)



Readmissions for those aged 75 and over have decreased in Forth Valley and Partnership wide. Forth Valley has decreased to 1.23 rate per 1,000 from 1.49 in 2015/16. The Falkirk position decreased from 1.53 rate per 1,000 in 2015/16 to 1.28 in 2017/18.

Figure 10 - Readmissions Rate per 1,000 75 years plus population (Indicator 44)



Pilot schemes across parts of the Partnership are assessing community focussed supports in a bid to see patients be treated at home or in a homely setting where appropriate.

Routine monitoring is to be adopted by the UCPB, and led by the Medical Director.

3.8. Service User Experience – Unscheduled Care, Delayed Discharge Indicator 54

Table 9- Indicator 54	
Forth Valley Performance	Monthly Number March 2018 = 42
Falkirk HSCP Performance	Monthly Number March 2018 = 23

Purpose
A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available, for example to purchase a care home place. When a delayed discharge occurs it not only affects the patient experience but impacts upon hospital flow hence this indicator is part of the MSG Unscheduled Care Suite of Indicators addressed by the UCPB.

Position
As of the March 2018 census date, the following delays were recorded:

- 23 people delayed in their discharge (standard delays)
- 19 people who were delayed for more than 2 weeks (standard delays)
- 6 people identified as a complex discharge (code 9)
- 19 people proceeding through the guardianship process
- 4 people identified as a Code 100 delay.

The Integration Joint Board receives regular reports on Delayed Discharge and this remains an area of priority for the Board. The Falkirk Delayed Discharge Steering Group is in place to monitor operational performance and find solutions.

In March 2018 the number of standard delays in Forth Valley is 42. Falkirk accounts for 23 or 54.8% of all standard delays. 82% (19/23) Falkirk delays are waiting over 2 weeks at the March 2018 census point. These Falkirk patients account for 86% of Forth Valley waits over 2 weeks.

Figure 11 - Standard Delays 2017/18 (Indicator 54)

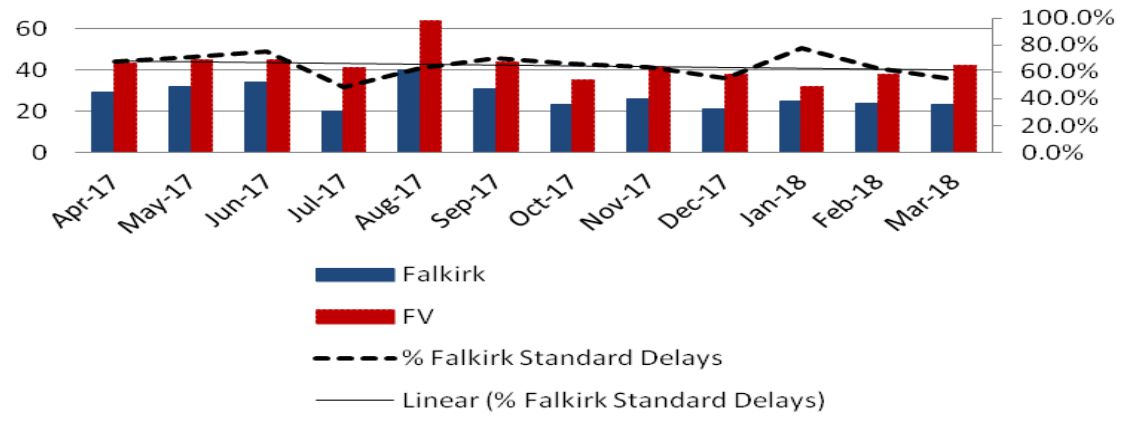


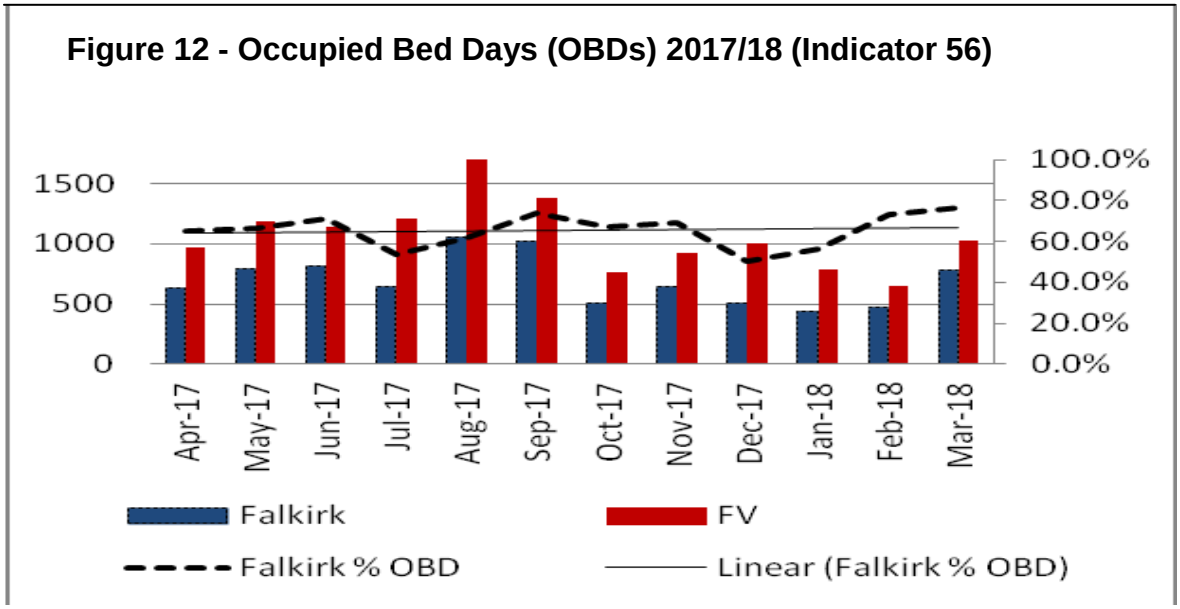
Table 10 - Standard Delays excluding Code 9 and Guardianship Delays from April 2017 to March 2018

	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Total Delay at census point	29	32	34	20	40	31	23	26	21	25	24	23
Total number of delays over 2 weeks	14	18	18	15	26	21	12	18	13	10	15	19

Across Forth Valley there has been an increase in the number of OBDs attributed to delayed discharges with the number at the March 2018 census 786 compared to 645 in February 2018.

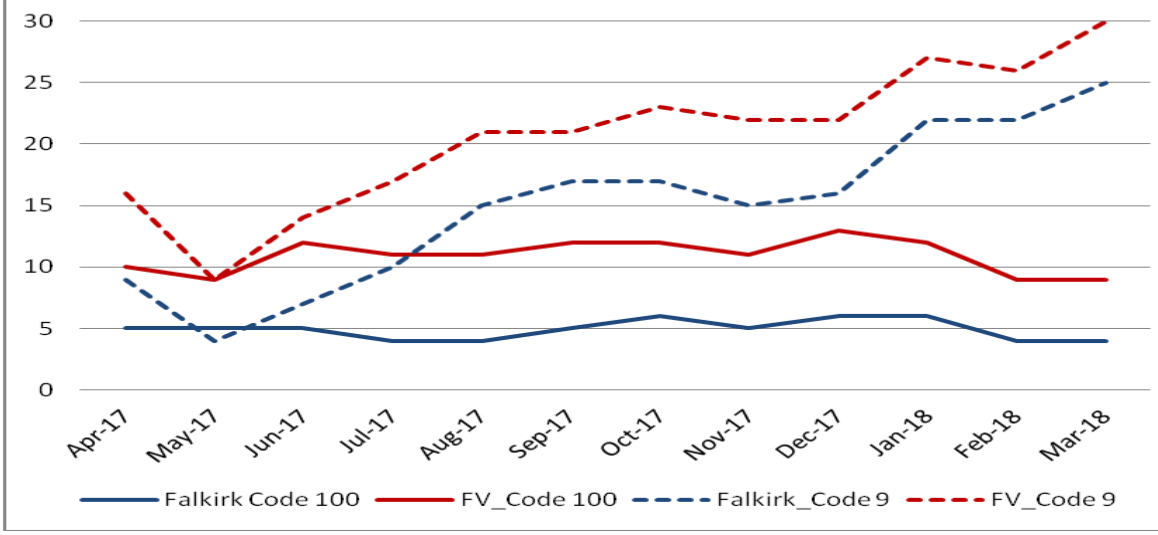
This is not indicative of a rising trend but a snap shot at the census point. Analysis since the baseline has shown the year of the most significant increase in OBDs occurred in 2016/17 with both Forth Valley and Falkirk rising by approximately a third. However the data for the financial year 2017/18 shows a 6% decrease in Forth Valley number from 1,129 in 2016/17 to 1,059 and 16.8% decrease in Falkirk from 831 in 2016/17 to 691 in 2017/18.

Figure 12 - Occupied Bed Days (OBDs) 2017/18 (Indicator 56)



There has been an increase in the number of Code 9 and Code 100 delays across Forth Valley. Across the Falkirk Partnership the position at the March 18 census is 25 Code 9 delays, with 30 for Forth Valley overall, therefore, 83% attributed to Falkirk residents within the Forth Valley setting.

Figure 13 - Code 9 and Code 100 Delay Codes (Indicators 57 & 58)



There are a number of key actions intended to support a reduction in delayed discharge through Partnership funded services:

- Identification of patients who are ready for discharge either home or from hospital to Short Term Assessment (STA)/Community Hospital or in appropriate cases to care homes.
- Identification of solutions and liaison with Social Work and Community colleagues to ensure a safe discharge is achieved. Seven day cover supports the review of and support to discharges at the weekend and identification of any potential issues regarding capacity prior to Mondays. Working at the weekend enables environmental visits to take place at more appropriate times to accommodate families.
- Review of patients who are identified for moves to community hospital to explore all options for discharge so that only those who require community hospitals are moved there.
- Assessment of equipment needs and review of home environments.
- Attendance at MDT meetings to identify discharge pathways and goals.
- Discharge Planning Meetings (DPMs) to enable full discussions in respect of patient's pathways and provision of support to relatives/carers in arranging plans for discharge
- Realise opportunities which have arisen with regards to preventing hospital admissions and keeping patients at home by providing equipment or referring to appropriate services.
- Identify and address gaps in knowledge in terms of the discharge processes and provide education and training as appropriate.

3.9. Service User Experience – Complaints to Social Work Adult Services; Indicators 64 & 65

Table 11 - Indicators 64 & 65					
		Baseline 2015/16	**2017/18 All**	**2017/18 Stage 1**	**2017/18 Stage 2**
64.	The number of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	113/156	77/122	70/110	7/12
	The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	73.4%*	63.1%	63.6%	58.3%
65.	Proportion of Social Work Adult Services complaints upheld ***NB. 2015/16 & 2016/17 were reported under the old complaints system (with 70% target). The target for 2017-18 is now 100%.**	% upheld		36.4	33.3
		% partially upheld		26.4	41.7
		% not upheld		37.2	25.0

Purpose:
Monitoring and managing complaints is an important aspect of governance and quality management. It also helps ensure that any necessary improvement actions arising from complaints are followed up and implemented.

Position:
In April 2017 the social work complaints handling procedure changed as to comply with SPSO requirements. Prior to this a series of training sessions were delivered to raise staff awareness of the new procedure. Support with logging and closing off complaints is now handled centrally. Weekly reports of complaints outstanding are provided to the Head of Service and Service Managers. Since April 2018 these are a standing item at the Adult Services managers' meetings. Performance has improved since 2016/17, but it is still below the target of 100%. However, the number of complaints is low (under 2%) given the large number of service user contacts during the year, with over 9,200 people receiving an assessment/review.

Figure 14 - Number of Social Work Adult Services (Stage 1&2) complaints completed (Indicator 64)

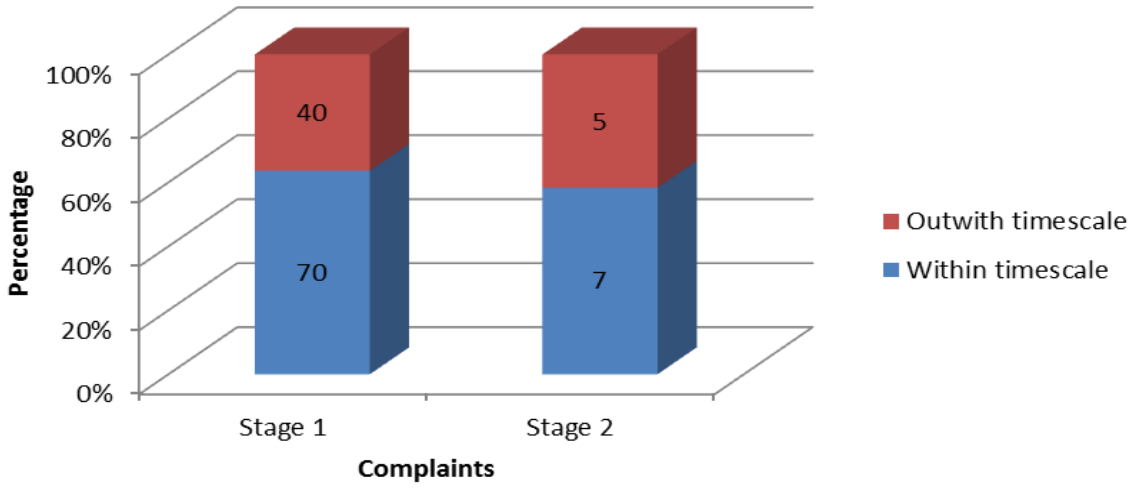
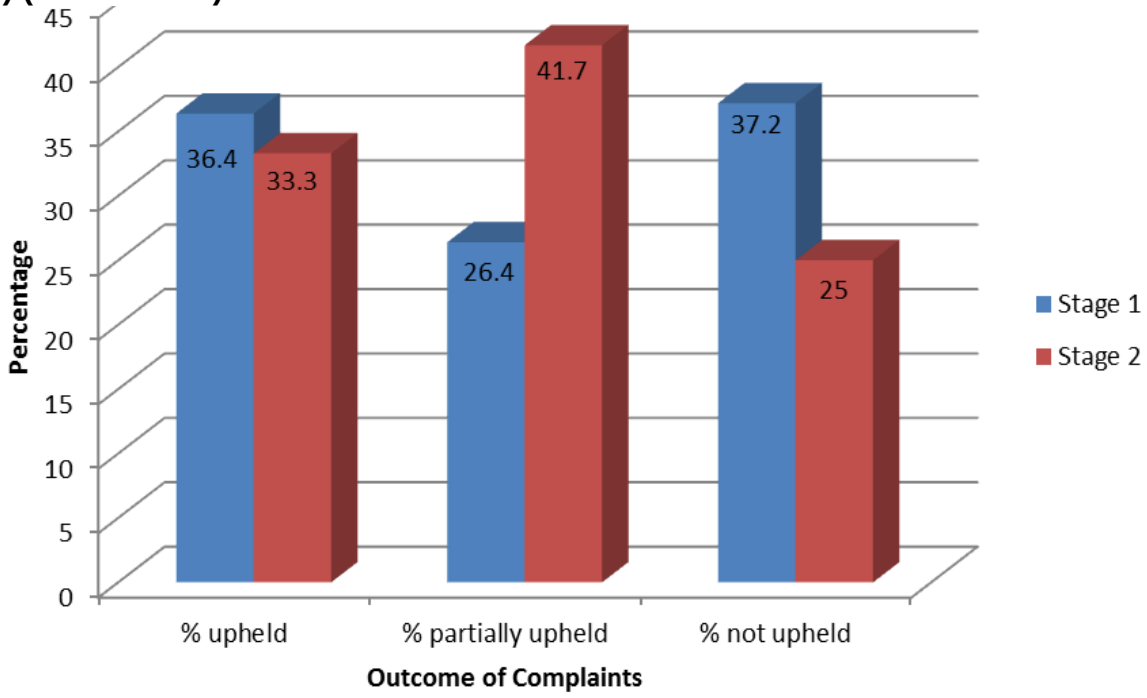


Figure 15 - Proportion of Social Work Adult Services complaints upheld (2017-18) (Indicator 65)



3.10. Service User Experience – Sickness Absence in Social Work Adult Services; Indicator 66

Table 12 - Indicator 66		
Sickness Absence in Social Work Adult Services (target – 5.5%)	**2015/16**	**2017/18 to end Q3**
	7.9%	**8.2%** ▼

Purpose:
The management of sickness absence is an important management priority since it reduces the availability of staff resources and increases costs of covering service. A target of 5.5% has been set for Social Work Adult Services in recognition of the fact that the service includes those engaged in Home Care and Residential Care which are recognised nationally as physically demanding and stressful occupations.

Position
2016/17 saw the implementation of significant planned change across the whole service, from service redesign to the introduction of new technology and new ways of working. All of this has impacted directly on employees. Whilst steps have been taken to engage and consult with staff, many report increased stress and anxiety, both work related and non work related. Traditionally, during the winter months Social Work Adult Services absence increases due to colds and flu. At the end of 2017 and beginning of 2018, flu hit the service and impacted on absence.

3.11. Service User Experience – Rehabilitation at Home services. Indicator 76

Table 13 - Indicator 76		
Percentage of Rehab At Home service users who attained independence after 6 weeks - (target – 80%)	2015/16	2017/18 to end Q3
	77.4%	69.4% ▼

Purpose:
A key objective in the integration of health and social care is to support people to remain independent at home, and to facilitate early discharge from hospital. It is a partnership priority to ensure that home care and support for people is available, particularly those with high levels of care needs.

Position:
This indicator notes people who have been enabled to leave the Rehab at Home service with no further package of care. This can be too limiting a measure when supporting people with complex care needs, as for some people a reduced package of care that maintains their independence can be a positive outcome. However, as shown above, performance has decreased by 8.1% to the end of Quarter 3.

Consideration will be given to broaden reporting to include reablement services provided through, for example, Summerford and Tygetshaugh.

3.12. Community Based Support – The number of Carers' Assessments carried out: Indicator 80

Table 14 - Indicator 80			
	Baseline 2015/16	2017/18	Direction of Travel
The number of Carers' Assessments carried out	1,936	1,656	▼

Purpose:
Supporting carers is recognised as an important element in the Falkirk Integrated Strategic Plan. So it is important to ensure we monitor and support carers through assessment and involvement in the planning and shaping of services required for the service user and for themselves.

Position:
The number of carers' assessments completed by community care teams declined between 2015-16 and 2016-17, but have remained stable between 2016-17 and 2017-18. The Service works in partnership and partly funds the Central Carers Association (CCA). The CCA supports carers in many different ways and now supports over 4000 carers in the Falkirk area. This decline in carer assessments by community care teams will be considered alongside the expanding role of the CCA to meet the requirements of the new Carers' Act in 2018.

It should be noted that the carer satisfaction indicators (indicators 62 and 63) show high levels of satisfaction amongst carers. Indicator 62 shows the percentage of carers satisfied with their involvement in the design of the care package for the person they support at 91% in 2017-18. Indicator 63 shows the percentage of carers who feel supported and capable to continue in their role as a carer, OR who feel able to continue with additional support has increased from 89% in 2015-16 to 91% in 2017-18.

3.13. Community Based Support – Overdue pending Occupational Therapy (OT) Assessments: Indicator 81

Table 15 - Indicator 81		
The number of overdue 'OT' pending assessments at end of the period	**March 2016**	**At 09 April 2018**
	352	**285 ▲**

Purpose:
The provision of OT assessments and the subsequent provision or arrangement of equipment or adaptations helps to maintain people in the community for longer.

Position:
Due to demographic pressures, demand for OT assessments has been increasing. Assessments can also be delayed by other competing pressures on staff resources, such as Adult Support and Protection work. However the number of overdue OT pending assessments as at March 2018 has reduced to 284 since March 2016.

Of those 284 cases144 (51%) were priority 2 and the remainder, 140 (49%) were priority 3. The service has consistently been able to respond to priority one assessment and there is no waiting list for these. This has resulted in priority 2 and 3 cases experiencing longer waits.

The reduction in outstanding assessments will partly be due to the work of the Reablement Project Team. This is a project team formed to test out new models of delivering reablement in a timeous and responsive way. It is made up of occupational therapists who have been redistributed from Community Care Teams to work in the Discharge to Assess model. The team has been small so the impact whilst moving in the right direction has been modest. However, the team is about to increase so it is predicted the impact will become more significant.

In addition, the introduction of the new eligibility framework will mean that service users with low level need will be sign posted to access their own solutions rather than waiting on pending lists for Occupational Therapist / Social Care Officer assessment. ADL Smartcare self assessment and Independence clinics will offer alternative solutions to Falkirk people with low/moderate need rather than requiring to wait for an assessment on a pending list. This development work is ongoing.

Chart Index

Table Index

Falkirk Integration Joint Board Strategy Map **Appendix 1**

Vision	**To enable people to live full independent and positive lives within supportive communities**				
Local Outcomes	***SELF MANAGEMENT-***	***AUTONOMY & DECISION MAKING***	***SAFETY***	***SERVICE USER EXPERIENCE -***	***COMMUNITY BASED SUPPORT -***
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+ years receiving intensive support at home **21*)** % of people admitted to hospital from home then discharged to care home **22*)** % people discharged from hospital within 72 hours of being ready
MSG Indicators	a. Number of A&E attendances and the number of patients seen within 4 hours	b. Number of emergency admissions into Acute specialties	c. Number of unscheduled hospital bed days, with separate objectives for Acute, Geriatric Long Stay and Mental Health specialties	d. Number of delayed discharge bed days	e. Percentage of last six months of life spent in the community f. Percentage of population residing in non-hospital setting for all adults and people aged 75+

Partnership Indicators

SELF MANAGEMENT	Freq	AUTONOMY & DECISION MAKING	Freq	SAFETY	Freq	SERVICE USER EXPERIENCE	Freq	COMMUNITY BASED SUPPORT	Freq
24. Emergency department 4 hour wait Forth Valley	M	28. Emergency admission rate per 100,000 Forth Valley population	M	42. Readmission rate within 28 days per 1000 FV population	M	54. Standard delayed discharges	M	67. The total respite weeks provided to older people aged 65+. Annual indicator	Y
25. Emergency department 4 hour wait Falkirk	M	29. Emergency admission rate per 100,000 Falkirk population	M	43. Readmission rate within 28 days per 1000 Falkirk population	M	55. Delayed discharges over 2 weeks	M	68. The total respite weeks provided to older people aged 18-64. Annual indicator	Y
26. Emergency department attendances per 100,000 Forth Valley Population	M	30. Acute emergency bed days per 1000 Forth Valley population	M	44. Readmission rate within 28 days per 1000 Falkirk population 75+	M	56. Bed days occupied by delayed discharges	M	69. Number of people aged 65+ receiving homecare	Q
27. Emergency department attendances per 100,000 Falkirk	M	31. Acute emergency bed days per 1000 Falkirk population	M	45. Number of Adult Protection Referrals (data only)	Q	57. Number of code 9 delays	M	70. Number of homecare hours for people aged 65+	Q
		32. Number of patients with an Anticipatory Care Plan in Forth Valley	M	46. Number of Adult Protection Investigations (data only)	Q	58. Number of code 100 delays	M	71. Rate of homecare hours per 1000 population aged 65+	Q
		33. Number of patients with an Anticipatory Care Plan in Falkirk	M	47. Number of Adult Protection Support Plans (data only)	Q	59. Delays - including Code 9 and Guardianship	M	72. Number receiving 10+ hrs of home care	Q
		34. Key Information Summary (KIS) as a percentage of the Board area list size Forth Valley	M	48. The total number of people with community alarms at end of the period	Q	60. Percentage of service users satisfied with their involvement in the design of their care package	Q	73. The proportion of Home Care service users aged 65+ receiving personal care	Q
		35. Key Information Summary (KIS) as a percentage of the Board area list size Falkirk	M	49. Percentage of community care service users feeling safe	M	61. Percentage of service users satisfied with opportunities for social interaction	Q	74. The proportion of Home Care service users aged 65+ receiving a service during evening/overnight	Q
		36. Long term conditions - bed days per 100,000 population	M	50. Number of new Telecare service users 65+	Q	62. Percentage of carers satisfied with their involvement in the design of care package	Q	75. The proportion of Home Care service users aged 65+ receiving a service at weekends	Q
		37. SDS Option 1: Direct payments		51. Rate per 1,000 Acute Occupied Bed Days attributed to Staphylococcus aureus bacteraemias (SABs)	M	63. Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	Q	76. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	Q
		38. SDS Option 2: Directing the available resource		52. Rate per 1,000 Bed Days attributed to Device Associated Infections	M	64. The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within 20 days	M	77. Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%)	Q
		39. SDS Option 3: Local Authority arranged		53. Rate per 1,000 Bed Days in the 65+age group attributed to Clostridium Difficile	M	65. The proportion of social work (Completed Stage 1 & 2) complaints upheld	M	78. Number of new Telecare service users 65+	Q
		40. SDS Option 4: Mix of options, 1,2,3				66. Sickness Absence in Social Work Adult Services (target – 5.5%)	M	79. The number of people who had a community care assessment or review completed	
		41. No recorded SDS Option						80. The number of Carers' Assessments carried out	
								81. The number of overdue 'OT' pending assessments at end of the period	
								82. Proportion of last 6 months of life spent at home or community setting	
								83. Number of days by setting during the last six months of life: Community	

Appendix 2

Glossary

- **Accident & Emergency (A&E) Services** - Collectively the term Accident and Emergency (A&E) Services includes the following site types: Emergency Departments; Minor Injury Units, community A&Es or community casualty departments that are GP or nurse led.
- **Admission** - Admission to a hospital bed in the same NHS hospital following an attendance at an ED service.
- **Admission rate** - the number of admissions attributed to a group or region divided by the number of people in that group (the population).
- **ALFY** - Advice Line For You
- **Anticipatory Care Plan (ACP)** - The measure is the number of patients who have a Key Information Summary or Electronic Palliative Care Summary uploaded to the Emergency Care Summary. The Emergency Care Summary provides up to date information about allergies and GP prescribed medications for authorised healthcare professionals at NHS24, Out of Hours services and accident and emergency.
- **Attendance** - The presence of a patient in an A&E service seeking medical attention.
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- Patients awaiting a 'reprovisioning' programme where there is a formal (funded) agreement between the relevant health and/or social work agencies
- Information on patients recorded as code 100 is not published but details are made available to the Scottish Government.

- **Emergency Department (ED)** – The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care
- **4 hour wait standard** - since 2007 the national standard for A&E waiting times is that new and unplanned return attendances at an A&E service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care such as EDs, assessment units, minor injury units, community hospitals, anywhere where emergency care type activity takes place.
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Falkirk Integration Joint Board Strategy Map **Appendix 1**

Vision	**To enable people to live full independent and positive lives within supportive communities**				
Local Outcomes	***SELF MANAGEMENT-***	***AUTONOMY & DECISION MAKING***	***SAFETY***	***SERVICE USER EXPERIENCE -***	***COMMUNITY BASED SUPPORT -***
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+ years receiving intensive support at home **21*)** % of people admitted to hospital from home then discharged to care home **22*)** % people discharged from hospital within 72 hours of being ready
MSG Indicators	a. Number of A&E attendances and the number of patients seen within 4 hours	b. Number of emergency admissions into Acute specialties	c. Number of unscheduled hospital bed days, with separate objectives for Acute, Geriatric Long Stay and Mental Health specialties	d. Number of delayed discharge bed days	e. Percentage of last six months of life spent in the community f. Percentage of population residing in non-hospital setting for all adults and people aged 75+

Partnership Indicators

SELF MANAGEMENT	Freq	AUTONOMY & DECISION MAKING	Freq	SAFETY	Freq	SERVICE USER EXPERIENCE	Freq	COMMUNITY BASED SUPPORT	Freq
24. Emergency department 4 hour wait Forth Valley	M	28. Emergency admission rate per 100,000 Forth Valley population	M	42. Readmission rate within 28 days per 1000 FV population	M	54. Standard delayed discharges	M	67. The total respite weeks provided to older people aged 65+. Annual indicator	Y
25. Emergency department 4 hour wait Falkirk	M	29. Emergency admission rate per 100,000 Falkirk population	M	43. Readmission rate within 28 days per 1000 Falkirk population	M	55. Delayed discharges over 2 weeks	M	68. The total respite weeks provided to older people aged 18-64. Annual indicator	Y
26. Emergency department attendances per 100,000 Forth Valley Population	M	30. Acute emergency bed days per 1000 Forth Valley population	M	44. Readmission rate within 28 days per 1000 Falkirk population 75+	M	56. Bed days occupied by delayed discharges	M	69. Number of people aged 65+ receiving homecare	Q
27. Emergency department attendances per 100,000 Falkirk	M	31. Acute emergency bed days per 1000 Falkirk population	M	45. Number of Adult Protection Referrals (data only)	Q	57. Number of code 9 delays	M	70. Number of homecare hours for people aged 65+	Q
		32. Number of patients with an Anticipatory Care Plan in Forth Valley	M	46. Number of Adult Protection Investigations (data only)	Q	58. Number of code 100 delays	M	71. Rate of homecare hours per 1000 population aged 65+	Q
		33. Number of patients with an Anticipatory Care Plan in Falkirk	M	47. Number of Adult Protection Support Plans (data only)	Q	59. Delays - including Code 9 and Guardianship	M	72. Number receiving 10+ hrs of home care	Q
		34. Key Information Summary (KIS) as a percentage of the Board area list size Forth Valley	M	48. The total number of people with community alarms at end of the period	Q	60. Percentage of service users satisfied with their involvement in the design of their care package	Q	73. The proportion of Home Care service users aged 65+ receiving personal care	Q
		35. Key Information Summary (KIS) as a percentage of the Board area list size Falkirk	M	49. Percentage of community care service users feeling safe	M	61. Percentage of service users satisfied with opportunities for social interaction	Q	74. The proportion of Home Care service users aged 65+ receiving a service during evening/overnight	Q
		36. Long term conditions - bed days per 100,000 population	M	50. Number of new Telecare service users 65+	Q	62. Percentage of carers satisfied with their involvement in the design of care package	Q	75. The proportion of Home Care service users aged 65+ receiving a service at weekends	Q
		37. SDS Option 1: Direct payments		51. Rate per 1,000 Acute Occupied Bed Days attributed to Staphylococcus aureus bacteraemias (SABs)	M	63. Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	Q	76. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	Q
		38. SDS Option 2: Directing the available resource		52. Rate per 1,000 Bed Days attributed to Device Associated Infections	M	64. The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within 20 days	M	77. Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%)	Q
		39. SDS Option 3: Local Authority arranged		53. Rate per 1,000 Bed Days in the 65+age group attributed to Clostridium Difficile	M	65. The proportion of social work (Completed Stage 1 & 2) complaints upheld	M	78. Number of new Telecare service users 65+	Q
		40. SDS Option 4: Mix of options, 1,2,3				66. Sickness Absence in Social Work Adult Services (target – 5.5%)	M	79. The number of people who had a community care assessment or review completed	
		41. No recorded SDS Option						80. The number of Carers' Assessments carried out	
								81. The number of overdue 'OT' pending assessments at end of the period	
								82. Proportion of last 6 months of life spent at home or community setting	
								83. Number of days by setting during the last six months of life: Community	

Appendix 2

Glossary

- **Accident & Emergency (A&E) Services** - Collectively the term Accident and Emergency (A&E) Services includes the following site types: Emergency Departments; Minor Injury Units, community A&Es or community casualty departments that are GP or nurse led.
- **Admission** - Admission to a hospital bed in the same NHS hospital following an attendance at an ED service.
- **Admission rate** - the number of admissions attributed to a group or region divided by the number of people in that group (the population).
- **ALFY** - Advice Line For You
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