Agenda Item 10

Falkirk Integration Joint Board Report

Agenda Item 10

Falkirk Council

Title: **Falkirk Integration Joint Board Report**

Meeting: **Emergency Executive**

Date: **25 June 2020**

Submitted By: **Chief Officer, Falkirk IJB and Health and Social Care Partnership**

1. Purpose of Report

1.1. The report presents to Executive Committee two reports that were considered by Falkirk Integration Joint Board (IJB) at their meeting on 19 June 2020. The reports are titled “Remobilise, Recover, Redesign” and “Covid-19 Update Report – Care Homes”.

2. Recommendation(s)

2.1. **The Executive is asked to:-**

(a) Note the contents of the reports.

3. Background

3.1. The 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.

3.2. The IJB considered the two reports presented to Executive Committee at their meeting on 19 June 2020. A verbal update on the outcome of the Board discussions will be shared with the Committee.

4. Remobilise, Recover and Redesign Report

4.1. The report provides a high level overview of the HSCP mobilisation in response to the Covid-19 pandemic. It outlines the key elements for recovery and the potential opportunities for redesign, within the context of the delivery of the National Framework, the IJB Strategic Plan and national policy and guidance. The report is attached at Appendix 1.

4.2. Initial review indicates that the key elements of the IJB delivery plan are very relevant for post Covid-19 planning. Recovery will require acceleration of some elements of the plan. The whole system approach will address inequality and strengthen community based care through improved care pathways, review of the community bed base and shifting the balance of care. It will require strong financial stewardship and bold decisions to reframe our services and commissioning to support our communities to improve wellbeing.

4.3. The HSCP mobilisation and recovery plan is aligned with those of NHS Forth Valley and Falkirk Council, the national route map and framework documents, national guidance and learning from other partners.

4.4. The report provides an overview of the key challenges and opportunities for recovery and redesign of community based care and support post Covid-19 some of which could accelerate some of the delivery of the HSCP Strategic Plan. The HSCP and strategic partners will need to reframe how we commission and deliver our services.

4.5. The report sought in principle agreement from the IJB to sustain successful elements of the Covid-19 response, delegating the IJB Chief Officer to work with colleagues in Clackmannanshire and Stirling HSCP and NHS Forth Valley to sustain specialist geriatrician support in the Enhanced Community Team as part of a broader whole system community model of care and support.

5. Covid-19 Update Report – Care Homes

5.1 The report provides an overview of the response to Covid-19 to support care homes and their residents and staff in Falkirk. This has been a multi disciplinary and multi agency response that has adapted to the pandemic and the issues presented as they arose. The report also notes the work that is ongoing and being developed and is attached at Appendix 2.

5.2. Across Scotland, including Forth Valley, Covid-19 has brought about unprecedented risks to people, and these are particularly significant for older people. People who live in our care homes are mainly older people who have underlying health conditions, and care home life by its very nature is shared living.

5.3. In response to the pandemic the HSCP has built on established arrangements and procedures with the care home sector and augmented this with localised, clear, concise approach to care delivery taking account of all the relevant national guidance. This approach provides care homes with clear direction and support from a key group of relevant health and social care professionals, PCU Team, Public Health, all working closely with colleagues from the Care Inspectorate, Scottish Care, care providers and Clackmannanshire and Stirling HSCP.

5.4. Reflecting on the learning of this work locally, Falkirk HSCP is developing a Care Home Assurance, Support and Review Team which will enable the continued provision of an integrated approach to care assurance which has proved to be successful at this time. This team will also ensure that care home reviews are undertaken in a timely manner by the appropriate professionals who will have access to any additional support required to ensure resident's care is delivered to a high standard and maintained at that level across the area. This will be a multidisciplinary team that is able to provide a holistic, supportive approach to assessment, ongoing individual care planning, quality assurance and care standards.

6. Considerations

6.1. These reports have been presented to the Falkirk Integration Joint Board on 19 June 2020 as they are responsible for these service areas.

7. Consultation

7.1. This is not required for the report to the Executive Committee.

8. Implications

Financial

8.1 The additional costs for Covid-19 have been captured in the finance element of the HSCP mobilisation plan submitted regularly to Scottish Government. The IJB received a separate Finance report outlining the financial position. The Chief Finance Officer will continue to liaise with Council finance colleagues about the HSCP financial position.

Resources

8.2 There are no resource implications arising from the report recommendations.

Legal

8.3 The are no legal implications arising from the report recommendations. The recovery plan will be incorporated into the IJB and HSCP risk management plans.

Risk

8.4 There are no legal Implications arising from the report recommendations. The recovery plan will be incorporated into the IJB and HSCP risk management plans.

Equalities

8.5 The plan and any resulting changes to service delivery would be subject to an Equality Impact Assessment, to ensure all implications are considered.

Sustainability/Environmental Impact

8.6 A sustainability assessment was not required for this report.

9. Conclusions

9.1 The reports are presented to the Executive Committee to provide information on the work of the HSCP to areas of interest to members. An update on the outcome of the consideration of the IJB to these reports will be provided as a verbal update.

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Chief Officer, Falkirk Health and Social Care Partnership

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Date: 19 June 2020

Appendices

Appendix 1: Falkirk IJB Remobilise, Recover, Redesign
Appendix 2: Falkirk IJB Covid-19 Update – Care Homes

List of Background Papers:

The following papers were relied on in the preparation of this report in terms of the Local Government (Scotland) Act 1973:

- None

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Falkirk Integration Joint Board

19 June 2020

Remobilise, Recover, Redesign

For Decision

1. Executive Summary

1.1. The report provides a high level overview of the HSCP mobilisation in response to the Covid-19 pandemic. It outlines the key elements for recovery and the potential opportunities for redesign, within the context of the delivery of the National Framework, the IJB Strategic Plan and national policy and guidance.

1.2. Initial review indicates that the key elements of the IJB delivery plan are very relevant for post Covid-19 planning. Recovery will require acceleration of some elements of the plan. The whole system approach will address inequality and strengthen community based care through improved care pathways, review of the community bed base and shifting the balance of care. It will require strong financial stewardship and bold decisions to reframe our services and commissioning to support our communities to improve wellbeing.

1.3. The report seeks in principle agreement from the IJB to sustain successful elements of the Covid-19 response, delegating the IJB Chief Officer to work with colleagues in Clackmannanshire and Stirling HSCP and NHS Forth Valley to sustain specialist geriatrician support in the Enhanced Community Team as part of a broader whole system community model of care and support.

2. Recommendations

The Integration Joint Board is asked to:

2.1. to agree the key priorities and actions for recovery and redesign as detailed in section 5.12 of the report and outlined in the route map at Appendix 2

2.2. agree to jointly fund the short term appointment of two Geriatricians with Clackmannanshire and Stirling HSCP and NHS Forth Valley. The Falkirk contributions to be funded initially from non recurring leadership funding if required to sustain the Enhanced Community Team (ECT) approach

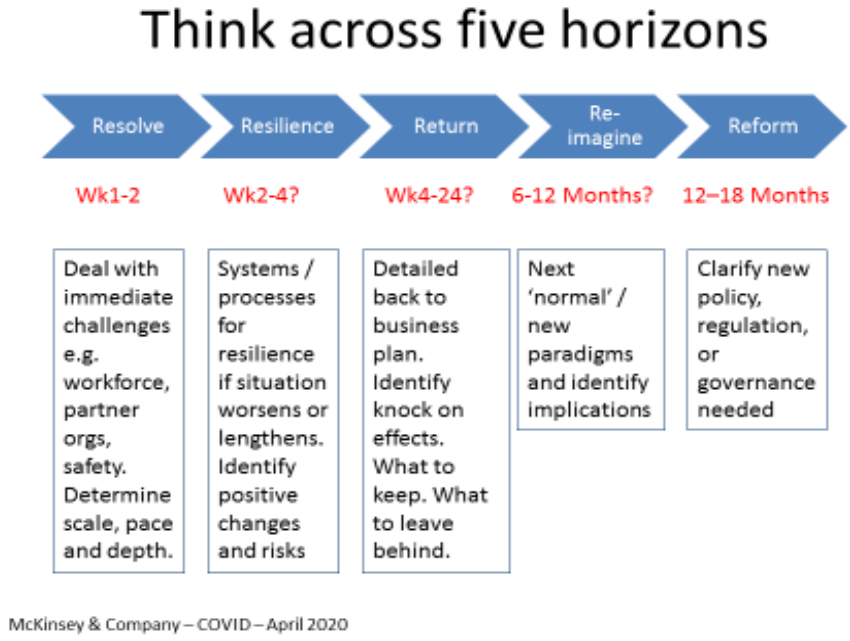
2.3. Agree that the Chief Officer work with the Clackmannanshire and Stirling IJB Chief Officer, Director of Acute Services and the Clinical Director Aging and Health to progress the proposed ECT model and clinical support by re-profiling existing resources including partnership funding and review of community bed base.

3. Background

3.1. The Health and Social Care Partnership began planning its response to the emerging Covid-19 pandemic in early March, updating business continuity plans to review services and build resilience in key services. A mobilisation plan and accompanying finance submission was submitted alongside NHS Forth Valley mobilisation plan as requested by Scottish Government in correspondence on 11 March 2020. This has been reported to the Board in the IJB Bulletin (May 2020) and in other papers on the agenda.

3.2. Scottish Government published the Covid-19 Route map on 21 May 2020 describing the phased approach to vary current restrictions as a framework for decision making. The summary of the four phases is set out below:

Table 1



3.3. Scottish Government published Remobilise, Recover, Redesign: the framework for Scotland on 31 May 2020 which outlines three key tasks for the NHS :

- moving to deliver as many of its normal services as possible, as safely as possible
- ensuring we have the capacity that is necessary to deal with the continuing presence of Covid-19
- preparing the health and care services for the winter season, including replenishing stockpiles and readying services.

3.4. The framework describes principles for safe and effective remobilisation, and the NHS will remain on an emergency footing over this period to support their delivery.

3.5. The HSCP mobilisation and recovery plan is aligned with those of NHS Forth Valley and Falkirk Council, the national route map and framework documents, national guidance and learning from other partners.

3.6. Initial review indicates that the key elements of the IJB delivery plan are very relevant for post Covid-19 planning. This was approved by the Board in December 2020, and sets out in detail how the partnership will deliver its strategic vision "*to enable people in the Falkirk HSCP area to live full and positive lives within supportive and inclusive communities*".

4. Mobilisation

4.1. Mobilisation

A key element of the response to the pandemic, Falkirk HSCP immediately formed an Incident Management Team (IMT) and Mobilisation Plan, with a local mobilisation control centre. This reported to Forth Valley Covid-19Control Centre and Falkirk Council's Core Team linking to the Local Resilience Partnership.

4.2. The Mobilisation Centre enabled the IMT to be responsive to emerging challenges and developing national guidance and evidence and was effective in both preparedness and resilience. This is evidenced in the partnership response and clinical support, swiftly mobilised in response to challenges in local care homes. This is highlighted through the Falkirk HSCP enhanced monitoring system for care homes which has been used as the exemplar in national guidance for enhanced care home monitoring.

4.3. The Falkirk HSCP Mobilisation plan was built on four themes:

- Community: support the demand for capacity to acute services in Forth Valley Royal Hospital sites by working towards zero delayed discharge position, including both community hospitals.
- Maintain Essential Services
- Reduction In Non-Essential Services
- Staff are safe, supported and protected.

4.4. The HSCP activity is summarised as:

- increased Homefirst team capacity across acute and community sites
- increased AHP and overnight MECS staff resources to increase overnight support and Rapid Response Teams
- developing at pace Hospital at Home services and increasing the enhanced care in the community team; refreshing pathways for community nursing and support Home Care, working with Third Sector Providers within our health system and work to discharge all acute delayed discharges and at least 95% of people currently delayed in our community and or mental health beds continues

- implementing the enhanced care home assurance system including the enhanced clinical and professional care oversight of care homes is well established in Forth Valley and a number of innovative ways of working across primary and secondary care supported by public health
- developed staff welfare and support including development of web based information and support, access to support and psychological service, regular 'wobble bulletins' and virtual staff chats and activities

4.5. Throughout the pandemic we have been able to safely sustain our core services including: care at home, community care team, community nursing and mental health officers, care homes and MECS. Day services were suspended in line with national lockdown requirements; however the service maintained regular contact and support for service users and their carers. We have been able to do this through realigning our resources. The staff absence data has highlighted a number of staff who are subject to shielding and this will impact on how we can plan to remobilise our services.

5. Remobilise, Recover and Re-design

5.1. Key points and lessons learned

The HSCP is continuing to provide essential front line services and planning, as part of phase one recovery aligned to the Covid-19 route map. At the same time the partnership has identified key challenges, opportunities and risks, through reviewing lessons learned. We are also planning contingency to respond should there be a second wave of Covid-19using lessons learned, vision and plan for future service provision. The presentation attached as Appendix1 provides an overview of key information.

5.2. Care Homes have been the focus of much of our activity over the last three months and this is described in a separate paper on the agenda. At the time of writing, there are 198 or 18% of vacant care home beds in the Falkirk area. There are 942 private nursing care home beds and 76 beds in Council run residential homes. The HSCP provided support to providers through block purchasing beds as part of the mobilisation plan. This ceased on 24 May 2020 and has been replaced by support aligned to the national principles agreed with COSLA.

5.3. At this stage it unclear how local providers will be able to manage in the long term with such a vacancy level, and there may be a further impact as a result of public confidence and demand for this type of care.

5.4. The IJB had previously agreed to review community hospitals, work which has been delayed by the pandemic. There is now an opportunity to:

- review the functionality of the community hospital beds as part of the whole system including reablement and intermediate care bed requirements
- work with partners and the sector to review the community bed base requirements and commission the required balance of bed and community based services.

5.5. It is important that this work proceeds with pace to ensure people who rely on services, their carers and communities have the services they need and that providers are able to work alongside us in the redesign of services.

5.6. In the short-term, a plan to extend local capacity for respite care for older adults is detailed in a paper elsewhere on the agenda. The Board previously agreed this provision and the extended capacity is to provide short breaks to alleviate carer stress.

5.7. The significant financial impact of COVID 19 will require careful financial stewardship. The 2020/2021 Business Plan agreed by the IJB requires £2.2m savings this financial year which have been delayed as a result of the pandemic. It is critical given the significant challenges on public sector finances that the IJB endeavours to meet this requirement to support the Council and Health Board. The IJB may be required to make bold decisions to increase the pace of transformation.

5.8. The HSCP is working with the Local Resilience Partnership undertaking a wide ranging debrief of the incident at a local care home and a more broad debrief of the Covid-19 response to date. Members will receive further information at the next board meeting. In addition the partnership has undertaken an initial review with the integrated service teams.

5.9. In addition to those areas listed above, the partnership response will be informed by:

- public protection concerns
- carers support
- withdrawal of day services what and how do we restart / change?
- Council strategic property review
- extend community based care due to social distancing
- Third sector and volunteering.

5.10. **Remobilise**

We are considering how we will resume services in phases 2 to 4 where we can safely do so with social distancing and infection control requirements. We need to take the opportunity to review and redesign services for post Covid-19 recovery continuing what has worked and redesigning to meet the emerging challenges. This will include reviewing which buildings we need to reopen as we continue to work remotely where appropriate.

5.11. **Recover and Redesign**

It is clear that the main priority areas in the current HSCP delivery plan still apply, with opportunities to accelerate delivery taking a whole system approach.

5.12. It is proposed that the HSCP recovery and redesign will be framed in the key priority actions where we can:

- accelerate integration
- sustain new models of care where they have proved effective
- redesign services / alternatives (for example day services) to meet individual need and safe distancing requirements
- review how we can accelerate the shift in the balance of care to extend community based support for people to stay at home longer and support carers
- continue to develop support and assurance model for Care Homes
- review community bed-based care across our whole system
- progress the review of care at home
- build on the COVID 'supporting communities' work to develop locality working.

The recovery plan route map attached at Appendix 2 provides a high level outline of the key steps for recovery and redesign. This will be an iterative plan which will develop taking account of lessons learned, national policy and resources. The Board will receive regular updates on progress.

5.13. During Covid-19 response a number of changes to service delivery have been successful and now require consideration as possible opportunities for redesign. Some examples of service changes, in particular those in Primary Care, are set out in the Chief Officer report.

5.14. Another successful service response to the pandemic was in relation to three WTE Consultant Geriatricians joining ECT following a request from the Covid-19 Hub. This was to provide assessment, management and care to frail elderly people across Forth Valley. This is been delivered as a 7 day service.

5.15. This work has evolved to include:

- assessments of those referred to the Rapid Access Frailty Clinic
- assessment and management of residents in care homes
- education and training to ECT nursing staff
- step up care to community hospitals
- most importantly they have provided an alternative to admission to FVRH.

5.16. The Board is asked to agree to jointly fund the short term appointment of two Geriatricians with Clackmannanshire and Stirling HSCP and NHS Forth Valley. The Falkirk contributions to be funded initially from non recurring leadership funding if required to sustain the Enhanced Community Team (ECT) approach.

5.17. It is further proposed that the Board agree that the Chief Officer work with the Clackmannanshire and Stirling IJB Chief Officer, Director of Acute Services and the Clinical Director Aging and Health to progress the proposed ECT model and clinical support by re-profiling existing resources including partnership funding and review of community bed base.

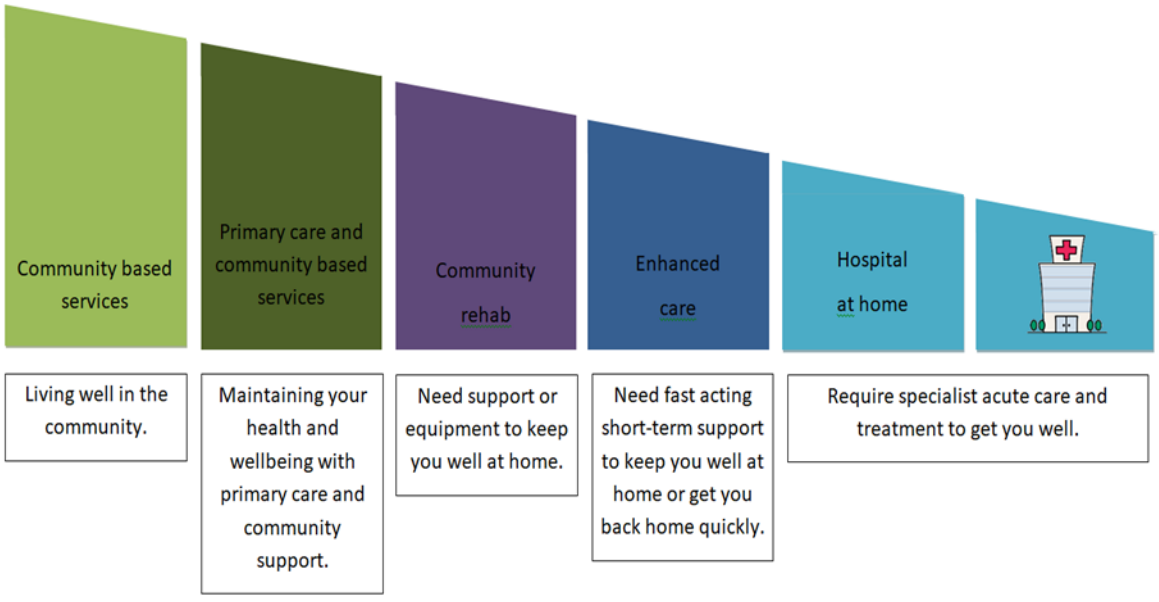
5.18. Further information on the proposal and the model and benefits are set out in the following paragraphs. These proposals will:

- capitalise on current practice which has significantly improved outcomes and enabled direct admission for step up care into the community hospital for the first time
- extended geriatrician expertise into community.

5.19. The table below illustrates the span of services and the need for fast acting short-term support to keep people well at home or get them back home quickly:

- intermediate care
- discharge to assess/Home First
- community hospital
- community Hospital Team
- step up to community hospital via ECT.

Table 2 Model of Enhanced Care



5.20. The impact of the Geriatrician Enhanced Care Team (ECT) was:

- avoided 58 hospital admissions over six weeks
- stepped up 5 patients to community hospital
- total bed days saved (acute) = 906
- total bed days saved (community based on 14% transferred there) = 378.

5.21. Frailty at the Front Door is a 7 day service which:

- increased discharge rate of people identified as frail direct from AMU
- reduced length of stay
- supports whole system working prevent admission to hospital
- supports reablement in community and intermediate care.

5.22. The impact of the ECT service is clear. Additionally the specialist and acute nature of the Hospital at Home work requires a workforce with the skills, competencies and confidence to manage acutely unwell patients safely at home. This requires comprehensive geriatric assessment by a member of the multidisciplinary team, as fits with specialist geriatric medicine in an inpatient setting.

5.23. Care needs to be specialist led to meet these standard along with a workforce including nurse/allied health professionals (AHPs)/paramedic practitioners with extended clinical and decision-making skills linking to community based care and support.

5.24. The medical workforce needs to be flexible to respond to the context and the available staff. There needs to be clear lines of responsibility with a named consultant acting as responsible medical officer, as fits with the General Medical Council requirements for acute hospital care.

5.25. The current ability to deliver support to geriatricians within the Enhanced Care Team is only sustainable to the 29 June 2020. The gap left on the acute site has been in part back filled by other medical specialities however with a return to scheduled care they will no longer be able to support this. In order to deliver this a minimum of 2 WTE Consultant Geriatricians at a total cost of £300,000 would be required. Workforce modelling for nursing and AHP and social care has already started and will form part of a future proposal.

5.26. It is proposed that in the short term the IJB should jointly commission the services of 2 Geriatricians while the Chief Officer works collaboratively on a sustainable longer term model of investment, primarily from within existing resources across NHS and IJBs including the ongoing partnership funding for ECT and other initiatives.

5.27. A number of external factors may also influence how we redesign services. Following the number of deaths in care homes, there may be a loss of public confidence in care homes which may increase the demand for more support at home. Currently the number of vacant beds in care home and community hospital provide an opportunity for review and potential resource transfer into community based services, to support people to remain in their own homes.

5.28. Models of day service provision will require alternative models of provision to meet social distancing requirements. The HSCP team is working to commission alternative opportunities within communities, building on the successful community action during Covid-19 and to plan a phased approach for these community supports

6. Conclusions

The report provides an overview of the key challenges and opportunities for recovery and redesign of community based care and support post Covid-19 some of which could accelerate some of the delivery of the Strategic Plan. The HSCP and strategic partners will need to reframe how we commission and deliver our services.

Resource Implications

The additional costs for Covid-19 have been captured in the finance element of the HSCP mobilisation plan submitted regularly to Scottish Government. This is detailed in the Finance report elsewhere on the agenda.

The proposed cost of £300,000 for two geriatricians to support the extended ECT and Hospital at Home service will be shared across the two IJBs and NHS Forth Valley. It is anticipated that this could be funded by review of the current partnership funding for admission avoidance and delayed discharge. It may require some initial upfront nonrecurring investment from the leadership fund while the review is completed.

An associated proposal for nursing and AHP staffing is being developed. It is anticipated that this could be funded through reallocation of existing resource across the system, including from a review of the community bed base.

Impact on IJB Outcomes and Priorities

This proposal would contribute to the delivery of the HSCP Strategic Plan, and Scottish Government Improvement Targets and improve outcomes for people and their carers

Legal & Risk Implications

The are no legal Implications arising from the report recommendations. The recovery plan will be incorporated into the IJB and HSCP risk management plans.

Consultation

The ECT proposal was presented at the NHS Forth Valley Systems Leadership Team on 1 June 2020 and agreed in principle. The Lead Clinician for Aging and Health, IJB Chief Officer Clackmannanshire & Stirling IJB and Director of Acute Services have been consulted.

Equalities Assessment

The plan and any resulting changes to service delivery would be subject to an Equality Impact Assessment, to ensure all implications are considered.

7. Report Author

Patricia Cassidy,
IJB Chief Officer

8. Appendices

Appendix 1 COVID Recovery Planning Presentation
Appendix 2 Roadmap to Recovery

Falkirk IJB

Remobilise, Recover, Redesign

19 June 2020

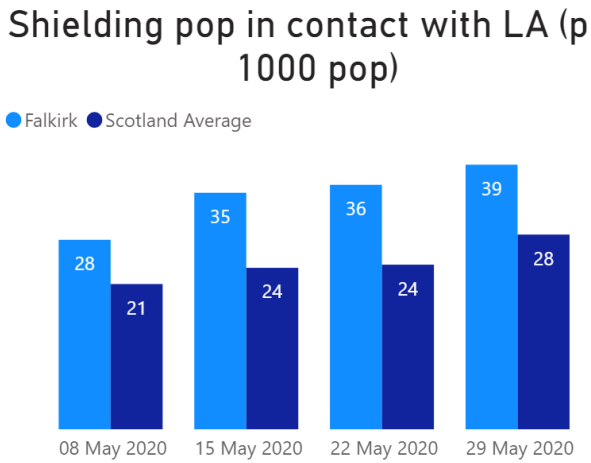
Presentation content

- Set out some initial management information during the covid-19 period
- Consider the implications and opportunities to remobilise, recover and redesign services
- Set the context for the IJB Board papers presented to the meeting

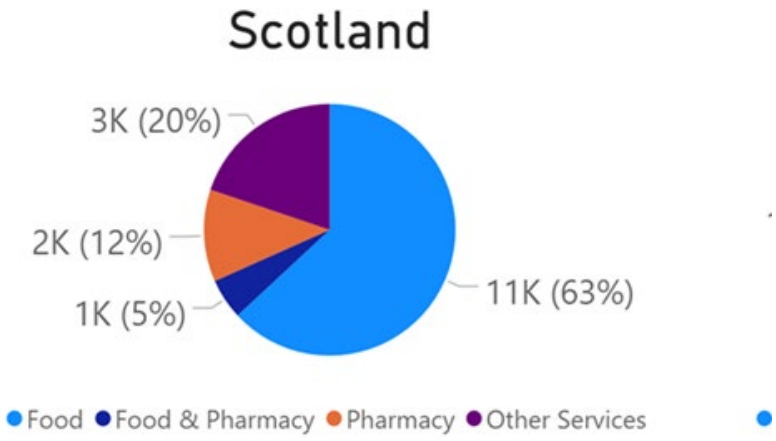
Shielding Letters: Falkirk

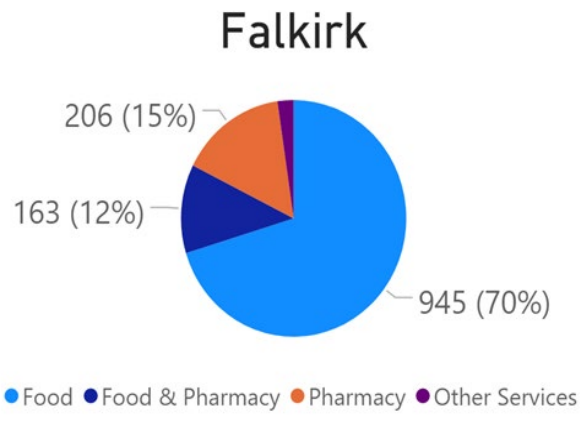
Number of shielding letters sent out to people in Falkirk area	**6,833**
No. of people* known to SWAS as current or past clients	**2,397** of which 683 are allocated or pending
No. of people known to MECS	**665**
No. of people known to Children's Services as current or past clients	**503** of which 65 are open or pending
No. of people known to CJ Services as current or past clients	**362** of which 22 are open to the CJS module and the rest closed
***People can be open to more than one module so some double counting**	

Shielding Statistics : w/e 29 May 2020



Assessed Support Needs



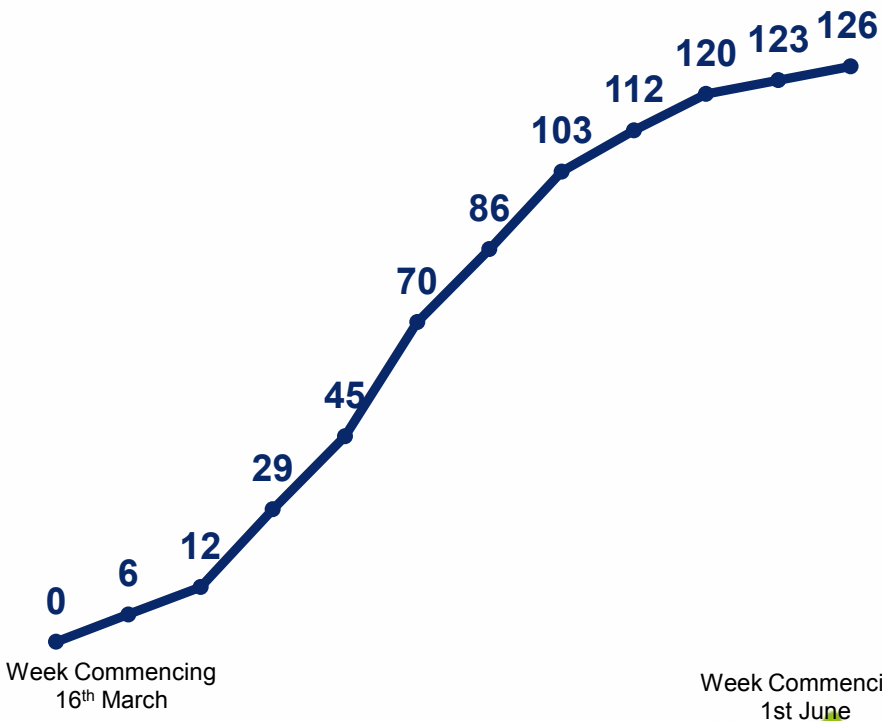


Falkirk Local Authority – Deaths involving coronavirus (COVID-19) up to 7th June

Cumulative deaths involving COVID-19 by week

As of 7th June, 126 Falkirk residents had a death registered which mentioned COVID-19.

The first mention of COVID-19 in a death registration in Scotland was in the week beginning 16th March 2020.

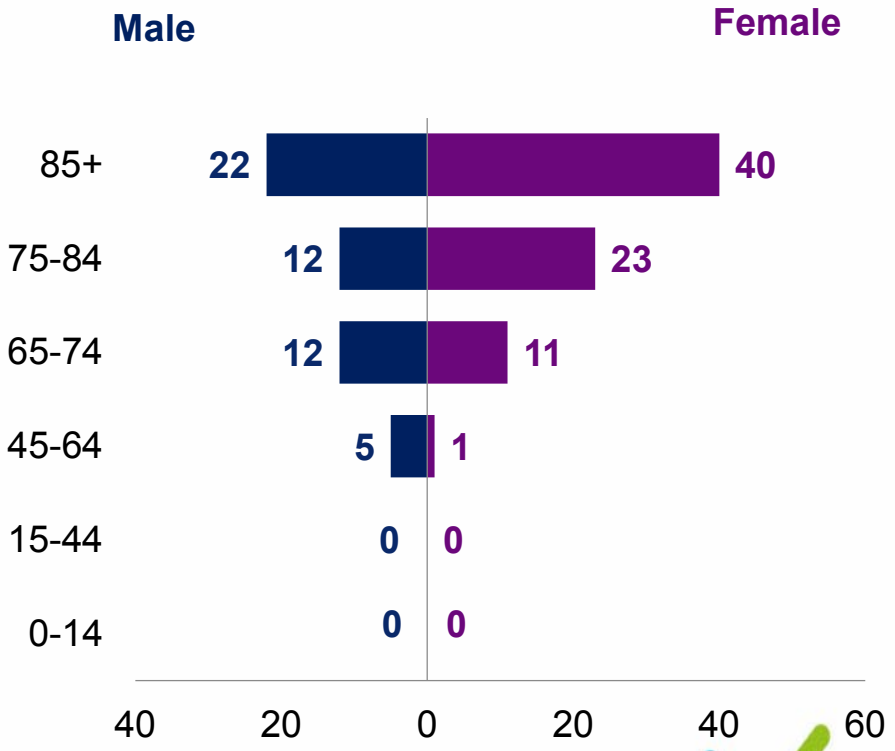


Falkirk Local Authority – Deaths involving coronavirus (COVID-19) up to 7th June

Number of deaths involving COVID-19 by age and gender up to 7th June 2020

The highest number of deaths have occurred in the 85+ age group.

Deaths in this age group accounted for 53% of female deaths and 43% of male deaths.

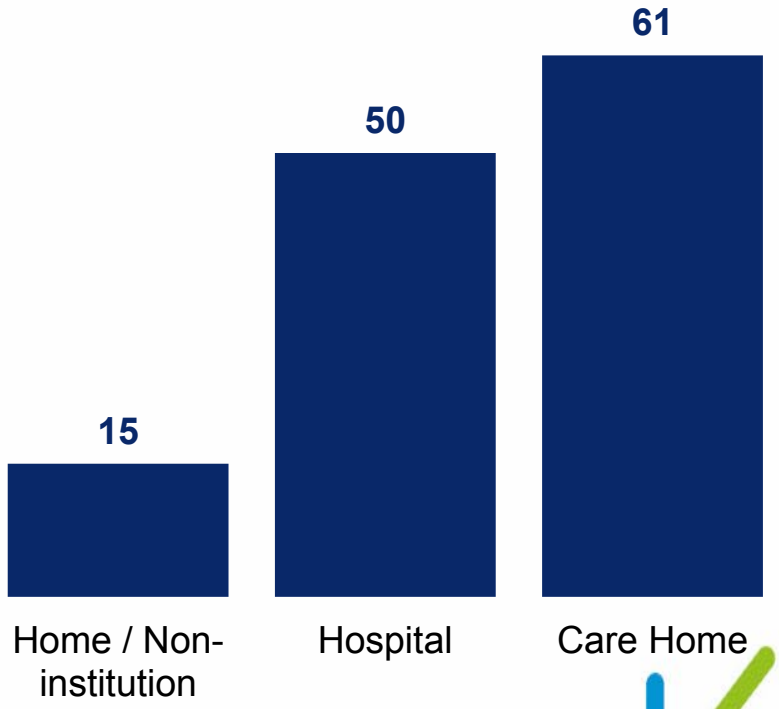


Falkirk Local Authority – Deaths involving coronavirus (COVID-19) up to 7th June

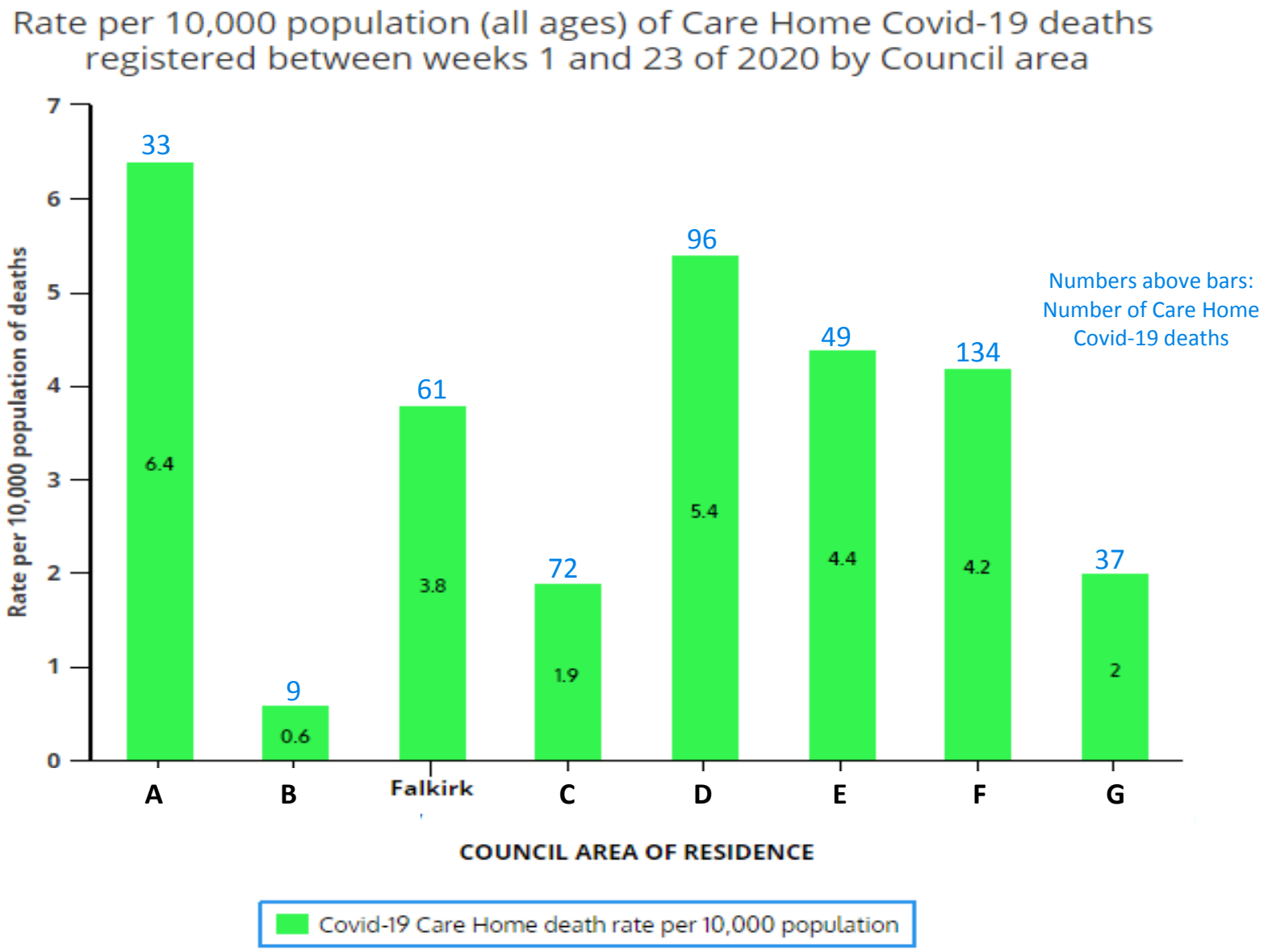
Number of deaths involving COVID-19 by location of death, up to 7th June 2020

Deaths vary by location.

- 48% of deaths have occurred in Care Homes,
- 40% have occurred in Hospital and a further
- 12% have occurred within the Home / Non-institution.



Rate of Care Home death by Council comparator groups



Care at Home

External Home Care

	End of January 2020	Beginning of April 2020	Difference
Active Service Users	1092	1111	+1.75%
Service Users with planned visit	1085	1093	+1.75%

In-House Home Care

	01/01/20 - 31/01/20	12/03/20 - 12/04/20	Difference
Active Service Users	821	781	-4.9%
Service Users with planned visit	792	753	-4.9%

Active Service Users are the number of service users during the period

Service Users with a planned visit are those who received a service visit during the period, but will still not count service users who for the full month were subject to cancellations, hospital admissions, respite periods and other temporary amendments.

Overview of Care Homes

Care Homes (Older People)

- 942 care home beds between 21 residential and nursing care homes.
- Five are residential care homes managed by Falkirk Council and 16 care homes owned by the independent sector

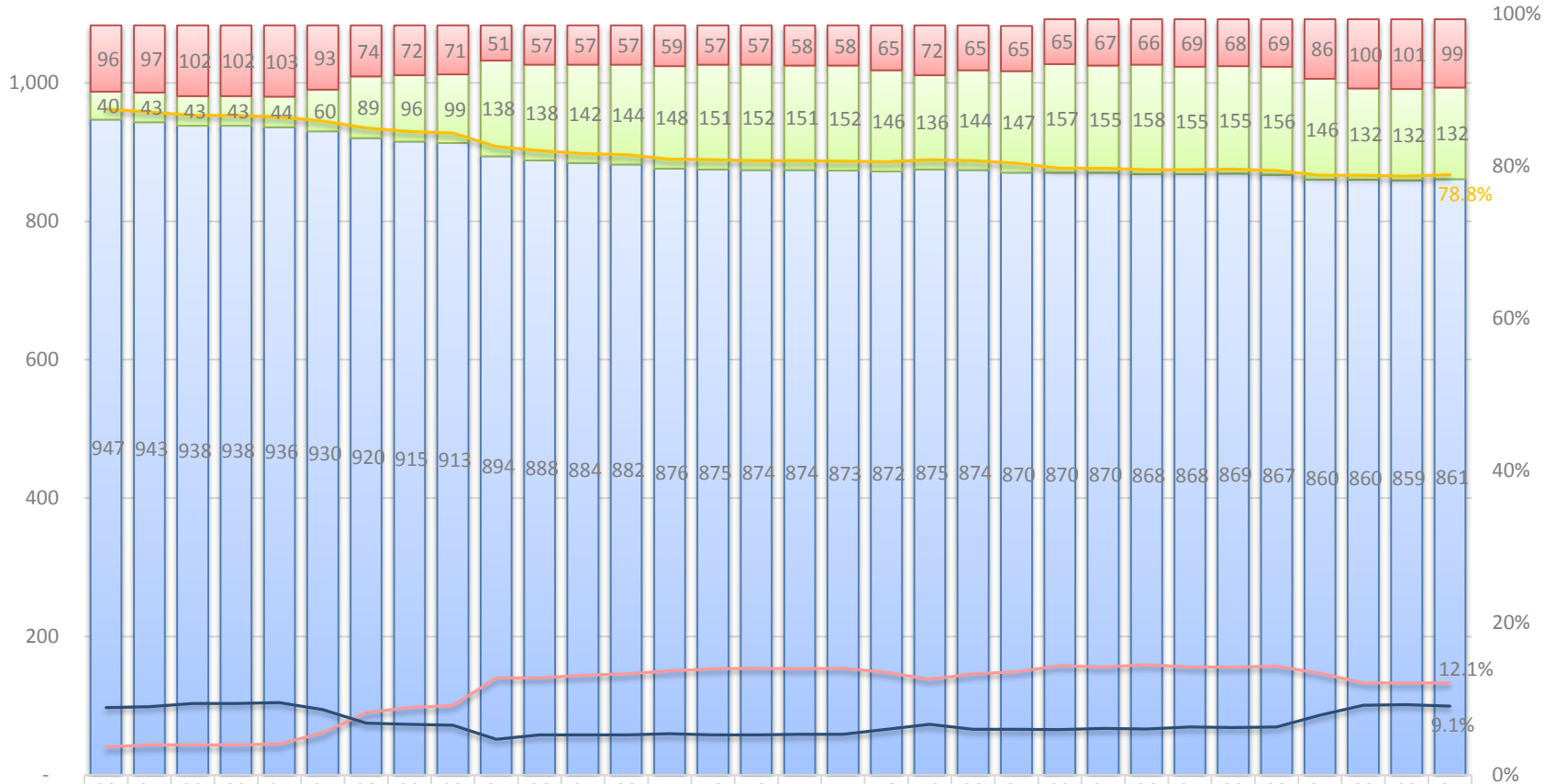
Residential Care Homes (Younger Adults)

- 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 managed by NHS FV

Position at 4 June 2020

- there were 99 (9.1%) vacant beds in total with the range across all care homes being 0% - 38.5%
- there were 861 (78.8%) occupied beds in total with the range across all care homes being 18.5% - 100%

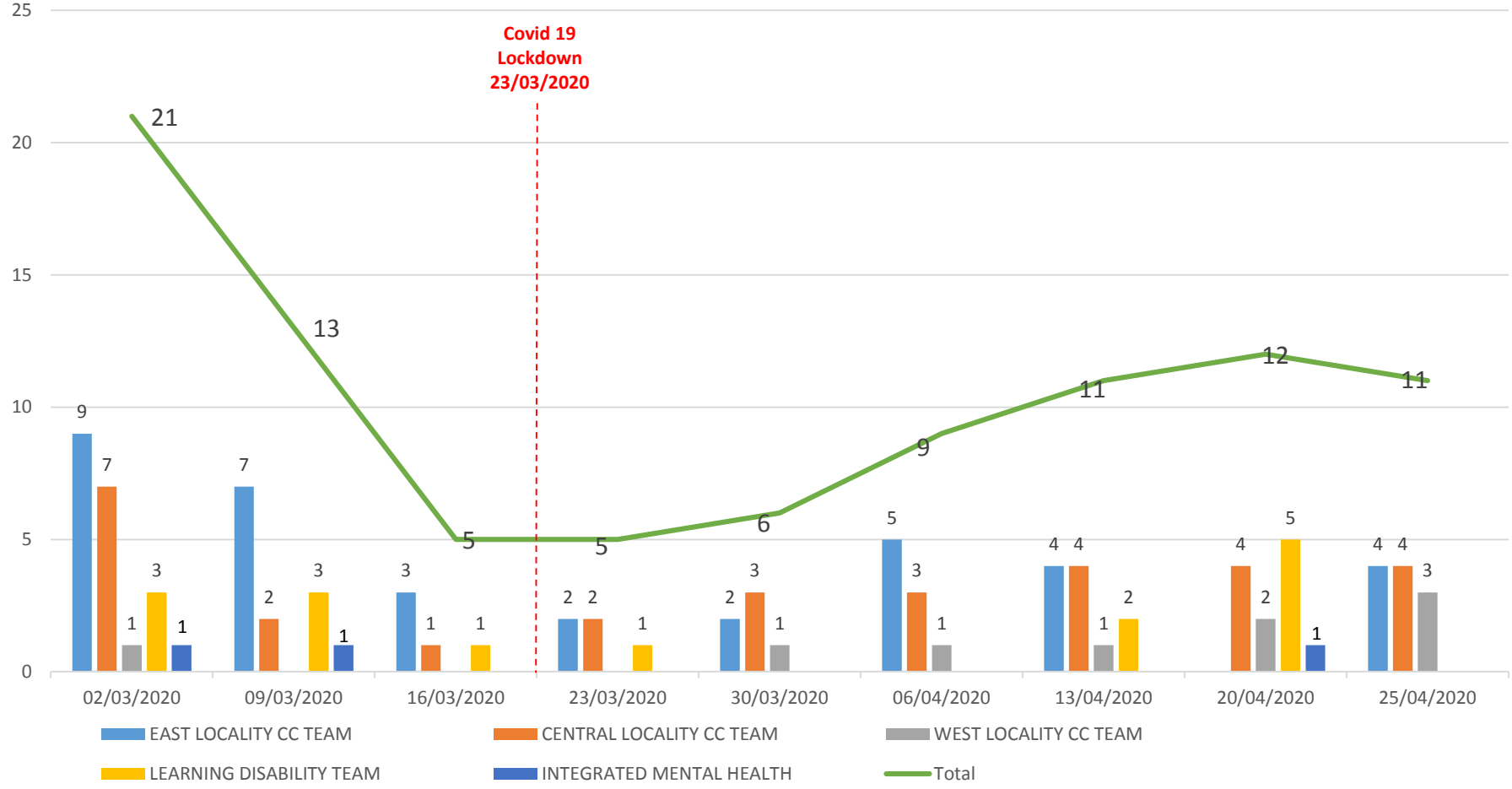
Falkirk Care Home Beds - 20 April to 4 June 2020



	20 Apr	21 Apr	22 Apr	23 Apr	24 Apr	27 Apr	28 Apr	29 Apr	30 Apr	04 May	06 May	07 May	08 May	11 May	12 May	13 May	14 May	15 May	18 May	19 May	20 May	21 May	22 May	25 May	26 May	27 May	28 May	29 May	01 Jun	02 Jun	03 Jun	04 Jun
Beds available	96	97	102	102	103	93	74	72	71	51	57	57	57	59	57	57	58	58	65	72	65	65	65	67	66	69	68	69	86	100	101	99
Beds Unavailable	40	43	43	43	44	60	89	96	99	138	138	142	144	148	151	152	151	152	146	136	144	147	157	155	158	155	155	156	146	132	132	132
Beds occupied	947	943	938	938	936	930	920	915	913	894	888	884	882	876	875	874	874	873	872	875	874	870	870	870	868	868	869	867	860	860	859	861
Total number of beds	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0	1,0
% unavailable	3.7%	4.0%	4.0%	4.0%	4.1%	5.5%	8.2%	8.9%	9.1%	12.7	12.7	13.1	13.3	13.7	13.9	14.0	13.9	14.0	13.5	12.6	13.3	13.6	14.4	14.2	14.5	14.2	14.2	14.3	13.4	12.1	12.1	12.1
% available	8.9%	9.0%	9.4%	9.4%	9.5%	8.6%	6.8%	6.6%	6.6%	4.7%	5.3%	5.3%	5.3%	5.4%	5.3%	5.3%	5.4%	5.4%	6.0%	6.6%	6.0%	6.0%	6.0%	6.1%	6.0%	6.3%	6.2%	6.3%	7.9%	9.2%	9.2%	9.1%
% occupied	87.4	87.1	86.6	86.6	86.4	85.9	84.9	84.5	84.3	82.5	82.0	81.6	81.4	80.9	80.8	80.7	80.7	80.6	80.5	80.8	80.7	80.3	79.7	79.7	79.5	79.5	79.6	79.4	78.8	78.8	78.7	78.8

Adult Protection Referrals by Team

Figure 3: Adult Protection Referrals by Team since week beginning 02/03/2020



IPC – Understanding our System

Discharged NFA
500

Admitted to Hosptial
1,000 (over 65's)

"Effective Assessment"
Right time, Right type, Outcome focused

"Low-level" support (eg follow-up from therapist or District Nurse)
200

Discharged requiring further support
300

"Effective Commissioning"
Understand demand
Commission the "right" provision
Focus on recovery and recuperation
Review performance

Intermediate Care

Short-term Reablement based residential care bed with theraputic and nursing support
50

Domiciliary Support
(eg Reablement based)
250

On-going Domiciliary Support
90

Residential Care
10

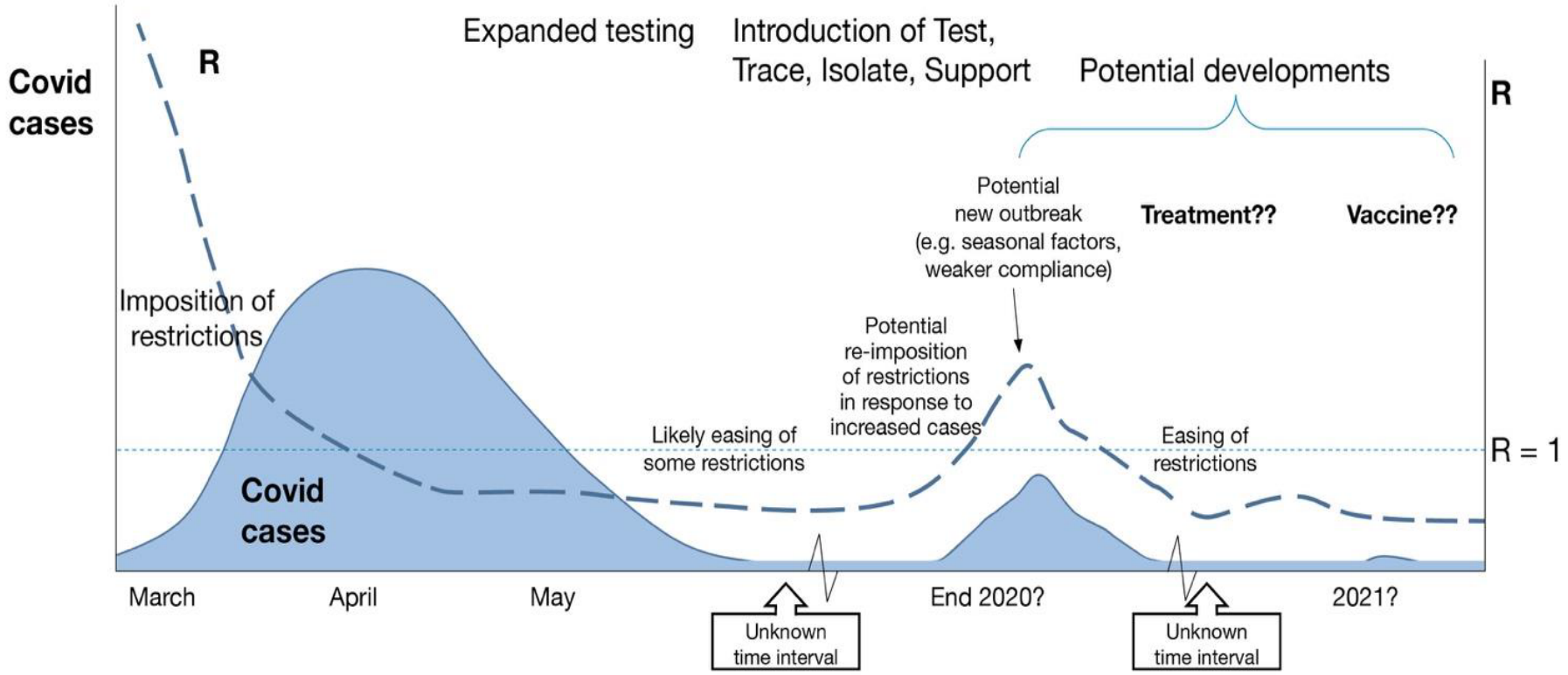
IPC Comparison of Key Measures (Oct – Dec 2018)

	Rate per 1,000 discharges		
	Falkirk HSCP	IPC	Somerset
Discharged Requiring Further Support	241	300	143
Community Hospital	44	n/a	41
Support Direct from Hospital	118	n/a	17
Care Homes	26	n/a	6
Home Care	92	n/a	11
Intermediate Care	79	300	85
Reablement	68	250	52
Summerford	11	50	33
Discharged No/low level support	759	700	857

- In IPC model, no one would go straight to a care home or home care from hospital. Instead would receive intermediate care before going on to one of these services
- 26 discharges per 1,000 go to a care home straight from hospital. In the IPC model, 10 per 1,000 discharges do go to a care home after receiving intermediate care first
- Big difference in intermediate care provision between Falkirk and the IPC model (IPC having almost 4 times more IC provision)

Recovery in context – waves

Scottish Government Covid-19 Framework for Decision Making May 2020



Approach: ApproximateTimescales

How we can use this work moving forward

- **Demand monitoring and modelling**
  - Impact of Covid-19 on demand for Home Care and Care Homes unknown
  - Previous IPC work could be built on and used as a baseline before Covid-19 in terms of understanding our system
  - Conclude Set aside modelling work
  - Commence community bed-based modelling work (Finance report)
- **Community based provision – Enhanced Community Team proposal (Chief Officer report)**
- **Conduct an in-depth review of reserves (Finance Report)**
- **Service Recovery Planning Tool**

HSCP Delivery Plan

Summary of Delivery Plan

Vision	Strategic Plan Priorities	Delivery Actions
"to enable people in Falkirk HSCP area to live full and positive lives within supportive and inclusive communities" **OUTCOMES** **Self-Management** **Safe** **Experience** **Strong Sustainable Communities**	1. Deliver local health and social care services, including Primary Care, through enabled communities and workforce	1.1. Adopt and implement the Home First Approach 1.2. Assessment & Planning will be person centred and asset based. 1.3. Locality Planning will be based on community needs assessments. 1.4. HQ Function will support and provide a framework for improvement.
	2. Ensure carers are supported in their caring role	2.1. Carers Strategy Implementation
	3. Early intervention, prevention and harm reduction that: ▪ improve people's mental health and wellbeing ▪ improve support for people with substance use issues, their families and communities ▪ reduce the impact of health and social inequalities on individuals and communities	3.1. Specialist Services
	4. Make better use of technology to support the delivery of health and social care services	4.1. Develop and delivery TEC Strategy

Enabling Activities
Adopt an Ethos of Promoting Independence – Home First and Living Well
Public Engagement
Workforce Engagement, Involvement and Development Plan
Review and Redirection of Partnership Funding
Support and Collaborative Working with all Partners
Data Confidence and HQ Support

Agenda Item: 11

Falkirk Integration Joint Board

19 June 2020

Covid-19 Update Report – Care Homes

For Noting

1. Executive Summary

1.1 This report provides an overview of the response to Covid-19 to support care homes in Falkirk.

1.2 Across Scotland, including Forth Valley, Covid-19 has brought about unprecedented risks to people, and these are particularly significant for older people. People who live in our care homes are mainly older people who have underlying health conditions, and care home life by its very nature is shared living.

1.3 In response to the pandemic the Partnership has built on established arrangements and procedures with the care home sector and augmented this with localised, clear, concise approach to care delivery taking account of all the relevant national guidance. This approach provides care homes with clear direction and support from a key group of relevant health and social care professionals, PCU Team, Public Health, all working closely with colleagues from the Care Inspectorate, Scottish Care, care providers and Clackmannanshire and Stirling HSCP.

2. Recommendations

The Integration Joint Board is asked to:

2.1 note good integrated working that has successfully supported care homes during the ongoing Covid-19 challenges

3. Update

3.1 This section provides a summary of the key areas of action being taken in response to the presenting issues for residents and staff in care homes.

3.2 Residents within our care homes are some of the most vulnerable people in our communities As such these people are also more susceptible to infection, and the consequence of contracting Covid-19 as seen nationally, is an increase in deaths within this group.

3.3 The HSCP has implemented a robust mobilisation plan for Covid-19 outbreaks across Falkirk care homes which is coordinated through the mobilisation centre. There are similar arrangements in place for

Clackmannanshire and Stirling HSCP. Care homes are asked to submit an electronic return by 10.00 am each morning providing an update including staffing levels, symptomatic or positive residents and staff, and PPE. They demonstrate that they have sufficient continuity plans in place which all staff members are aware of; including their responsibilities in these plans and when different stages of the plan should be implemented.

3.4 The mobilisation centre have provided updates on all policy guidance as well as direct support with staff training, PPE and infection control.

3.5 All care homes are provided with key pieces of operational guidance which the partnerships require including:

- FV Standardised Operating Procedure on 'Zoning'
- FV Standardised Operating Procedure on PPE/infection control
- Health Protection Scotland's Covid-19: Information and Guidance for Care Home Settings.

3.6 Scottish Care - a representative body for social care in Scotland - advised care homes to close to visits on 11 March. On 13 March, the government's guidance from 25 February was updated to say that "care home providers are advised to review their visiting policy, by asking no-one to visit who has suspected Covid-19 or is generally unwell, and by emphasising good hand hygiene for visitors". A clear, consistent message has been given to all Falkirk care homes to ensure the risks to older people are managed effectively. We decided to close to non-essential visitors to reduce footfall within their area at the start of the Covid-19 pandemic thus reducing the number of people potentially bringing the virus in to their home.

3.7 This is underpinned by a rolling programme of Care Assurance visits carried out jointly by senior staff from health and social care to ensure that all guidance is being followed and residents and staff are kept as safe as possible at this time.

3.8 Personal Protective Equipment (PPE) was initially directed to the NHS and Acute Hospitals, and a number of providers were unable to secure sufficient stock of PPE from their suppliers. Additionally, initial guidance on when PPE should be used evolved as more lessons were learned about the spread of Covid-19.

3.9 To ensure support to the care homes with PPE, we established a lead officer for PPE within the Partnership and ensured we have a central hub for distribution of essential PPE supplies across our areas. Care homes have been encouraged to order their PPE from National Services Stores (NSS) however if they have a shortage they can receive additional supplies from our central hub to ensure safety of staff and residents until their next delivery arrives.

3.10 Testing for Covid-19 within care homes was for residents initially and staff testing subsequently followed. Public Health are now leading on a programme of enhanced testing for staff and residents of all care homes. This programme has been started in Forth Valley.

3.11 As of 7 June 2020 there have been 126 deaths recorded in Falkirk which mention Covid-19 of which 61 were in a care home. To date 11 care homes for older people have had 159 residents tested positive and 10 care homes have had no positive cases.

4. Lessons Learned and Next Steps

4.1 We have learned lessons from local and national experiences in care homes where there was a significant Covid-19 outbreak. Following a significant outbreak in one of our care homes we have established a Covid-19 response team which consists of GPs, Advanced Nurse Practitioners (ANPs), Nurses, Public Health staff and carers which can be mobilised should any care home require their support.

4.2 Public Health assumed governance for Care Homes nationally on 17 May 2020. They established the following RAG rating for homes. No positive Covid-19 CASES-Green, 1-2 cases-Amber, 3 or more Red. Where a home has required significant support and intervention these have been rated Purple.

4.3 On receipt of the daily data submission, the HSCP care assurance team, review the information received and follow this up with a telephone discussion, after which we produce a risk rating report on each care home. This is based on the Public Health rating, in addition to the additional information we receive.

4.4 This process has allowed us to provide early support and intervention to care homes rated Green, covering Advanced Care Planning (ACP), infection control and giving them a lead contact within the Partnership should they have any queries or need support.

4.5 For care homes who are rated Amber, the daily contact ensures that residents are being assessed appropriately and the spread of the virus is kept to a minimum.

4.6 Red rated homes are offered direct assistance and support from the GPs/ANPs to ensure their Key Information Summaries are up to date and ACPs are updated if required whilst ensuring regular contact and updates to family members/guardians.

4.7 For those care homes rated as Purple (highest level of risk), they receive the support that Red rated homes have plus the addition of extra staffing from the mobilisation team to ensure an increased level of care can be provided, particularly where home staff are absent from work due to their being Covid-

19 positive.

4.8 At the time of writing we currently have 21 care homes which have a capacity of 942. The current RAG status is as follows:

- Zero are Purple
- Zero are Red
- 4 are Amber
- 17 are Green.

We continue to monitor and support cares on a daily basis.

4.9 A rolling programme of broad testing for Covid-19 is underway, targeting residents and staff within care homes as well as care assurance staff visiting all our homes. The aim of this is to identify Covid-19 early, minimise spread of infection and protect vulnerable residents.

4.10 A care home strategy group chaired by the Consultant in Public Health has a daily teleconference call to ensure oversight of care home scrutiny, testing and support across the area.

4.11 An additional Assurance and Oversight Group, chaired by NHSFV Director of Nursing was established, first meeting was held on 5 June 2020. This group has representation from NHSFV, Director of Nursing, Medical Director, Public Health and the Health and Social Care Partnerships. Its remit is to obtain quality assurance of the care and management of residents within care homes in Forth Valley.

4.12 Care homes that have Covid-19 positive residents remain closed to admissions until they are clear of the virus and all residents and staff are reported negative for Covid-19 after broad testing. Any new admission to a care home is tested prior to admission to ensure they are negative for Covid-19, once again reducing the risk of bringing this virus in to any care home locally. In addition to testing, new admissions to care homes are isolated for 14 days after admission.

4.13 End of life care for people with Covid-19 in many instances presents as an extremely rapid deterioration in their health. To address this a new process has been developed whereby care homes will have Just In Case Medications delivered from the Acute Hospital within an hour, to ensure care can be given effectively and symptom control can be managed in a timely manner. This also reduces the need for care home staff to try to obtain prescriptions from local community pharmacies which can be very time consuming. Local GPs have Just In Case prescriptions in place should any care home resident need them, these prescriptions are available out of hours via Out of Hours GP service.

4.14 A Care Home Assessment and Recovery Team has been established to ensure any resident within a care home who has become unwell can be assessed by a GP or Advanced Nurse Practitioner urgently. This has

reduced footfall from many different GPs within care homes with the intention of reducing risk of bringing infection in to care homes locally. This also ensures consistency in care and direct access to other teams that may be required such as Public Health, Infection Control etc.

4.15 Next Steps - Reflecting on the learning of this work locally, Falkirk Health and Social Care Partnership is developing a Care Home Assurance, Support and Review Team which will enable the continued provision of an integrated approach to care assurance which has proved to be successful at this time. This team will also ensure that care home reviews are undertaken in a timely manner by the appropriate professionals who will have access to any additional support required to ensure resident's care is delivered to a high standard and maintained at that level across the area. This will be a multidisciplinary team that is able to provide a holistic, supportive approach to assessment, ongoing individual care planning, quality assurance and care standards.

5. Conclusions

5.1 The report provides an overview of the work being taken forward to support residents and staff in care homes. This has been a multi disciplinary and multi agency response that has adapted to the pandemic and the issues presented as they arose. The report also notes the work that is ongoing and being developed.

Resource Implications
There are no resource implications from this report.

Impact on IJB Outcomes and Priorities
There is no impact on IJB Outcome and priorities from this report

Legal & Risk Implications
There is no legal and risk implications from this report.

Consultation
There is no consultation required from this report

Equalities Assessment
An equalities assessment is not required from this report.

6. Report Author

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