Agenda Item: 7

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Chief Officer Report**
Meeting:	**Integration Joint Board**
Date:	**16 June 2017**
Submitted By:	**Chief Officer**
Action:	**For Decision**

1. INTRODUCTION

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

2. RECOMMENDATION

The IJB members are asked to:

2.1 note the ongoing discussion on the Support Services requirements

2.2 note work will be overseen by the Leadership Group and Chief Finance Officer, to finalise the HSCP Local Delivery Plan

2.3 note the progress in the development of the GP Fellows role in strengthening community based services and next stages

2.4 note that the IJB will receive further reports on the Primary Care Transformation Fund

2.5 remit the Delayed Discharge Steering Group to present the revised Discharge Improvement Plan to a future IJB meeting as noted at section 7.5

2.6 remit the Clinical and Care Governance group to consider and bring forward recommendations to implement the Duty of Candour requirements as noted in section 10.7

2.7 note the Chief Officer group will submit a joint response on behalf of IJB's to the Safe and Effective Staffing in Health and Social Care consultation and the Chief Officer will report this to the Board for information as noted at section 11.1

2.8 note the duties relating to the IJB and climate change and that these will be progressed by the Leadership Team, with an update to the Board, as set out in section 12.1.

3. BACKGROUND

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

3.2 Progress continues to be made in all the areas as detailed in this report, although there are emerging issues with capacity to respond to the known demands and new areas of work as these emerge.

4. HSCP LEADERSHIP TEAM

4.1. Support Services Arrangements

The capacity requirements of the HSCP, including planning, performance, improvement, business support and workforce development will require a more formalised arrangement to move at the pace required to deliver transformation. This will be addressed in the ongoing Support Services discussions between the Chief Officer and the Chief Executives.

4.2. Adult Social Work Services

A verbal update on the operational issues and actions being taken within Adult Social Work Services will be provided at the Board meeting.

4.3. Local Delivery Plan

The Board has received updates on the work to prepare a draft Local Delivery Plan for consideration. The work has taken into consideration the 9 national health and social care integration priorities and their alignment with the Strategic Plan outcomes and priorities and the logic models. This has been informed by the Strategic Planning Group. This is attached at Appendix 1 for information.

Work is also ongoing to review performance measures, including the 6 national indicators for 2016/18:

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

More work is required than originally anticipated to develop the draft delivery Plan due to the complexity of the budget setting process and the work required to on the 6 national indicators. Following agreement of the budget, work will continue to take place through the Leadership Team to more fully develop the Delivery Plan. This will include where required additional detail on efficiency and savings programmes, with a linked Recovery Plan to be developed.

4.4. **Measuring Performance Under Integration – Ministerial Strategic Group (MSG)**

Integration Joint Boards were asked to set out local objectives for each of 6 indicators for 2016/18 and the Board was previously advised on the submission.

Since then, correspondence has been received on 4 and 18 April 2017 providing an update on the national work. This includes providing a more detailed analysis of the data on local improvement objectives shared by Integration Authorities with the Ministerial Strategic Group for Health and Community Care.

The intention is that the indicators will be submitted quarterly and will be based wherever possible on existing data collection methodologies. The Scottish Government is looking to understand both the contribution of social care and primary care services to high level systems indicators and how they support important outcomes in respect of independent living and the protection and maintenance of health. There is expected to be consistency between National Health Service Local Delivery Plans (LDPs) and Health and Social Care Partnership plans for implementation of their Strategic Plans.

Locally work is being led by the Medical Director through the Unscheduled Care Group and the Chief Officer who will work with the Director of Nursing to develop the measures and plan for end of life care.

5. SERVICE ARRANGEMENTS

5.1. **Staff Engagement Sessions**

A programme of 6 staff engagement events started in May through to June 2017. The sessions have been well attended with a range of staff across the Falkirk Health and Social Care Partnership including Third and Independent sector colleagues. The emerging themes and opportunities for better integrated working will be compiled and considered by the Leadership Team and the OD and Workforce Development Group.

5.2. **GP Fellows Update**

5.2.1. The key national drivers supporting the introduction of GP fellows are:

- Scottish Government's Sustainability and Seven Day Services Taskforce - convened to help deliver on the 2020 vision and the quality ambitions set out in the Healthcare Quality Strategy for NHS Scotland
- Everyone Matters: 2020 Workforce Vision (2013)
- The National Clinical Strategy which set out the ongoing challenges of sustainability of the GP workforce
- The Shape of Medical Training Review (2013) which highlighted that a new kind of doctor was needed to deliver more care in the community to an ageing population. These doctors would require more generic skills enabling them to work across the interface between primary and secondary care
- The 2016 Scottish Government commitment which set out a vision to *'transform primary care, delivering a new Community Health Service with a new GP contract, increased GP numbers and new multi-disciplinary community hubs'*.

5.2.2. Forth Valley's drivers include supporting more people to remain at home through augmentation of Closer to Home, reducing time spent in hospital, providing the most appropriate support for people with complex needs and reducing pressure on General Practitioner [GP] services arising from the shortage of GPs.

5.2.3. Over the last 12 months, a local project group supported by the Efficiency, Productivity, Quality and Innovation Team has been working with the Scottish Government to develop a new model of care involving GP Fellows (Appendix 2). The Fellows will essentially 'bridge the gap' between primary and secondary care, initially providing support for frail elderly patients and those with complex multi-morbidities. Their key focus is to improve outcomes and where possible avoid hospital admission.

5.2.4. The GP Fellowship is a three year programme with year one being funded by the NHS Education for Scotland and subsequent funding being provided by NHS Forth Valley. A Scottish Government allocation has been made available to support the Programme locally during Year One including consultant time for mentoring and project support.

5.2.5. The initial pilot envisaged six GP Fellows being in post from January 2017. Forth Valley successfully recruited five Fellows, three of whom are currently in post, contracted to work a minimum of two sessions a week in General Practice to allow them to remain on the Performers List. It is anticipated that the other two Fellows will return to Forth Valley in Autumn 2017.

5.2.6. The GP Fellows have completed their education and training programme in 2016. On the 9 January 2017 three GP Fellows took up contracts to work as an integral part of the Enhanced Community Team (ECT) providing medical input/intervention. The aim is that this brings to the ECT increased and more complex referrals, strengthening community based services and contributing to the aim of avoiding hospital admissions by keeping people well at home.

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

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

5.1.8. Additionally, each GP Fellow will add value in the system through maximising their enhanced skills and knowledge. For example, their perspective of risk and ability to spread and share learning between primary and secondary care has already been acknowledged as a benefit.

5.1.9. A core project group is meeting monthly to assess the impact of the Fellows within ECT, remove any barriers to progress. The delivery of the model is reviewed and changes made, with a view to a reliable effective model being attained. The progress of the project has been reported to the EPQi Programme Board and the

NHS Forth Valley Corporate Management Team with briefings provided to the Health and Social Care Partnership Chief Officers.

5.1.10. Locally a measurement framework has been developed to assess the impact of key elements of the Closer to Home model and the impact of GP Fellows within the ECT is included in this. It is anticipated that the model within which the GP Fellows are operating will continue to be evaluated and redesigned over the next two years with closer working with acute, primary and community care teams. A key challenge in the evaluation will be to assess the contribution and impact of each part of this complex system of care, existing and new services and, in particular, the role of the GP Fellows within the broader Closer to Home and intermediate care models.

5.1.11. Analysis of Emergency Department and admissions data has provided an assessment of activity as a guide to potential demand, to help plan use of their capacity. A virtual ward round test with front door colleagues was also conducted to assess potential for intervention pre-admission. Analysis of Enhanced Community Team referrals prior to the GP Fellows model going live is available.

5.1.12. The pilot sites have contributed to NHS Health Scotland's evaluability assessment of the community hub concept and theory of change, commissioned by The Scottish Government. A research team at the University of Stirling has been asked by NHS Health Scotland to conduct a qualitative evaluation of the GP Fellow-community hub pilots. This will explore the development and early implementation of the initiative and what impact, if any, it could or has had on patient care and inter-professional working.

5.2. **Advocacy tender**

The Board has previously received a report advising of the Forth Valley arrangements to contract for Advocacy Services. This work is being led by Stirling Council on behalf of the three Councils and NHS Forth Valley. The tender specification document has been reviewed and updated and is currently being finalised. It will be of interest to the IJB to note that an additional section has been added to reflect linkages between advocacy outcomes and the local and national outcomes.

The tender timetable is summarised as follows:

Tasks	**Timescales**
Date of issue of Tender Pack	7 June 2017
Deadline for receipt of queries prior to deadline for submission of ESPD and Bids	12pm on 20 July 2017
Deadline for receipt of ESPD and Bids	12pm on 28 July
Evaluation of ESPD and Bids	28 July – 18 August 2017

Presentations to Service User Evaluation Panel	14 August 2017
Anticipated issue date for Intent to Award letter and rejection letters to unsuccessful Bidders	21 August 2017
Standstill Period	15 days
Anticipated date for contract award	11 September 2017
Anticipated contract implementation commencement date	1 November 2017

6. HSCP CHANGE PROGRAMME

6.1. Capacity Modelling

The partnership is continuing to work with i-Hub and TRIST to take forward work on whole systems mapping. Work has taken place to include the experiences of service users and carers to ensure the lived experience has been taken into account. This will also ensure the improvement activity that will follow will be reflective and informed.

The Board will be aware of the ongoing work through the Reablement group, facilitated by NHS Education for Scotland (NES) as noted in section 6.6. In preparation for the whole systems mapping event in June 2017, a workshop was held with the Reablement Group on 31 May 2017. The aims of the session included:

- An understanding of whole systems mapping for services in Falkirk and the learning for the re-ablement pathway
- Discussion of service user stories and how the ethos of re-ablement can be introduced across the whole system
- An understanding of the high-level outcomes from the evaluation of the re-ablement projects.

A workshop with wider stakeholder groups will take place on 23 June 2017 and invitations have been sent out to a wide range of stakeholders including the Leadership team, Strategic Planning Group and the Unscheduled Care group. The event will receive an update on Phase 1 of the whole systems mapping work, supported by i-Hub and NES and consider the findings to date. There will be discussion on the proposed next stages of this work. Appendix 3 summarises the improvement phases, partnership progress and timeline for this work.

6.2 Adult Social Care Services Change Projects

Falkirk Council has approved an additional one year investment of £325,000 to support Adult Social Work Services change programme. This is supporting additional capacity within the service and the necessary arrangements are being progressed by the Head of Adult Social Work Services.

6.3 **Discharge to Assess**

The Discharge to Assess pilot has been operational from 13 December 2016 and has been extended to 31 August 2017. There are early indications that the pilot aims is preventing avoidable admissions; reducing length of hospital stay and reducing delays in discharge through supported early discharge of people over 65 years for assessment and care at home. There is ongoing work with Performance and LIST analysts to evaluate the project.

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

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

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

6.5 **Primary Care Transformation Fund Update**

The purpose of the Primary Care Transformation fund (PCTF) is to allow testing and evaluation of what primary care models works in individual communities, with a view to spreading out the most successful models of care across Scotland. The funding will encourage GP practices to work together in clusters, as well as taking a multi-disciplinary approach to patient care within the community. This will involve health professionals such as pharmacists, physiotherapists, mental health practitioners and advanced nurse practitioners in delivering aspects of patient care – freeing up GPs to focus on more complex cases and provide clinical leadership". New models of primary care support for people with mental health challenges are central to this fund. Improving access for people with mental health problems to the most appropriate treatment as quickly as possible, in the most appropriate setting is central to the new mental health strategy for Scotland 2017-2027.

The Urgent Care Out-of-Hours Transformation fund is to be used to implement the recommendations from the "Report of the Independent Review of Out of Hours Primary Care Services, 2015". Sustainable primary and community care models, both in and out of usual working hours, are at the centre of our strategic vision and are key underpinning factors in the development of locality models of care. We have immediate challenges with regards sustaining the current model of Out of Hours service and in General Practice, have already delivered transformed models of care in Kersiebank and Bannockburn.

Forth Valley Partnerships submitted joint primary care and mental health transformation plans to Scottish Government in summer of 2016 and were allocated NRAC share of the primary care fund over two years to take these forward (Falkirk Partnership share being £232k PCTF, £165k for Mental Health in Primary Care, £88k Urgent Care, each recurring for two years).

Forth Valley PCTF and MHTF overarching aims:

- transform overnight Urgent Out of Hours Primary Care to a sustainable robust model that provides care to the highest standards of quality through a delivery approach which offers robust alternatives to direct medical input where possible

- enable General Practice to support effective delivery of locality based models of care
- provide proactive support to people identified as High Health Gain Individuals in 3 locality/ cluster areas within 18 months
- increase General Practice Sustainability: Reduce direct GP demand in at least three test areas
- increase GP capacity to lead primary care delivery, managing complex and undifferentiated cases
- minimise (compress/ delay) health decline and Improve Wellbeing people with frailty within the community
- reduce demand on unscheduled care, care homes and other high tariff services.

Further update reports will be presented to future IJB meetings.

7. DELAYED DISCHARGE

7.1 As of the April census date, the following delays were recorded:

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

7.2 Table 1 below shows the total number of standard delays. The April position shows an improving position since January. The numbers of people waiting over 2 weeks has been reducing.

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Total delays at census point	27	23	32	45	51	46	39	35	37	45	38	24	29
Total number of delays over 2 weeks	18	12	18	30	33	29	25	22	26	24	25	17	14

Table 1 (excluding Code 9 & Code 100)

7.3 Table 2 shows the total picture of delays in Falkirk Partnership across all categories expressed as occupied bed days. These figures are for full months to the end of April and show seasonal variation on bed days. Current bed day position is broadly equivalent to April 2016.

	Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sep '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr '17	Equiv Beds (Apr
Standard delays	975	875	854	1247	1468	1463	1393	1376	1247	1252	1171	964	857	29
Complex Delays / Guardianship (Code 9)	277	186	158	256	275	376	454	363	374	377	428	328	273	9

Table 2 - total occupied bed days up to February 2017

7.4 **Delayed Discharge Performance: Additional Target Agreed with Cabinet Secretary for Health and Sport**

Table 3 below shows the Falkirk Partnership performance in meeting the trajectory at the April census point. This shows that the Partnership is currently behind the trajectory.

	December	January	February	March	April
Target	53	44	37	28	28
Actual	46	57	51	31	38

Table 3: Falkirk 2016/17 – Trajectory

7.5 **Discharge Improvement Plan**

The Discharge Improvement Plan is in the process of being reviewed and updated to include additional priorities for 2017/18. A team, led by Brain Slater from the Scottish Government, is supporting the Partnership and Delayed Discharge Steering Group to review the improvement actions being taken forward and advise on any additional actions required to further improve and sustain performance. The revised Discharge Improvement Plan will be presented to a future IJB meeting for information.

7.6 **Monitoring**

The Discharge Hub shares tables of data on a weekly basis to key contacts in the partnership. The LIST team analysts have used this data to create a weekly delayed discharge dashboard which will utilise statistical methods to aid interpretation and present the data in a more visual way. Presentation to the Delayed Discharge Steering Group and the Discharge to Assess Project Board have been arranged to roll this out on a pilot basis. The Delayed Discharge performance report is attached for information at Appendix 4.

7.7 **Winter Beds**

Ward 5, Falkirk Community Hospital remains open due to ongoing and sustained pressure on hospital capacity. An exit plan for the beds has been agreed through the Operations Group of NHS FV and further work is now required to monitor the progress and impact.

8. IJB FINANCIAL UPDATE

8.1 The Leadership group has been meeting regularly and an update on the budget position is detailed in the IJB Financial report at agenda item 8. The financial pressures described in the report require clearer lines of accountability between the managers of in-scope functions and the Leadership Team. This will be included in the ongoing discussions between the Chief Officer and the Chief Executives.

9 INTEGRATION JOINT BOARD ANNUAL REPORT

9.1 The Public Bodies (Joint Working) (Scotland) Act 2014 specifies that a performance report must be produced by an integration authority to ensure that performance is open and accountable and sets out an assessment of performance in planning and carrying out the integration functions for which they are responsible.

9.2 The Scottish Government Guidance for Health and Social Care Integration Partnership Performance Reports in March 2016 reinforces the requirements set out in the 2014 Act and provides detail of the specific matters that require to be reported. The purpose of the performance report is to provide an overview of performance in planning and carrying out integrated functions. This is to be produced for the benefit of Partnership and their communities.

9.3 The guidance stipulates the requirement to publish performance reports from 2016/17 onward. The guidance summarises details of the requirement to publish the performance report within four months of the end of the performance reporting period. Reporting years begin on 1 April each year. For example, a Performance Report covering the period April 2016 to March 2017 is required to be published no later than the end of July 2017.

9.4 Publication should include making the report available online, and Partnerships should ensure that these are as accessible as possible to the public. Partnerships may wish to consider a range of media to engage with the public, illustrate performance and disseminate the Performance Report.

9.5 It is for Partnerships to decide the layout of their own Performance reports. Partnerships are expected and encouraged to include additional relevant information beyond the minimum set out below in order 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 should be presented in a way that is clear for non-experts and should include:

- Assessing Performance in Relation to the National Health and Wellbeing Outcomes
- Financial Performance and Best Value
- Reporting on Localities
- Inspection of Services
- Review of Strategic Plan.

10 DUTY OF CANDOUR

10.1 The duty of candour provisions in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill were given Royal Assent on April 6, 2016. A target implementation date of 1 April 2018 has been agreed. This duty will apply to local authorities and NHS Boards – and for the Integration Authority it will apply to the health and social

care services being commissioned and will be an element of the Clinical and Care Governance arrangements.

10.2 The purpose of the new duty of candour provisions is to support the implementation of consistent responses across health and social care providers 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.

10.3 The principles of candour already inform the approach that is taken in many organisations. The professional duty currently applies to many health and social care professionals across Scotland as this is a part of the requirements of their practice by their professional regulators.

10.4 Regulations will be developed using powers created by Section 22 of the new Act. These will set out the detail of the Duty of Candour Procedure to be followed by each organisation. These Regulations will be legally binding and require the approval of the Scottish Parliament.

10.5 The key principles are:

- Providing health and social care services is associated with risk and there are unintended or unexpected events resulting in death or harm from time to time.
- When this happens, people want to be told honestly what happened, what will be done in response, and to know how actions will be taken to stop this happening again to someone else in the future.
- There is a need to improve the focus on support, training and transparent disclosure of learning to influence improvement and support the development of a learning culture across services.
- Candour is one of a series of actions that should form part of organisational focus and commitment to learning and improvement.
- Transparency, especially following unexpected harm incidents is increasingly considered necessary to improving the quality of health and social care.
- Being candid promotes accountability for safer systems, better engages staff in improvement efforts, and engenders greater trust in patients and service users.

10.6 Guidance will be issued in due course by the Scottish Government to support implementation of the duty of candour part of the Act and outline supportive information on how the Act is applied in practice, including the preparation of an annual report. The Guidance will address how the duty can be integrated with existing processes for responses to complaints, adverse event and incident reporting, which are part of the clinical and care governance arrangements for the IJB, emphasising the requirements for support, training and identification of learning and improvement actions.

10.7 The Board are asked to remit the Clinical and Care Governance group to consider and bring forward recommendations to implement the Duty of Candour requirements.

11. CONSULTATIONS

11.1 **Safe and Effective Staffing in Health and Social Care**

The Scottish Government are consulting on proposals to enshrine safe staffing in law, starting with the nursing and midwifery workload and workforce planning tools. The consultation paper proposes the introduction of legislation that would require organisations providing health and social care to:

- apply nationally agreed, evidenced based workload and workforce planning methodologies and tools
- ensure that key principles, notably consideration of professional judgement, local context and quality measures, underpin workload and workforce planning and inform staffing decisions
- monitor and report on how they have done this and provide assurance regarding safe and effective staffing.

Proposals are intended to:

- strengthen and enhance arrangements already in place to support continuous improvements and transparency in workforce planning and employment practice across Scotland
- enable consideration of service delivery models and service redesign to ensure Scotland's health and social care services meet the needs of the people they serve.
- provide assurance – including for patients and staff - that safe and effective staffing is in place to enable the provision of high quality care
- actively foster an open and honest culture where all staff feel safe to raise concerns regarding safe and effective staffing.

The proposals set out in this consultation document focus intentionally on the application of evidence based approaches to nursing and midwifery workload and workforce planning as there is already a validated framework, methodology and suite of planning tools that are mandated for use in NHS Scotland as part of Local Delivery Planning. However, the consultation proposes that this approach could be extended to other staff groups and care settings when methodologies are developed.

The Chief Officer is a member of a national working group considering these proposals. The Board are asked to note that the Chief Officers group are collating a joint response on behalf of the IJB's to the consultation. This will be submitted by the consultation deadline of 3 July 2017 and will be reported to the Board for information.

12. SCOTTISH GOVERNMENT CORRESPONDENCE

12.1 **Integration Joint Boards and climate change duties**

The Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015, came into force in November 2015, requiring all public bodies classed as 'major players' to submit a climate change report to the Scottish Government. Integration Joint Boards (IJBs) appear on schedule 1 within the Order as 'An integration joint board established by order under section 9(2) of the Public Bodies (Joint Working) (Scotland) Act 2014(c)'.

IJB's all have a strong role to play in terms of overall public leadership and incorporating / embedding climate change and sustainability issues in their day to day operations and within decision making. This could include but is not limited to sustainable procurement decisions; provision of services and role in climate change adaptation such as emergency preparedness, response and health issues when dealing with sudden events such as extreme weather.

It is expected that a degree of proportionality should be applied to the completion of the reports. As each of the local authorities and NHS Boards are also submitting their own climate change report each year on their own operations, there may be areas of the report that are not applicable to the IJB's to avoid the double counting of emissions. For example, section 3 of the report covers emissions, targets and projects which include emissions from assets that are controlled or owned by the body (e.g. utilities and travel).

Health Facilities Scotland and SSN will work together to produce bespoke guidance for the boards on each section of the report which will be produced to coincide with the launch of the online reporting platform.

The key actions for the IJB include:

- Providing details of at least one named contact (name and email address) who will be issued login details to access the form and also be empowered as the main contact on behalf of the IJB for the reporting requirement. This was required by 9 June 2017 and a verbal update will be provided to the Board

- Prepare and submit a climate change report by 30 November 2017. The first report required from the IJB's will be for 2016/17 activities using a standardised online template.

The Board are asked to note that the work required will be overseen by the Leadership Team and an update will be presented to the November 2017 meeting.

13. CONCLUSIONS

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

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

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

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

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

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

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

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

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Approved for submission by: Patricia Cassidy, Chief Officer

Author – Suzanne Thomson, Programme Manager – Falkirk HSCP
Date: 6 June 2017

List of Background Papers:

Falkirk HSCP Local Delivery Plan Strategic Context

Falkirk Community Planning Partnership: SOLD 2016-2020	Falkirk HSCP Local Outcomes 2016 - 2019	National Health & Wellbeing Outcomes	Falkirk HSCP Local Priorities 2016-2019	HSCP Logic Model Activities	9 National Priorities for Integration Authorities								
				SM= Self-Management S= Safe C= Community Based Support	Reduce occupied bed days	Palliative and end of life care	Enhance primary care provision	Mental Health Strategy	Prevention & Early Intervention: Children's Services	Delivery of Alcohol and Drugs Partnerships' work	Living wage implementation	Continue implementation of Self Directed Support	Implement Carers (Scotland) Act 2016 on 1 April 2018
SOLD Outcome and HSCP Vision: People live full, independent and positive lives within supportive communities	Self-Management	Healthier living and Reduce inequalities	We will lead the cultural change required across agencies and communities to support the change necessary to deliver integrated care	SM2 Developing an empowering leadership at all levels to bring about cultural change S3 Strong and distributive leadership C4 Leadership	←								→
			We will redesign services so they are flexible and responsive, ensure feedback drives continuous improvement and are aligned to our outcomes	SM4 Community & individual engagement in service/support/process redesign	●	●	●			●		●	
			We will continue to develop the ways in which we support carers	SM8 Carer training, support, tools, resources & information	●	●	●			●			●
			We will support people to use technology solutions to support them to have more independence and control over their lifestyles and the management of their condition	SM5 Develop & implement technology & redesign care pathways/services/infrastructure and assets C15 Effective use of technology/telecare	●		●						
			We will implement our Organisational Development and Workforce Plan to support our staff and partners though training and organisational development	SM3 Professional engagement, WFD training & case management approaches/roles S5 Staff support, development, training, OD, supervision and peer review C5 Training/WFD (incl. third sector and volunteers)			●			●	●		
			Communication will be central to everything that we do. We will continue to engage with stakeholders to shape our services to meet needs	SM9 Communication & IT systems/processes/shared data S11 Awareness raising/communications campaigns regarding harm	←								→
			We will provide information that enables people to manage their condition is accessible and delivered consistently	SM7 'Patient' training, support, tools, resources & information C12 Housing advice support & provision	●	●	●			●		●	

Autonomy And Decision Making	Quality of life	We will develop a single point of contact for people and their carers to support access to a wide range of information on services across all sectors	SM6 Integrated, joint, single, shared assessment, anticipatory care/care plans, reviews & process SM11 Consistent response at single point(s) of contact/customer care approach C10 Single points(s) of contact(s) appropriate needs based referrals, social prescribing C12 Housing advice support & provision		●	●						
		We will develop one Single Shared Assessment as standard across the Partnership	SM6 Integrated, joint, single, shared assessment, anticipatory care/care plans, reviews & process C9 Single shared assessment/ACP/CP/pathways/reviews/process		●	●						
		We will promote the uptake of Anticipatory Care Plans that reflect the current views of people and their carers. We will ensure this information is shared where appropriate.	SM6 Integrated, joint, single, shared assessment, anticipatory care/care plans, reviews & process C11 Effective discharge to assess process	●	●	●	●		●			
		We will continue to design community based models of care, such as Closer to Home and Advice Line For You (ALFY)	SM10 Additional support for patients & carers where needs escalate SM13 Pilot/upscale projects	●	●		●					
		Information sharing protocols are in place	SM9 Communication & IT systems/processes/shared data S12 Information/data is accurate, provided on time, shared appropriately and highlights concerns/risks C16I T/support for data sharing	←								→
Safe	People are safe	We will ensure there is a greater focus given to individual case management, enhanced by the provision of advocacy support, where required	S6 Develop agreed eligibility thresholds & criteria for service access/care pathways S10 Individual case management, care programme approach, guardians S14 Advocacy for those identified as vulnerable. Crisis support	●	●		●		●		●	
		We will ensure risk is acknowledged and managed effectively and risk based support is in place	S9 Single point of contact, centre for social work & multiagency safeguarding S12 Information/data is accurate, provided on time, shared appropriately and highlights concerns/risks S16 Single shared assessment & review empowers individuals to manage risk effectively	●	●		●		●		●	
		We will continue to work across the partnership to ensure adults at risk of harm are supported and protected.	S1 Ensure safeguarding S11 Awareness raising/communications campaigns regarding harm S15 Heath & care providers/patients and				●		●			

			carers are supported to speak up when they see compromising practice (whistleblowing policy)									
		We will implement our Clinical & Care Governance framework	S2 Implement Clinical & Care Governance Framework S4 Clinical & care governance frameworks across HSCP S18 Internal & external scrutiny of policies, procedures, commissioned & multi-agency services, audit regulated services and improvement responses				●					
		We will continue to invest in Technology Enabled Care as an effective and appropriate way to support care.	SM5 Develop & implement technology & redesign care pathways/services/infrastructure and assets S17 Use technology and systems to improve quality, safety & care	●	●							
		We will pursue co-location of staff and services where appropriate to support integration		←								→
Service User Experience	Positive experience & outcomes Engaged workforce	We will ensure consistent high quality services are delivered, informed by a robust service evaluation framework	SM14 Monitoring & Evaluation S12 Information/data is accurate, provided on time, shared appropriately and highlights concerns/risks S19 Review, impact assess, monitor & evaluate services C17 Pilot, review, monitor and evaluate	←								→
		We will ensure our decision-making processes are consistent, fair and transparent, and are based on reliable information and evidence based good practice	S7 Use tools, processes, codes of practice, evidence, performance management, quality assurance to be a learning organisation S13 All stakeholder design/redesign services based on need C17 Pilot, review, monitor and evaluate							●		
		We will complete Equality and Poverty Impact Assessments for all subsequent changes to policies and services to ensure we identify and address inequalities		←								→
		We will implement our Participation and Engagement Strategy	SM4 Community & individual engagement in service/support/process redesign C7 Engagement/marketing/communication/signposting	←								→

Community Based Support	Independent living Carers are supported	We will establish <u>locality planning structures</u> within the three local areas agreed which will align with the Community Planning Partnership	S20 Maximise links and contributions of wider partners C9 Single shared assessment/ACP/CP/pathways/reviews/process C13 Transport support	←								→
		We will adopt a consistent framework when commissioning services that will build sustainable capacity within all sectors	S8 Agreed, appropriate, consistent approach to mapping, assessment, commissioning & monitoring of commissioned health & social care C1 Core/essential HSCP services – statutory provision C2 Discretionary commissioned services C3 Services/projects essential to achieve outcomes but not responsibility of HSCP C6 Commissioning frameworks/processes that ensure proportionate governance, offer choice and result in flexible, safe services				●		●	●		
		We will build on existing strengths within local communities	SM11 Consistent response at single point(s) of contact/customer care approach C5 Training/WFD (inc. third sector & volunteers)				●				●	●
		We will provide information about community based support is accessible and presented in a consistent manner	C7 Engagement/marketing/communication/signposting C8 Mapping (community directory) review & updating C10 Single points(s) of contact(s) appropriate needs based referrals, social prescribing C12 Housing advice support & provision C14 Specialist, supported, sheltered, adapted accommodation/residential care				●		●		●	●
							Improved mental Health & Wellbeing	**Addressing the impact of poverty in children**	**Minimising the impact of substance misuse**			

Falkirk CPP SOLD Plan: Key Priorities

Box 1: NHS Forth Valley Proposed Pilot of a new Model of Care

The pilot will commence in the Bo'ness, Grangemouth, Braes (BGB) locality for frail elderly patients and those with complex multi-morbidities. Their key focus will be to avoid unnecessary admissions to hospital.

Initially the GP Fellows will provide cover 8am – 6pm, Monday to Friday.

GP Fellows will:

- Be integrated with and provide the medical input to the Enhanced Community Team under the broader Closer to Home model of care, including rapid access to diagnostics.
- Manage at least one step-up hospital bed in Bo'ness Community Hospital.
- Subject to current testing - work with front door colleagues (ED/AAU/CAU) to support comprehensive Geriatric Assessments and facilitate 'discharge to assess' prior to potential admission to ward areas.
- Work two sessions a week (FTE) hosted by a GP Practice to remain on the Performers List.
- Have one session a week (FTE) SPA.

The 'Closer to Home' model of care provides a portfolio of co-ordinated community health and social care services that aim to improve people's resilience at home through linkage with the appropriate care and support. Key elements of this model are:

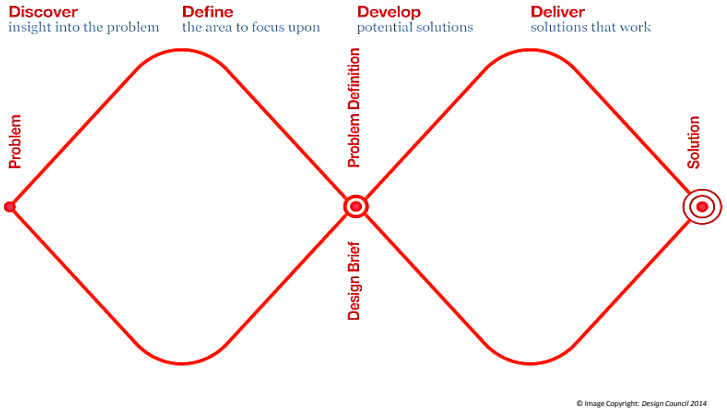
- ALFY – a 24/7 nurse led telephone support line for public.
- Pro-active approach to anticipatory care planning.
- Multidisciplinary Enhanced Community Team (ANP, DNs, night nursing, AHPs, MH nurse) providing seven day urgent, co-ordinated and enhanced response at time of crisis.
- Access to Rapid Access Frailty Service.
- Access to the ReACH, community rehabilitation.
- Intermediate care step up/step down beds as part of a broader rehabilitation care model.

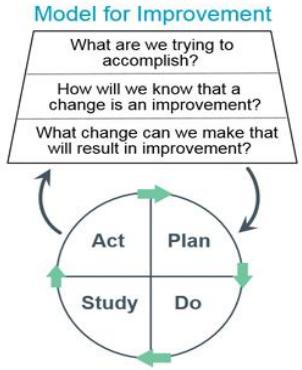
improvement phases

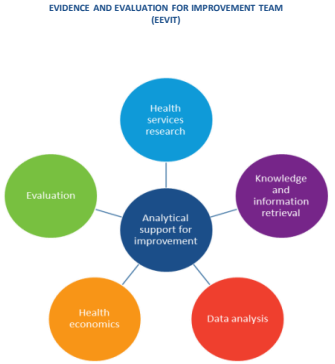
Change management and organisation culture

Third and Independent Sector Engagement: Principles of Coproduction and Human Rights

Understand	Design	Implement	Evaluate
Strategic Planning: Whole System Flow	Transformational Service Redesign	Outcome Based Commissioning	







Start up	Initiation	Delivery	Close	Start up	Initiation	Delivery	Close	Start up	Initiation	Delivery	Close	Start up	Initiation	Delivery	Close

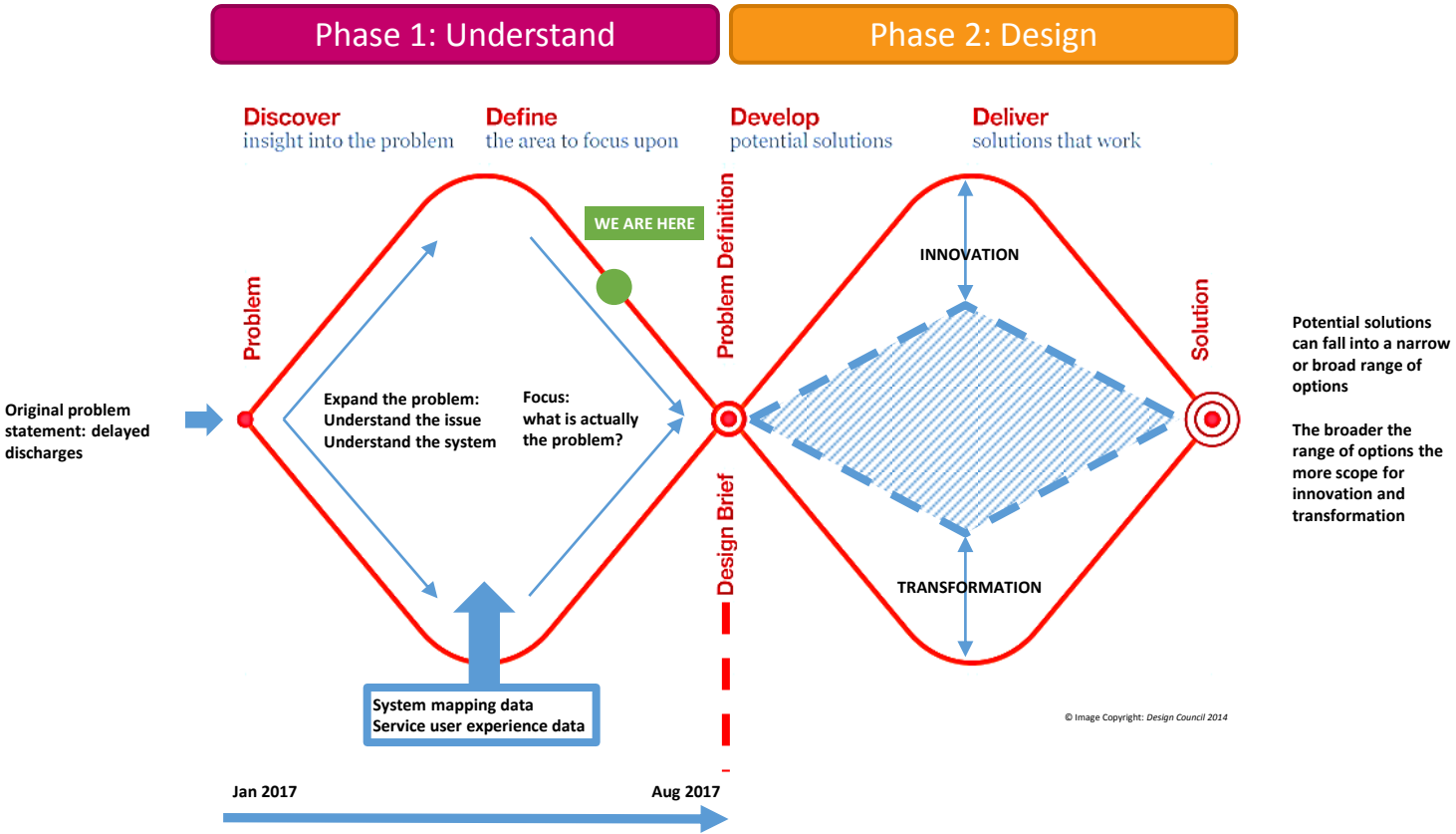
project management stages

Falkirk Health and Social Care Partnership

Understand Phase:

OUR PROGRESS

ihub supporting health and social care



Potential solutions can fall into a narrow or broad range of options

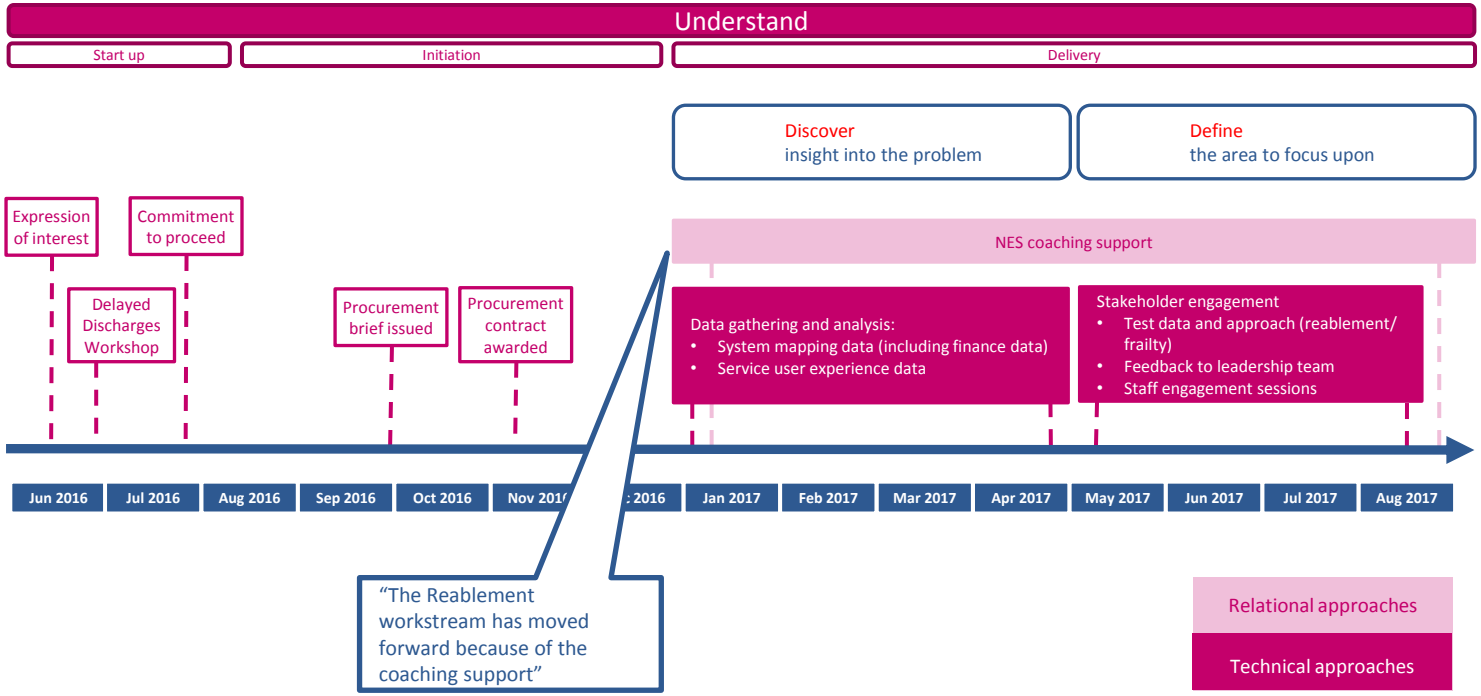
The broader the range of options the more scope for innovation and transformation

Falkirk Health and Social Care Partnership

Understand Phase:

TIMELINE

ihub supporting health and social care



Falkirk Delayed Discharges – Whole System Summary Report
June 2017

Falkirk Health and Social Care Partnership

Please note this report was prepared using data from the ISD delayed discharge census.

Figures presented in this report may differ to other IJB reports, see notes below for details:

Delayed Discharge figures reported in some other IJB reports (e.g. IJB Performance Report) are sourced from NHS Forth Valley's **EDISON System** which counts delays of Falkirk residents in Forth Valley Hospitals.

The **ISD census** collates delays of Falkirk residents in all Scottish Health Boards. Numbers delayed outside Forth Valley are very small and while this makes a minor difference to the overall numbers of delays and bed days occupied it is important to document all delays that the partnership are responsible for.

Please note that the ISD Census generally runs two months behind so data presented in the IJB performance report will be more up-to-date than the delayed discharge data presented below.

Last updated - 22/05/2017

For further information on data presented in this summary report please contact Ross Lawrie

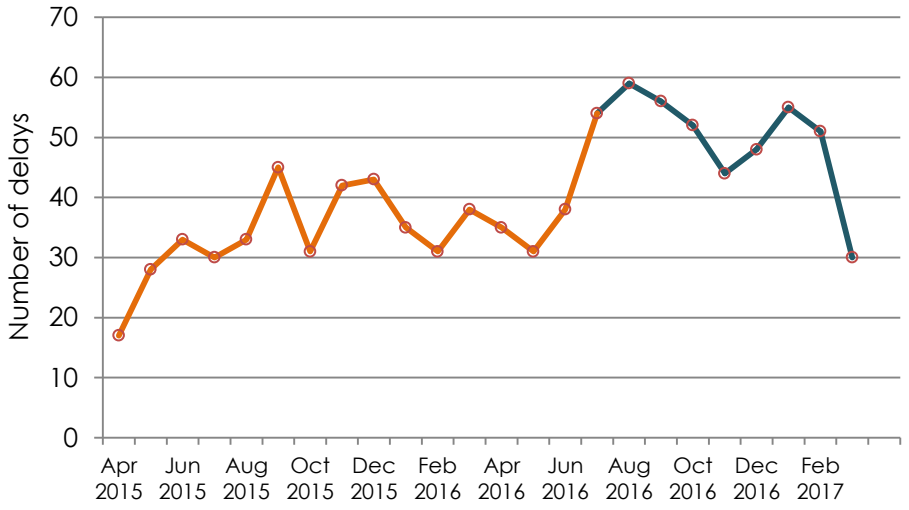
Email: Ross.lawrie@nhs.net

1

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

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

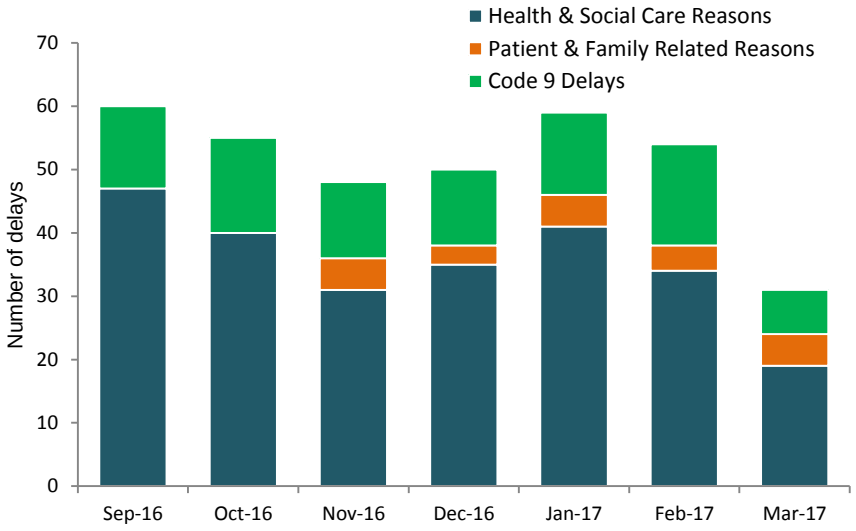
Source: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/data-tables.asp?id=1681#1681



2

Primary Reason for Delay – Falkirk Sep 2016 to Mar 2017

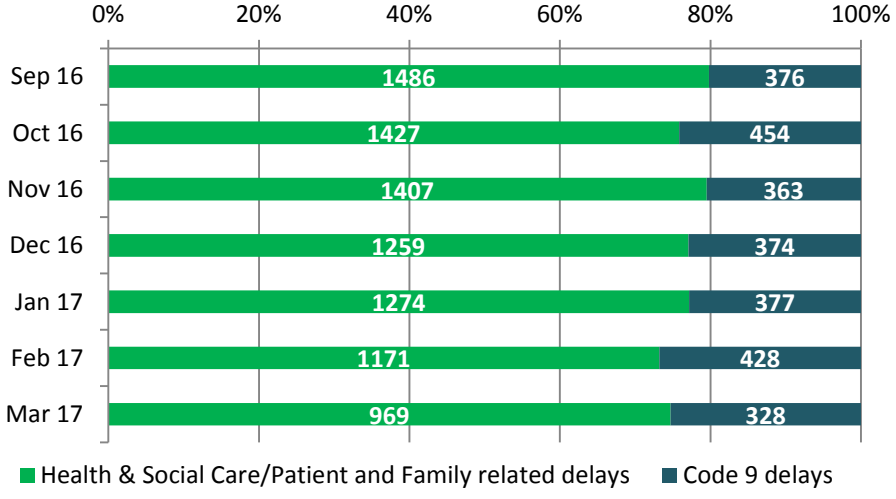
Source: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/data-tables.asp?id=1681#1681



3

Delayed Discharge Bed Days – Falkirk Sep - Mar 2016/17

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

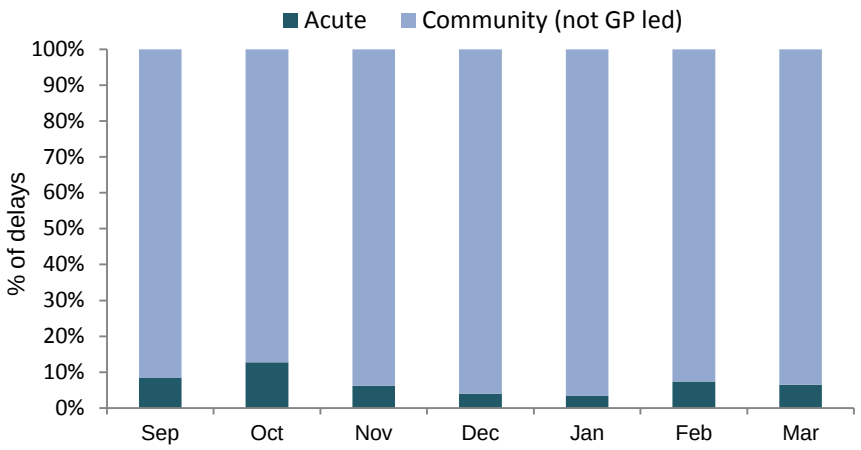


4

Primary Reason for delay	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Total delays at census point	**48**	**50**	**59**	**54**	**31**
Total health and social care reasons	**31**	**35**	**41**	**34**	**19**
Assessment	5	7	15	11	6
Place availability	20	21	20	14	10
Care arrangements	6	7	6	9	3
Total Patient and Family reasons	**5**	**3**	**5**	**4**	**5**
Disagreements	4	2	4	4	5
Legal/Financial	1	1	1	-	-
Total code 9 delays	**12**	**12**	**13**	**16**	**7**
Adults with incapacity (AWI)	6	7	6	8	3
Other code 9 reasons (not AWI)	6	5	7	8	4

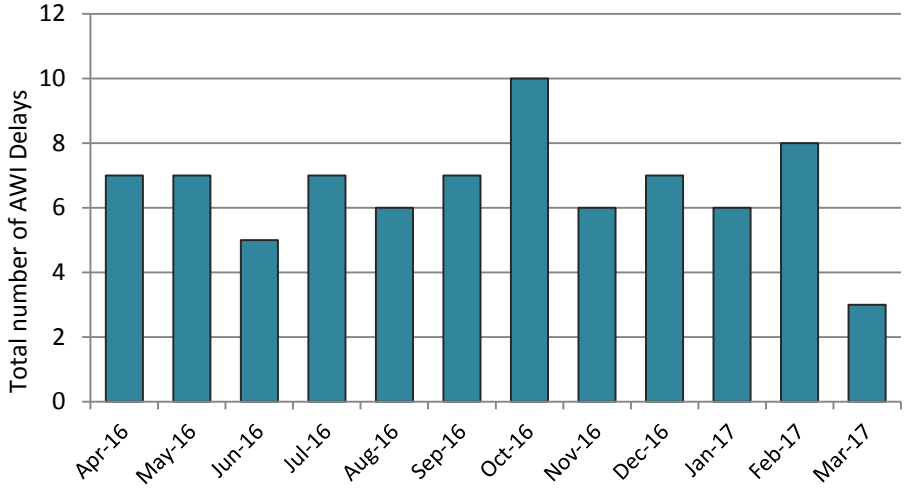
5 Delay Location – All Delays in Falkirk Sep 2016 to Mar 2017

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



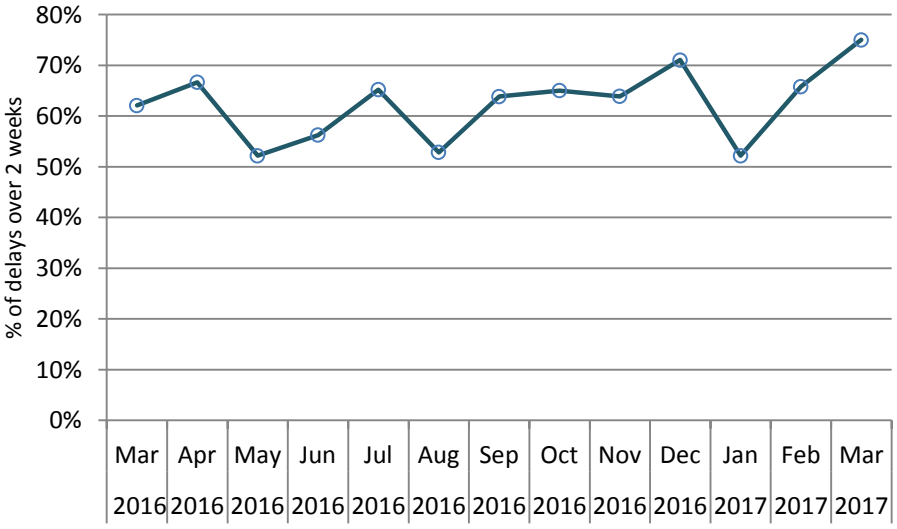
6 Number of delayed discharges in Falkirk coded as Adults with Incapacity (AWI) – April 2016 to Mar 2017

Source: Delayed Discharges Team - ISD



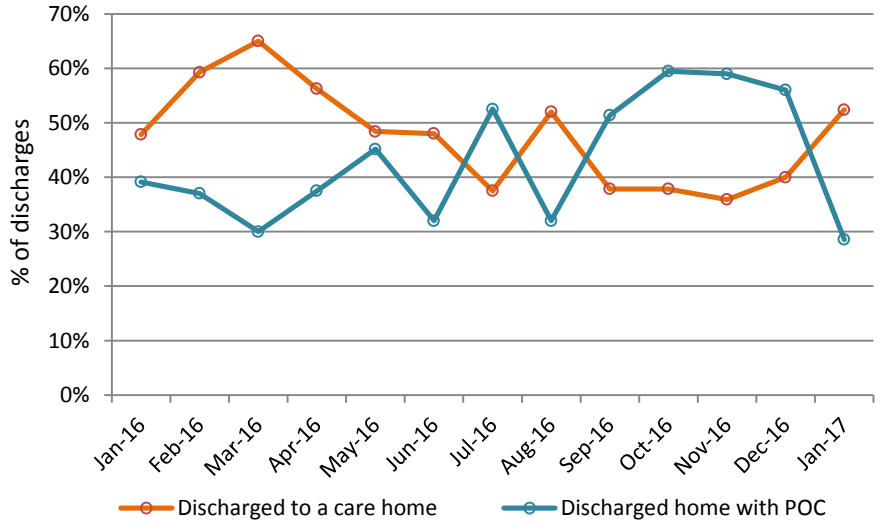
7 Percentage of Falkirk delays (excl. Code 9) that were over 2 weeks (Mar 16 – Mar 17)

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



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

Source: Gina Anderson - Social Care Team Manager

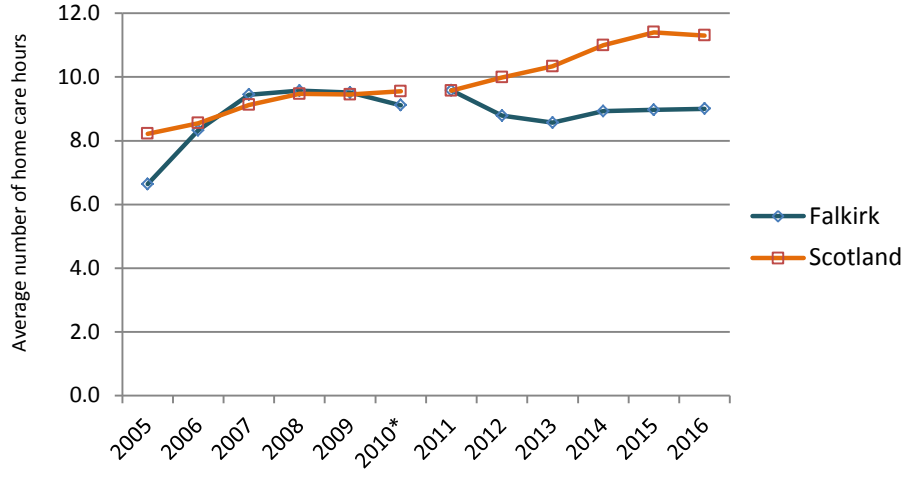


* Includes all adults over 18 years old who were resident in hospital and referred to Social work, whether a delayed discharge or not.

9

Average Home Care hours per client [2,3]

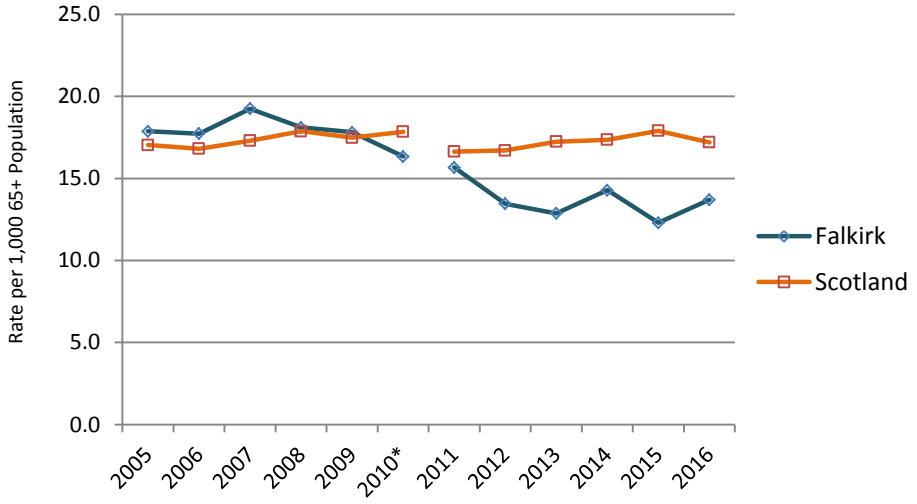
Source: http://www.gov.scot/Topics/Statistics/Browse/Health/Data/Homecare



10

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

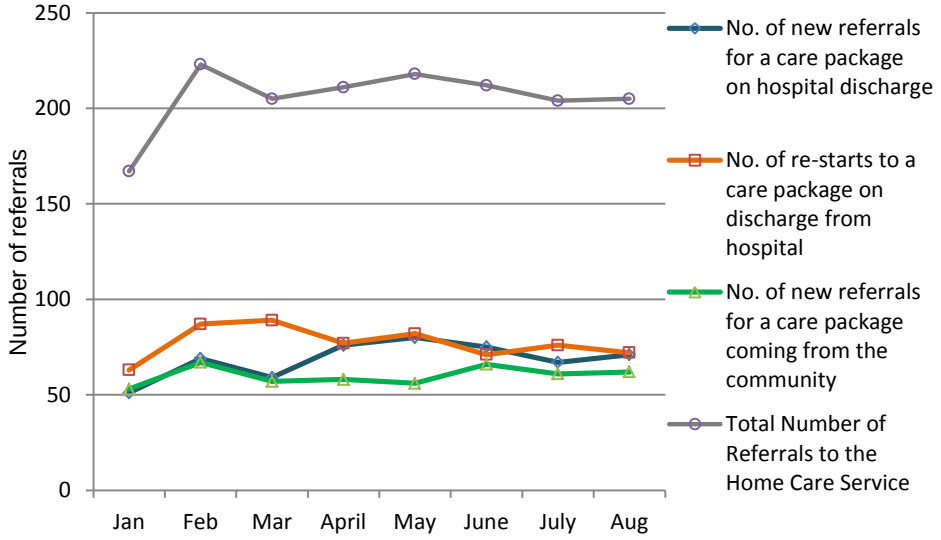
Source: http://www.gov.scot/Topics/Statistics/Browse/Health/Data/Homecare



11

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

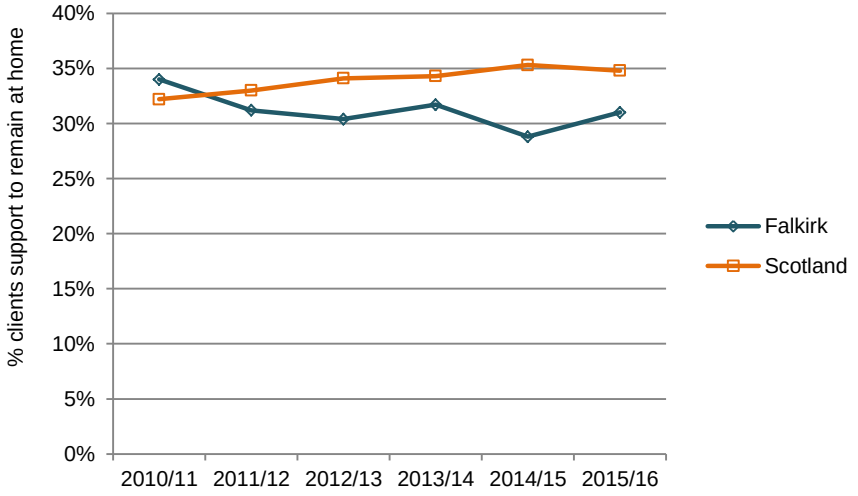
Source: Falkirk Social Work Services



12

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

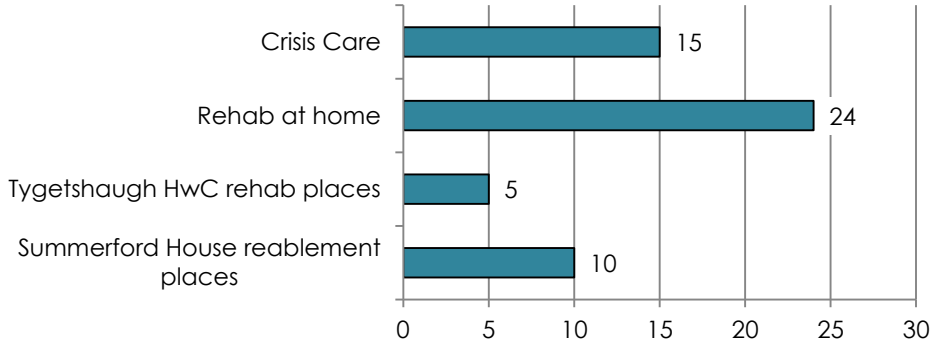
Source: http://www.improvementservice.org.uk/benchmarking/tool.html



13

Falkirk Intermediate Care / Reablement maximum capacity at March 2017

Source: Falkirk Social Work Services



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

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

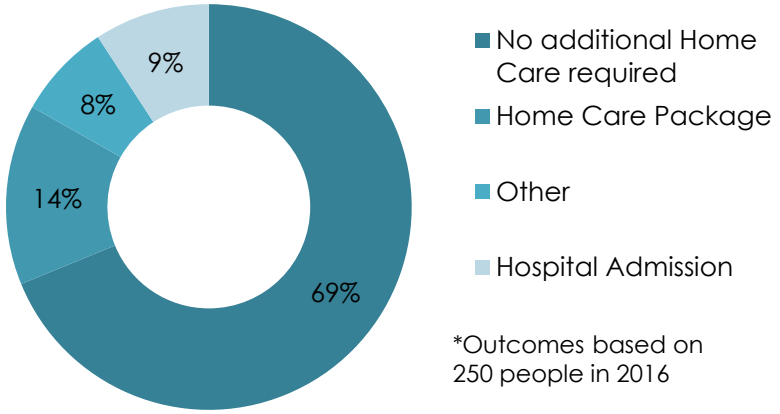
*** Summerford House is under refurbishment to accommodate the 10 IC beds lost due to the closure of Oakbank.

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

14

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

Source: Social Work Services 24/7 Team



*Outcomes based on 250 people in 2016

15

Summerford House Intermediate Care – 2016/17 Quarterly Performance

Source: Kenny Moran – Centre Manager Summerford House

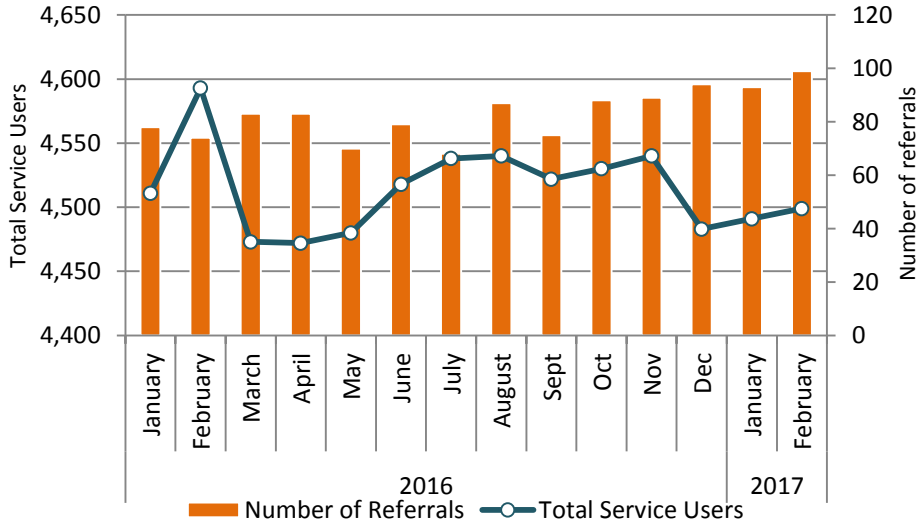
	Q1 2016/17	Q2 2016/17	Q3 2016/17
Number of new admissions	14	10	15
Number discharged home with POC	8	7	9
Number discharged home without POC	1	0	1
Number readmitted to hospital	3	2	2
Number identified to require Long-term care	2	1	0

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

16

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

Source: Kenny Moran – Centre Manager Summerford House



KEY POINTS – June 2017

- At the most recent Census date there were **31 patients delayed in their discharge** (Fig 4.) In March 2017, **1,297 bed days** were occupied by delayed discharge patients.
- The top reason for delayed discharge at the last census date was 'place availability' (Fig 4.) which accounted for 10 of the delays. However it should also be noted that in the most recent census month of March, delays due to place availability reduced to 50% of the number in January.*
- In 2016, 69% of clients required no additional Home Care at the end of rehab at home (RAH) (Fig 14.)

*Census figures

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

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

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

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

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

[P] – Provisional data.