Agenda Item: 7

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Chief Officer Report**
Meeting:	**Integration Joint Board**
Date:	**6 October 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 initial progress in the development of a draft structure and the outline timeline for the implementation of an integrated management and locality structure, including the required support services

2.2 request the Director of Nursing and Chief Officer to bring a more detailed plan for consideration at the next Board meeting in December

2.3 note a Board Development session will be held on 3 November 2017 to provide an overview of the Priority Setting Framework Project

2.4 note the Advocacy Award of Contract has been issued by Stirling Council on behalf of the partnership

2.5 note the work to establish the Locality Development Groups and that an update will be provided to a future Board meeting

2.6 note the contract extension to the Discharge to Assess provider until the end of October 2017 and that the tender process is underway for the provision of the Discharge to Assess model from end of October 2017 to end of March 2018

2.7 remit the Chief Officer to approve the Winter Plan 2017-2018 for submission to the Scottish Government

2.8 note the AHP Strategy and the establishment of a Delivery Group to implement the strategy

Falkirk Council

NHS Forth Valley

2.9 note the update on Regional Planning

2.10 remit the Audit Committee to consider the Audit Scotland Self Directed Support Progress Report 2017 and self-assessment as detailed in section 10.4

2.11 note the HSCP consultation response to the Carers Draft Regulations and that a response to the Carers Charter will be submitted by the Chief Officer

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.

4 HSCP LEADERSHIP TEAM

Development of an Integrated Structure and Support Services Arrangements

4.1 In order to expedite the delivery of the strategic plan, it was agreed at the last meeting of the IJB that the Director of Nursing would lead work to develop a draft integrated structure and associated support services. Since the last meeting a number of key staff have been on sequential periods of annual leave and it has been difficult to progress this work at pace.

4.2 Initial meetings have taken place. The Falkirk HSCP draft proposed structure has been further developed and the NHS General Managers have undertaken some scoping work. Discussions need to take place with the Clackmannanshire and Stirling IJB Partnership to agree with NHS Forth Valley colleagues which area wide services are hosted within each partnership.

4.3 As outlined in section 8 of this report it is critical that operational and budget management of services is aligned.

4.4 The Director of Nursing and Chief Officer will bring a more detailed project plan for consideration at the next Board meeting in December.

4.5 **Priority setting framework**
Following IJB approval to participate in the research project, a briefing session for Board Members will take place on 3 November 2017. This will be led by Professor Cam Donaldson from Glasgow Caledonian University and will provide an overview of the project. The project will run over 3 years during which time the HSCP anticipates direct benefits in supporting decision making and strategic commissioning.

5 SERVICE ARRANGEMENTS

5.1 **Update on Independent Advocacy Contract**

The Board has received previous reports on the Independent Advocacy contract. Following a tender process led by Stirling Council, including Falkirk and Clackmannanshire Councils and NHS Forth Valley, an award has been made. The successful provider is Forth Valley Advocacy and this will ensure continuity for people who currently receive advocacy services.

5.2 **Locality Planning Arrangements**

The Board will be aware that to date there has been a range of work undertaken in relation to planning for locality working. This activity has included:

- analysis of statistical information in relation to the demographics of each of the 3 localities
- budget analysis
- scoping of services and staff resource in each locality
- consideration of structural model.

5.3 Taking the above into account, Service Managers responsible for Community Care; District Nursing, Mental Health for Older People and Care and Support at Home teams will work together with middle managers. Together they will establish Locality Development Groups to facilitate local, quality dialogue in the 3 locality areas.

Core membership of these groups will include:

- Community Care Team Manager
- Clinical Nurse Manager District Nursing
- Team Manager - Care and Support at Home
- GP locality co-ordinator
- AHP lead
- Housing Manager
- CVS representative
- Carers Centre representative.

5.4 The 3 Locality Development groups will consider and explore the key questions and tasks over the course of 4 meetings before the end of February 2018. These will include:

- current examples of integrated/joint working
- who is involved?
- is it happening regularly and consistently?
- what are the outcomes achieved?
- how can your locality engage service users and carers in the development of a locality model?
- each locality to gather information regarding local community resources/groups in order to develop a local directory
- each locality to understand links to Community Planning Partnership and SOLD plan

- what outcomes does each locality aim to achieve?
- each locality to consider opportunities for more frequent front-line practitioner interaction/dialogue and integrated working
- each locality to consider how best to link with specialist services e.g. integrated LD team and Integrated Mental Health teams.

5.5 The IJB will receive an update on the Locality Development groups once the above noted work has been completed.

5.6 **Falkirk Community Justice Partnership**
The IJB previously received a report in June 2016 noting the implications of the Community Justice (Scotland) Act 2016 for IJB's. For the purposes of the Act, the IJB are identified as a Community Justice partner. As a partner, the IJB is required to engage in the planning and delivery of services. The Chief Officer represents the IJB on the Falkirk Community Justice Partnership (CJP), which sits within the Community Planning Partnership structure.

5.7 People with lived experience of Community Justice Services often have a range of needs. These will require partnership working between the IJB and CJP to ensure people access and make use of relevant services to address areas of need such as physical and mental health, housing, social welfare, education and employment.

5.8 The Falkirk Community Justice Partnership has been successful in recent funding bids, as noted below:

5.9 **Aspiring Communities Fund**
Led by Cyrenians, stage 1 of the Prepare, Support and Sustain (PSS) project aims to scope out what the needs, skills, assets and deficits are across Falkirk for people coming to the end of their involvement with the criminal justice system who wish to access volunteering or work opportunities. Stage 1 of the project will run for a six month period during which time we will engage with service users, communities and organisations in order to develop a business case to run stage 2 of the project as a pilot. The project aims to dispel some of the myths about people with convictions and strengthen relationships with local employers to create a greater range of work placements. The project will work in partnership with CVS Falkirk to maximise the volunteering opportunities available to our cohort. An important aspect of the project aims to sustain placements by using a buddy system to support both the individual and the organisation. The post of project co-ordinator is currently out to advert on the Cyrenians website with links through Goodmoves voluntary sector recruitment and CVS Falkirk.

5.10 **Employability, Innovation and Integration Fund**
The Tackling Inequalities and Improving Outcomes project aims to reduce health inequalities and improve the health and wellbeing of people in the criminal justice system in order to improve their ability to engage in employment and training. The project builds on a model of practice that is already established in Falkirk currently for our female clients. The project aims to work with people to improve their mental health, deliver anticipatory care through keep well assessments, liaise with other health professionals over compliance and changes to medication, liaise with psychiatry and psychology and work with criminal justice and employability services to jointly plan supported pathways to employment. The project aims to establish a

health and wellbeing steering group to oversee health and wellbeing improvement across the whole criminal justice cohort. This project will run for approximately 18 months and will include a formative evaluation.

5.11 Oversight if these projects will be through the Community Justice Partnership who will receive regular progress reports at their meetings.

5.12 **Older People's Day 2017**
CVS Falkirk is leading in the organisation of an Older People's Day 2017 drop-in event for the Partnership. This free event will take place on Friday 29 September 2017 at the Archibald Russell Centre, Dennyloanhead.

6 HSCP CHANGE PROGRAMME

6.1 **Understanding our System**
The Board will be aware of the work completed under the heading "whole systems mapping", and of previous updates that have been provided.

6.2 Following an event held on 23 June 2017, a report on the first phase of the collaborative programme of work with i-Hub has been produced. This is attached at Appendix 1 for information.

6.3 During phase 1 of this work the ihub provided the following support to Falkirk HSCP:

- Whole systems mapping to understand the health and social care system
- Leadership and workforce development via coaching support provided by NHS Education for Scotland (NES)
- Service user and carer engagement via the ihub's person-centred care programme.

6.4 The work completed during phase 1 of this project has suggested that a key part of the care pathway is the Reablement service. Work has been undertaken with a group of managers focused on the redesign of Reablement services both in terms of mapping the system and also in relation to the provision of coaching support. This work has contributed to a state of change readiness which suggests that it will be appropriate to undertake further work in this area. It is therefore anticipated this will be the focus for phase 2 of the project, connecting this work to other change initiatives, some of which are set out in this report, including the links to the AHP Strategy, which is reported at section 9.7.

6.5 Given there are a number of other change initiatives currently being planned/ undertaken which will impact on this work, consideration will be given by the Leadership Team to ensure the required capacity and priority is in place. These change initiatives include:

- Frailty at the Front Door collaborative
- Primary Care Transformation Programme and Mental Health Transformation Programme
- Review of Community Hospital

- "Developing and Evaluating an Economic and Ethico-legal Framework for Priority Setting in Health and Social Care" work being undertaken by the Chief Scientist Office and Glasgow Caledonian University Housing - Adapting for Change Site; complex needs and hospital use depth work; step up/ step down pilot site; OT integration/ service review.
- Strategic Commissioning review
- Care at Home contract
- Eligibility Criteria and RAS implementation
- Carers Act implementation.

6.6 **Eligibility Criteria**

The Board has received previous reports on eligibility criteria. The report to the IJB on 2 December 2016 outlined the background and legislative context to the necessary changes and approved a consultation exercise to test out the revised criteria. On 16 June 2016 the IJB approved the implementation of the revised Eligibility Criteria framework, following a comprehensive consultation process. The following provides an update on the process and actions in place to support implementation.

6.7 Falkirk Health and Social Care Partnership is committed to supporting people in Falkirk to achieve better personal outcomes. This is within the context of the Social Care (Self Directed Support) (Scotland) Act 2013, based upon an eligibility criteria framework which enables the achievement of improved personal outcomes; and a coherent approach to the allocation of financial resources based on transparency and equity.

6.8 The implementation programme will entail training and development for Social Work Adult Services staff and awareness raising for relevant staff working across partner agencies. There is a requirement for some small scale adaptations to our IT recording systems. There will be a programme of communication with elected members, our partner provider organisations and stakeholders more widely. The new approach to resource allocation and the use of an Individual Budget Calculator will be tested and reviewed with an initial review report completed for February 2018.

6.9 **Primary Care Transformation Programme**

In the period since Falkirk IJB approved the Primary Care Transformation Programme there has been significant progress within the work streams both in Falkirk West and Urgent Out of Hours Primary Care. The following provides a summary of the work that has taken place:

General Practice Sustainability in the Falkirk West Locality

- A GP sustainability workshop was held with all GP practices in the Falkirk West Locality on the 5 September 2017. The focus of this work was to engage with the GP practices directly to identify sustainability challenges and priorities which would provide direct benefit to practices.

- The outcome from this workshop has informed a proposal for improving access for mental health in primary care by the introduction of mental health nurse practitioners, Community Psychiatric Nurses (CPNs) to test a practice based model which effectively redirects GP day to day workload and provides improved access and signposting to the right support earlier.
- This proposal will build on a strong history of community based supports for mental health and existing models of support for mental health in the Falkirk area, including highly valued social prescribing supports in some practice areas provided by FDAMH. A vision for developing mental health supports through the stepped approach to mental health care is fully supported by general practice, beginning at the earliest point of intervention with the right person in the right place.

Urgent Out of Hours Primary Care

- The GP Urgent Out of Hours Working group concluded the analysis work on overnight care
- The findings have informed the immediate workforce model requirements across the whole service and identified future need to align within a wider community out of hours model.
- A proposal outlining the rationale for the introduction of Advanced Nurse Practitioner (ANP) training posts and paramedic specialists was made to the primary care transformation group, Falkirk Leadership Team, Clackmannanshire & Stirling Joint Management Team in September and is due to go to NHS Forth Valley Corporate Management Team.
- We have however lost Dr Anna Lamont who has contributed significant leadership to this work, as OOH clinical lead. Anna has taken up a seconded post of Associate Medical Director with NHS 24.

6.10 **Frailty at the Front Door Collaborative Proposal**

NHS Forth Valley has submitted an application to Healthcare Improvement Scotland to take part in an 18-month improvement collaborative – the Frailty at the Front Door Collaborative. The aim of this collaborative is to improve the processes for identifying frailty and coordinating care to deliver better experiences and outcomes for people living with frailty. While this specific work is focused on the front door of acute care, it is driven by an approach that recognises the importance of thinking about flow across the whole system. Getting the care pathway right for older people and people living with frailty in acute care has a wider impact on the whole system.

6.11 The collaborative will work in synergy with a range of programmes across the ihub, including Living Well in Communities, to ensure a joined-up approach to frailty identification and management. It will also work in collaboration with the Scottish Government and other national improvement initiatives to support improvements across the pathway of care. Taking this integrated approach to improvement will maximise opportunities to improve quality, experience and flow while contributing to the aims of the Health and Social Care Delivery Plan.

6.12 There is compelling evidence to support the benefits of early and effective comprehensive geriatric assessment, reablement and intermediate care for people living with frailty. However, optimal outcomes are only achieved when community health and social care services and hospital systems are fully aligned and well-coordinated, and care and support are attuned to the specific needs of people living with frailty.

6.13 iHub plan to recruit three NHS boards to work with them to improve the way frailty is coordinated at the front door of acute care through a collaborative approach. The key dates are noted below:

Milestone	Date
Applications open	18 July 2017
Closing date for applications	18 August 2017
NHS board interviews	4 October 2017
Successful NHS boards informed	October 2017
Collaborative Programme starts	October 2017 – April 2019

6.14 At the time of preparing the report NHS Forth Valley has received confirmation that they have been shortleeted. The interview will be held on 4 October 2017 and the Board will be advised of the outcome when available.

6.15 **Discharge to Assess**
The Discharge to Assess pilot has been extended to October 2017 and the tender has been issued for the period October to March 2018. This approach will ensure the model of service runs consecutively until the end of March 2018 when the new Care at Home tender will be in place. Funding to support the new contract extension has been identified from an underspend in the Adult Social Care budget and Leadership Fund as reported in the IJB Budget Recovery Plan at agenda item 7. From April 2018 this will be incorporated into the budget as part of the new Care at Home tender process.

6.16 **Information and Data Sharing Update**
There has been a significant level of work undertaken by the Data Sharing Partnership (DSP) and IT colleagues across councils and health, in the last 12 months. This work-plan supports a number of integration strategic strands with a focus on enabling information sharing and access across the care settings.

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

6.18 In relation to supporting Delayed Discharges there has been key work underway to plan for the replacement of the delayed discharges system and to tighten up on information flows across council and health settings. The replacement computer system is expected to be in place by early 2018. In addition there has been work to support Day of Care audit in community hospitals. This is a monthly review working with Discharge Co-ordinators helping provide information of the underlying reasons for delay.

6.19 Considerable work has also been undertaken to agree Single Shared Assessment (SSA) information and this has been led by clinical operational leads working with Information and IT colleagues. This allows important SSA information to flow electronically between practitioners in health and social care across the system. There is still further work to do to integrate information into the electronic systems which are expected to be addressed when new Community and Social Care systems come into play over the next 2 to 3 years.

6.20 There has been considerable discussion and work around developing a Health and Social Care Information Sharing Portal to support clinical services. This is currently at the "Business Requirements Gathering" stage following the desire from both health and social care partnerships to progress with a full detail specification rather than a proof of concept stage. This will be a significant piece of work going forward and will require a full project board and resource commitment to take to the next stage of procurement and market test.

6.21 In relation to Information Portals, the Data Sharing Partnership recently organised a demonstration by NHS Lothian colleagues on work that they had done around information sharing for clinical service requests and how this had been streamlined across the various council and health settings. Whilst focusing on a specific aspect of Health and Social Care interaction, the presentation was well received and will be considered as part of the wider portal requirements.

6.22 Work continues with the establishment of information sharing needs and requirements of the IJBs. In particular over the last few months more detailed requirements have been developed covering access to shared files, printing, and electronic workflow improvements. These are being reviewed by technical leads within Health and Local Authorities to agree the various solutions taking account of the security and infrastructure constraints.

6.23 Information Governance - The Joint Data Protection Officers Group and the Information Governance workstream have been merged and now form the Forth Valley Information Governance Group. They are involved in a range of work including the development of procedures for Subject Access Requests, Freedom of Information Requests, information sharing procedures, and SLA's.

7 DELAYED DISCHARGE

7.1 The Delayed Discharge update is included in the Performance Framework Report, as a separate agenda item 12.

8 IJB FINANCIAL UPDATE

8.1 The Leadership Team has been meeting regularly and an update on the budget position is detailed in the IJB Budget Recovery Plan at agenda item 8. The financial pressures and risks described in the report continue from the previous reporting period. The Chief Finance Officer is working closely with finance colleagues in the NHS and the Leadership Team to firm up their plans for the delivery of savings and to identify proposals to address the budget shortfall. This is a key risk and area of

concern. In 2017 each partner was responsible for balancing their budget. The IJB now has the responsibility to manage the combined budget including the pressures across the in-scope functions.

8.2 NHS operational managers and budget holders are managing a mixture of budgets across the NHS and both IJBs making it difficult for them to report and take action separately on the IJB elements of their budget. The IJB is creating different requirements and demands which can appear burdensome on managers still working within pre IJB structures and reporting lines. It is imperative and that the operational management restructure is developed at pace and agreed alongside a revised budget structure to reflect the partnerships' reporting requirements. This will be crucial to manage risks effectively.

8.3 In the interim the Leadership Team requires to identify solutions to address the on-going risk through the development of a robust Budget Recovery Plan. The options available to the Board are detailed in this report on the agenda.

9 SERVICE PLANNING

9.1 **Winter Plan**

The Scottish Government issued DL (2017) 19 – Preparing for Winter 2017/18 guidance on 11 August 2017. The purpose of the guidance was to help to ensure that Health and Social Care Services are well prepared for this winter.

9.2 Winter Plans should provide safe and effective care for people using services and should ensure appropriate levels of capacity and funding are in place to meet expected activity and demand. This will support service delivery across the wider system of health and social care

9.3 Preparation of the Winter Plan 2017-18 is underway, with an initial draft lodged with the Scottish Government, as per the timetable below. The draft plan was prepared with input from health and social care colleagues. Many of the actions are drawn from the unscheduled care sections of the Local Delivery Plan 2017-18, which also aligns with the actions in the Improvement Plans prepared by both Health and Social Care Partnerships. In addition, there are further actions outlined in the Winter Plan, associated with further demands present in the winter, and particularly over the festive period, and actions associated with flu, norovirus and respiratory conditions. The Winter Plan also refers to resilience arrangements, performance management, information and communications. The NHS Forth Valley Communications Department will lead a winter health communications campaign.

9.4 The operational and support services leads for the Winter Plan, who are responsible for operational delivery of aspects of the plan, have been asked to review the draft plan and submit any improvements or amendments. In particular, it is essential that all relevant services confirm that they will have staffing rotas in place by the end of October for the winter and especially for the festive period, which includes two 4-day "breaks". This is to ensure that sufficient resources are in place across health and social care to avoid hospital admissions where possible, and where admissions are necessary, to care for patients back at home or closer to home, as soon as appropriate. It is essential that services pull together and that a

shortfall in staff availability in one area must not have a detrimental impact on the ability of another service or department to meet the additional demands of winter.

9.5 The Unscheduled Care Programme Board, chaired by Dr Andrew Murray, has representation from health and social care and will take responsibility for agreeing and monitoring the Winter Plan. Formal sign off for the plan will be through the IJBs and the NHS Forth Valley Performance and Resources Committee on 31 October. The Winter Plan will be submitted to the Scottish Government on 31 October. Given the Winter Plan is still under development. The IJB are asked to remit the Chief Officer to approve the plan for submission to the Scottish Government. The finalised plan will be circulated to the Board for information.

9.6 Winter Plan Timescale 2017-18

Date	Item
29 Aug – 12 Sep	Send draft Winter Plan to FV Health and Social Care leads
31 Aug	Submit draft Winter Plan to SGHD
14 Sep	6EA National Event – Preparing for Winter
26 Sep	Unscheduled Care Programme Board Meeting
2 Oct	Deadline for comments, additions and amendments from operational and corporate Winter Plan Leads
6 Oct	IJB Meeting (Falkirk) – Chief Officer Report – update on development of plan
18 Oct	IJB Meeting (Stirling & Clacks) – Chief Officer Report
31 Oct	Performance and Resources Committee
31 Oct	Submit Winter Plan to SGHD

9.7 **AHP Strategy 2017**
A programme of work was commissioned by NHS Forth Valley Corporate Management Team (CMT) in November 2015 that aimed to consider the contribution made by Allied Health Professionals (AHPs) to both corporate and professional priorities.

9.8 Phase 1 (Jan – Mar 16) considered visibility and impact of AHPs. The work involved an inclusive process of questionnaires and individual interviews of a range of stakeholders across health, social care and education.

9.9 The outcomes of that phase showed that while those who work with AHPs value their input, most people were unaware of the breadth of work that AHPs undertake, were unsure that there was robust evidence of their impact and were unsure about their visibility and impact at higher levels within the NHS Board and within HSC Partnerships.

9.10 In response to this, the second phase of the work (Jun – Dec 16) considered

(i) how the AHP contribution to delivery of local and national strategy could be maximised and made more visible and how impact could be more clearly demonstrated

(ii) how we can provide a consistent and robust method of assurance of person centred care and professional practice for AHPs
(iii) the professional leadership arrangements required to deliver (i) and (ii).

9.11 Phase 2 involved a number of workshops with AHP staff across health and social care to debate and develop a collective position on the above. An engagement event presented the outputs from this phase for staff comment and validation. AHP leadership capacity has been freed up to provide some focussed leadership to the work. This involves a strengthened reporting line for the current AHP Strategic Lead to Nurse Director in the role of Associate Director of AHPs (interim). This will be a more strategic, less operational role with a set of key deliverables as set out above.

9.12 A delivery group will be established, chaired by the Nurse Director and supported by Associate Director of AHPs (interim) to ensure the delivery, monitoring, reporting and governance of the above. As part of this work, the opportunity to relook at the strategic positioning of AHPs within a more integrated context could be explored.

9.13 The findings from phase 2 provided the basis for the strategic direction for AHPs over the next 4 years. This strategic direction is described in ASPIRE AHP Strategy 2017 attached at Appendix 2. To succinctly describe the AHP contribution to delivery of local and national strategy, a 4 tier approach to service delivery was developed. This enables the breadth of work across each service to be clearly described and provides a framework to articulate the opportunities for future service delivery. The four tiers are:

- enabling others
- generalist
- specialist
- advanced practice.

To ensure implementation of the strategy key work will include:

- measuring impact
- workforce planning and workforce development
- care assurance
- AHP professional leadership arrangements.

9.14 The strategy was initiated before the HSCP was established and will now need further development to take account of the wider Health and Social Care AHP workforce. AHP's are key part of the HSCP workforce and are critical to support the shift in balance of care from hospitals to community settings. Their roles include the delivery of reablement, admissions to hospital and providing care closer to home.

9.15 **Mental Health Strategy**

The Chief Officer report to the Board in August 2017 provided an update on the publication of a new Mental Health Strategy 2017-2027. The national strategy sets out the main priorities that the Scottish Government consider will deliver significant improvements in mental health for the population of Scotland. A total of 40 actions are contained within the strategy focusing on improving access to services, earlier interventions and giving mental health the same prominence as physical health. This will require a wide range of public sector partners and stakeholder working together to plan and implement the change required.

9.16 To begin this process a multi-agency Forth Valley planning event was held on Friday 15 September 2017 to:

- raise awareness of the new national Mental Health Strategy
- undertake a gap analysis of its recommendations
- identify as local partners its joint implementation
- identify options for joint monitoring of local progress.

9.17 Fifty one participants from across a range of statutory agencies and third sector organisations working with adults, children, educational and criminal justice services attended this event. A formal evaluation report of the outputs of this event is presently being prepared and will be shared across all relevant agencies.

9.18 **Regional Planning**

In December 2016 the Scottish Government (SG) published the Health and Social Care Delivery Plan which sets out the SG aims for Scotland in relation to health and social care and the programme to further enhance health and social care services. The plan identifies:

- the changing needs of the nation; identifying, whilst necessary, investment must be matched with reform to drive further improvements in services
- services are facing increasing demand from the population particularly from people with long term conditions needing support from health and social care
- the importance of bringing together the different programmes of work to improve health and social care.

9.19 Although the plan concentrates on health services it recognises the wider range of services that will require to work collaboratively to achieve the outcomes set out in the plan, encouraging more collaboration between partners and identifying the need to progress this work at pace.

9.20 The Health and Social Care Delivery Plan acknowledges the work of the National Clinical Strategy (NCS) and also sets out the requirement to consider not only the local planning and delivery but to consider also which services should be planned and delivered regionally or nationally using population based planning for hospital services. NHS Boards are encouraged to work together through the three regional groups; the appropriate national and regional groups are expected to set out in 2018 how services will evolve over the next 15-20 years in line with the NCS.

9.21 The West of Scotland Boards are required to develop a regional transformation plan over the next 6-12 months which sets out how they will support achieving the national delivery plan with board local delivery plans setting out their contribution both to the regional and national plans. There is a strong expectation that there will be a whole system approach to planning and delivery. Integration Joint Boards (IJBs) and Health Boards will be key in developing and implementing the regional delivery plan. This will need a strong connection between locality, local, regional and national planning.

9.22 By 2018 each region is expected to have a plan setting out how services will evolve to deliver against a range of national strategies. To achieve this we must look at population health needs and consider how we will deliver sustainable care and treatment going forward. This will need to be considered over the life course of start well, live well, age well and die well. In addressing these issues we must be aware of the need to address workforce and financial sustainability and transforming our offer will be essential. Therefore the plans will need to consider how services will be evolved over the next 15-20 years to support the transformation of health and social care and ensure the longer term investment in services and estate is committed to the right areas to deliver the aims of the national delivery plan.

9.23 A paper prepared by the West Regional Board is attached as Appendix 3. The paper summarises the purpose of the Board.

9.24 This work is at an early stage within the region and it is important that the IJBs are involved in this work to develop the regional delivery plan; ensuring that the regional delivery plan supports and is supported by local and locality plans. Alex Linkston is Chair of the West of Scotland Regional Board and John Burns, Regional Implementation Lead (West), the voting members of the IJB and the Chief Officer were invited to attend a regional workshop on 20 September 2017. The current programme structure is attached at Appendix 4.

9.25 The workshop was attended by NHS and IJB Board members, NHS Chief Executives and Chief Officers from across the West Region and included facilitated sessions on:

- the Case for Change
- the common purpose
- creating a framework for future services
- communication and engagement
- programme structure.

9.26 The immediate next steps following the workshop are:

- Prepare the discussion paper for 29 September 2017 for submission to the Director for Workforce and Strategic Change at Scottish Government
- West of Scotland Health and Social Care Delivery Board to meet on 29 September 2017 to consider draft discussion paper

- Letter to all Local Authority Chief Executives in West of Scotland setting out our current position and asking how they would wish to be involved going forward
- Follow up briefing workshop in October for colleagues who were unable to attend the workshop on 20 September and wish an opportunity to discuss this work
- Timeline and work plan to be prepared to ensure delivery of plan for March 2018 taking account of the communication and engagement activity.

Progress will be reported to the IJB through the Chief Officer reports.

10 PUBLICATIONS

10.1 **Audit Scotland Self Directed Support 2017 Progress Report**
Audit Scotland published a progress report on SDS in August 2017. The evidence shows many examples of positive progress in implementing SDS, however there is no evidence that authorities have yet made the transformation required to fully implement the SDS strategy.

10.2 The report also notes that SDS implementation stalled during the integration of health and social care services. They attributed this to changing organisational structures and the arrangements for setting up, running and scrutinising new integration authorities which diverted attention.

10.3 The key messages from the restructure are:
- Social Care – most people rate their social care services highly
- Choice and Control – but not everyone is getting the choice and control envisaged in the SDS strategy
- Personalisation – staff are positive about the principles of personalisation and SDS
- Staff Support – front-line staff who feel equipped, trusted and supported are better able to help people choose the best support for them
- Significant pressures – authorities are experiencing significant pressures from increasing demand and limited budgets for social care services
- Flexibility of provision – there are tensions for service providers between offering flexible services, managing their costs and making extra demands on their staff

10.4 The Audit Scotland report contains a number of recommendations for local authorities and Scottish Government to take forward. In line with previous Audit Scotland reports, it is proposed to complete a self-assessment against recommendations for local authorities, identify actions and timescales required. This work will be reported to the Leadership Team and IJB Audit Committee for consideration.

11 CONSULTATIONS

11.1 **Carers (Scotland) Act 2016: Draft Regulations**
The Scottish Government were seeking views on the draft regulations being made under the Carers (Scotland) Act 2016. The consultation closed on 24 September 2017 and the Falkirk HSCP response is attached at Appendix 5 for information. The contents of the draft regulations are a culmination of work which has been informed by the Parliamentary Bill process and consistent stakeholder engagement. In addition, Falkirk HSCP officers, along with a number of other partnerships, attended a Guidance Co-production day on 29 September 2017 hosted by the Scottish Government. The purpose of the event was to seek views on the draft chapters of guidance and to draw on different experience and backgrounds.

11.2 A response to the consultation on the Carers Charter will be submitted by 22 October 2017.

12. CORRESPONDENCE

12.1 **Transforming Urgent Care: Pharmacy First**
The IJB received correspondence dated 14 September 2017 confirming allocation of funding to support the roll out of the Pharmacy First Initiative across Scotland. NHS Board Directors of Pharmacy will work with IJB Chief Officers to take forward local implementation plans. Further reports will be presented to the IJB detailing how this allocation will be used.

12.2 **IJB Model Complaints Handling Procedure**
The Scottish Public Services Ombudsman has confirmed the Falkirk IJB Complaints Handling Procedure is compliant. A Falkirk HSCP Complaints Handling Group has been established and will oversee implementation of the procedure, including links with the Performance workstream group to incorporate the reporting arrangements for complaints key performance indicators.

13. CONCLUSIONS

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

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

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 and a draft integrated structure.

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

Legal and Risk Implications
Legal and risk issues will be considered as required.

Consultation
Stakeholders will be involved as required.

Equalities Assessment
There will be appropriate consideration of the equalities implications and equalities impact assessments as required for work noted in this report.

_____
Approved for submission by: Patricia Cassidy, Chief Officer

Author – Suzanne Thomson, Programme Manager – Falkirk HSCP
Date: 27 September 2017

List of Background Papers:

Appendix 1

TRIST and Strategic Commissioning Support Unit

End of Phase Report

August 2017

Purpose

An End of Phase Report is used to give a summary of progress to date, the overall project situation, and sufficient information to ask for a Project Board decision on what to do next with the project.

Strategic Context and Background

Developing an understanding of what matters to people who use integrated health and social care services, how people 'flow' through or use services and how they are connected, is critical to planning and commissioning services to deliver the 2020 vision for health and social care. Improving the flow of patients, service users, information and resources within and between health and social care organisations has a crucial role to play in driving up service quality and productivity.

Overall progress

In September 2016 Falkirk HSCP ran an event focused on their challenges around delayed discharge. They subsequently identified a need to look at flow across the whole health and social care system, with a focus around demand, capacity, cost, and activity. The Tailored Responsive Improvement Support Team (TRIST) from the Improvement Hub (ihub), part of Healthcare Improvement Scotland, subsequently worked with Falkirk HSCP to identify a range of support from the ihub and other national partners to support their understanding of their integrated system.

The partnership has been working with the ihub to develop a joint understanding of the integrated system across health, social care, and the third and independent sectors. This has involved a range of activity, informed by available data on the demand, capacity, and flow across the system including the following support offered through the ihub:

- Leadership and workforce development.
- Whole systems mapping to understand the integrated system across health, social care, and the third and independent sector.
- Service user and carer engagement via the ihub's person centred care programme.

A workshop took place on 23 June 2017 with Falkirk HSCP staff to present the initial findings from the whole system mapping work. This was presented under the banner of 'Understanding our system'. The session was well attended by a cross section of senior staff from acute, primary and community care, third and independent sector partners.

Since the project started in December 2016 approximately 90 people have participated in this work. This included employees across all partners, including the third and independent sectors. People from a range of backgrounds who currently experience health care, social care and/or support services, and their carers were involved to describe their experiences and to identify the improvements that matter most to them.

Deliverables/ achievements to date

Leadership and workforce development

The ihub has worked closely with the NHS Education Scotland (NES) Organisational Development and Leadership Unit to shape an offer of coaching support for senior leaders across Falkirk HSCP and NHS Forth Valley, and a group of mangers and practitioners across Forth Valley focused on the redesign of Reablement services. Four coaching sessions have been delivered for each group. Coaching for each group was individually contracted and agreed, and facilitation was fully tailored to each group/team. Such has been the success there will be additional sessions offered.

> *"Coaching sessions have made the difference and moved the reablement work forward"* (Participant)

Whole system mapping

The ihub worked with Falkirk HSCP to identify an external contractor who was engaged to:

- Develop a visual representation of a whole systems map that illustrates the range of services and teams across Falkirk HSCP, populated with data.
- Work with staff (including the third and independent sectors) to co-create visual representations of their view of Forth Valley and Falkirk integrated system.

Since December 2016 approximately 90 people have participated in this work and have drawn their representation of the Falkirk HSCP health and social care system. Examples of the mapping process have been provided as part of Appendix A and further analysis of a sample of the maps drawn can be viewed within the Falkirk HSCP Integrated Systems Service Map analysis document at Appendix B.

Service user and carer engagement: purpose of engaging/involving people

The person-centred care team from the ihub worked with Falkirk HSCP to develop an engagement and involvement plan to:

- Gather insights from patients, clients, families, and carers to shape the decisions made around future services.
- Ensure that people were involved as much as they wished to be in the process.
- Ensure that people were able to continue to be involved in shaping decisions around future services once the engagement period had been completed.

Fifteen service users and carers were interviewed to develop an understanding of:

- The health care staff/services they had contact with over last 12 months.
- Their experience of these services.

Five stories were analysed in more depth using a sense-making method which asked four key questions:

- What was their (service users and carers) experience?
- What were the positive aspects?
- What were the negative aspects?
- Any surprises?

High-level themes were developed that included:

- Access to care

- Knowing what support is available
- 'Turning points'
- Relationships
- Family and carer expertise
- Lack of opportunity to self-manage

(For further detail please see Appendix C)

Review of project objectives

The ihub is now working to develop a map that visually illustrates the range of services and teams across Falkirk HSCP and NHS Forth Valley and is populated with data (collated during the mapping process) that shows flow across health, social care, and the third and independent sectors (see Appendix D).

This process, alongside analysis of other data and intelligence gathered as part of phase I, will provide a platform for discussion with Falkirk HSCP to plan and develop the scope for phase II of the ihub support.

Lessons learned

A more detailed lessons learned report has been developed as part of a formal ihub process, what follows are high-level themes gathered from formal feedback and reflections throughout phase I:

- Ensure a well-developed and co-produced scope and PID for phase II
- Ensure detailed mapping of interdependencies within the wider Falkirk HSCP
- Clearly identified communication process and roles for data gathering process led by Falkirk HSCP, supported by the ihub
- Realistic timeframe agreed within PID for data gathering
- Engage with local LIST analysts at all stages of the process
- Set out clearly defined roles and responsibilities around programme management with Falkirk HSCP and the ihub.

Issues and risks

- Engaging with local stakeholders in a timely fashion to complete work to timescales required.
- Access and availability of data across health, social care, and the third and independent sectors.
- Capacity to support data gathering and analysis locally.

Next steps

The insights and data gathered have contributed high-level themes and intelligence, providing insights into the Falkirk HSCP health and social care system from the perspective of patients, clients, families, carers, and those who work within the system. This work has been shared and disseminated via a range of events with staff across NHS Forth Valley. The ihub and Falkirk HSCP will now work together to scope and define phase II.

Appendix A: Whole system mapping

Figure 1: Drawing a map of our system

Figure2: Example of a whole system map

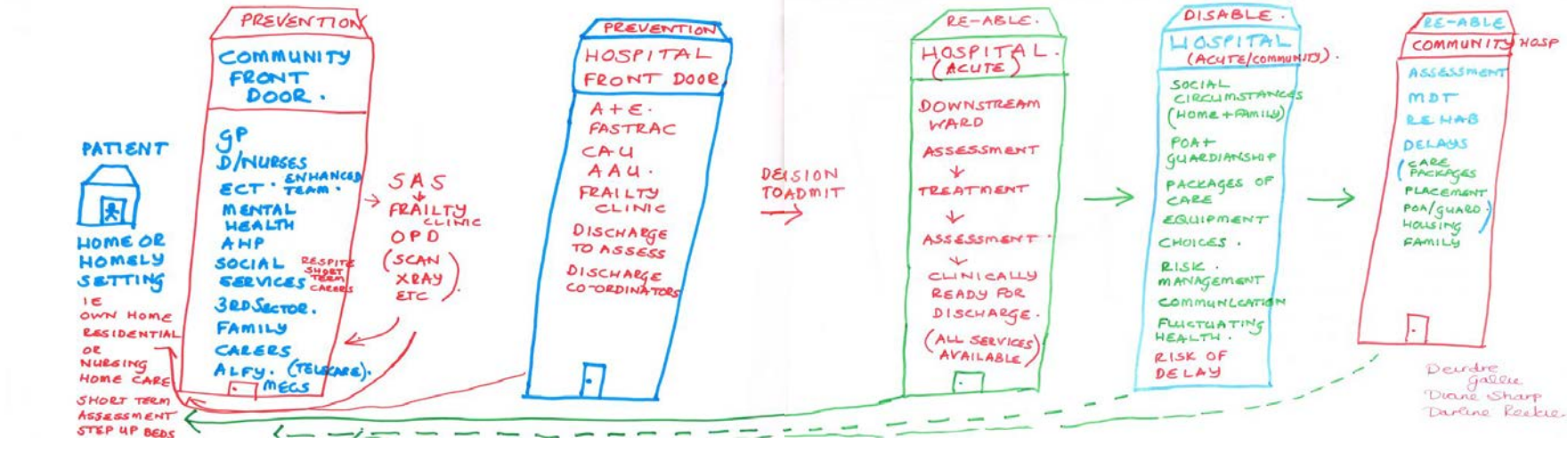
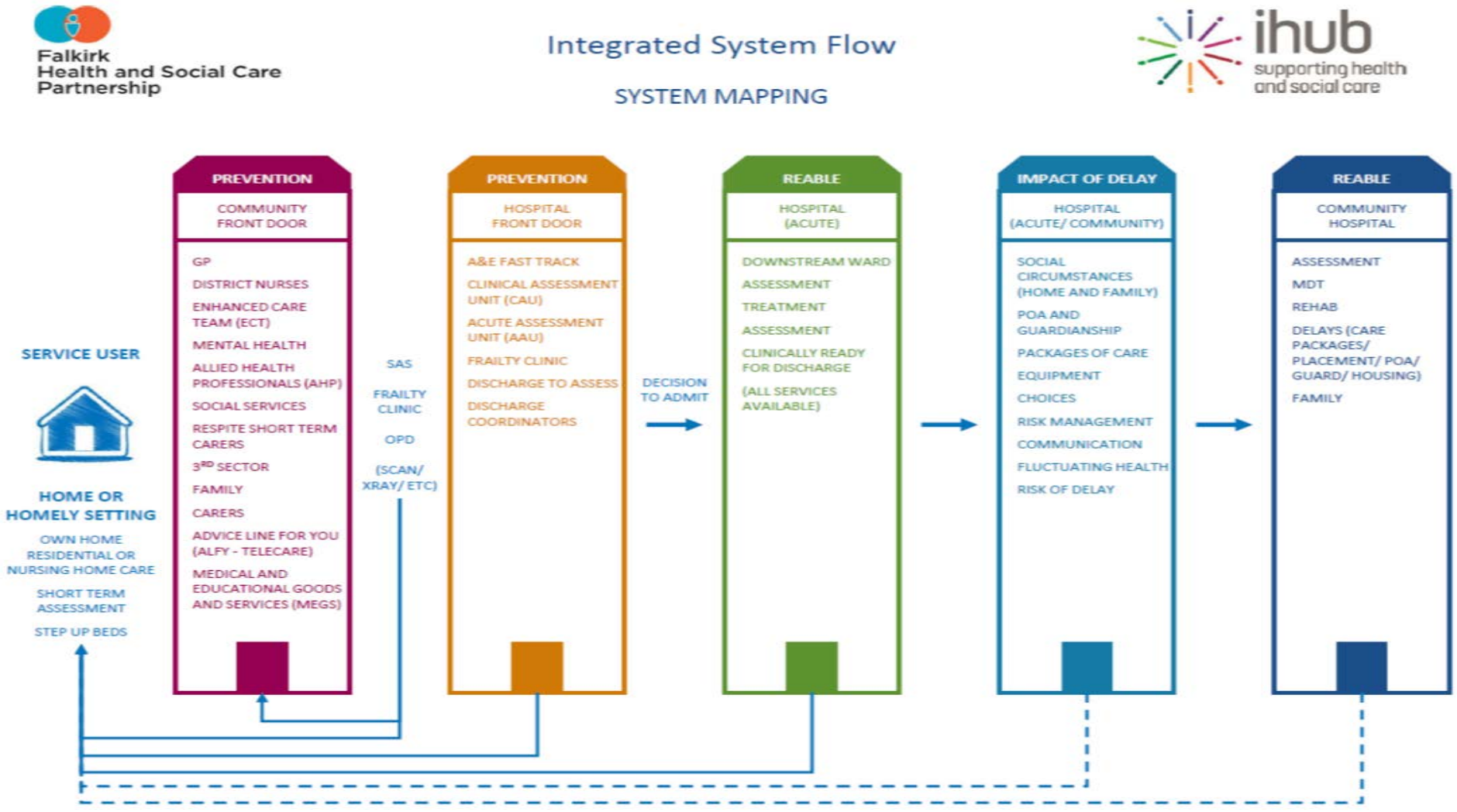


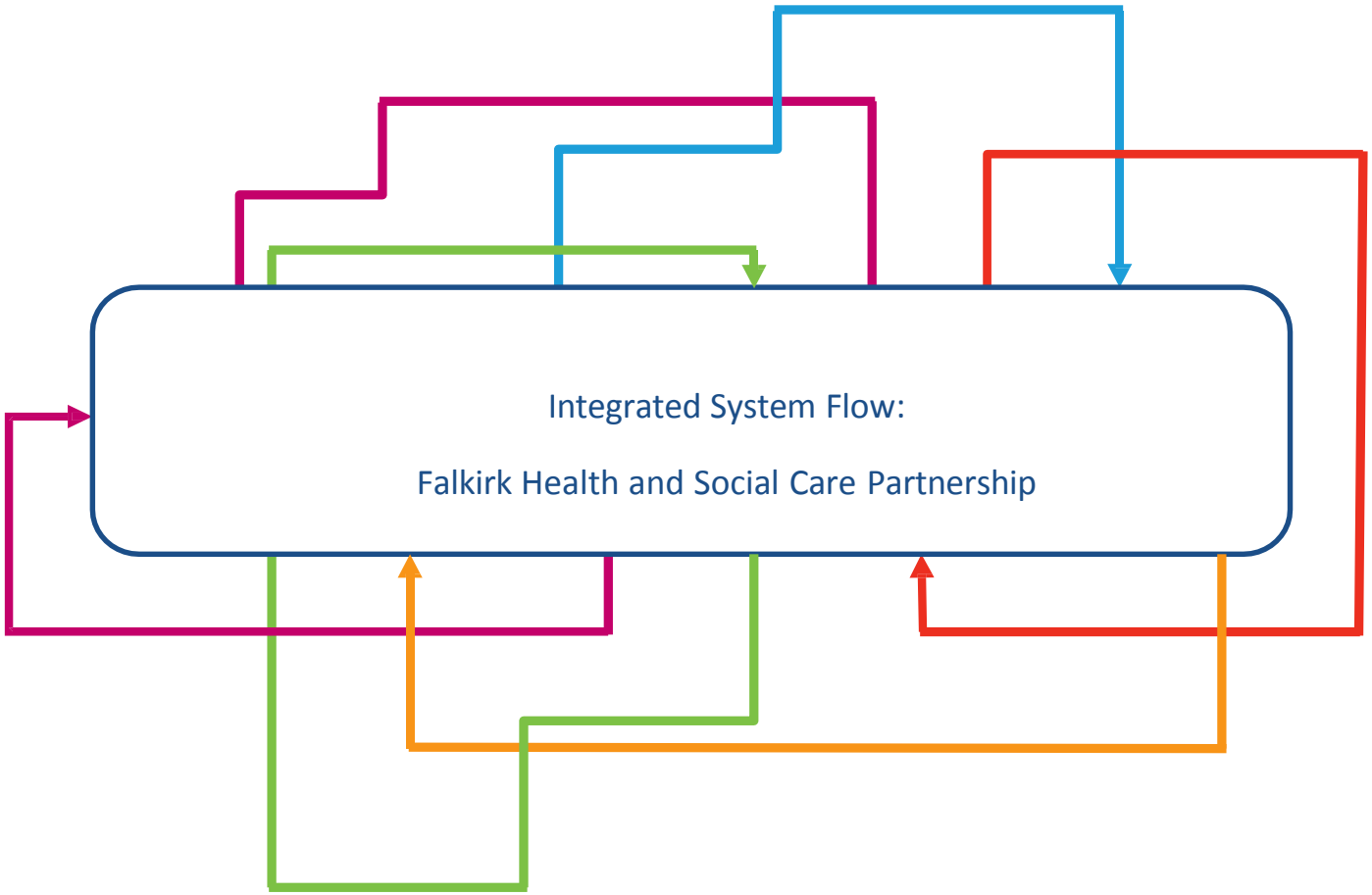
Figure 2: Visualisation of figure 2



Appendix B: System Map Analysis

Falkirk
Health and Social Care
Partnership

ihub
supporting health
and social care

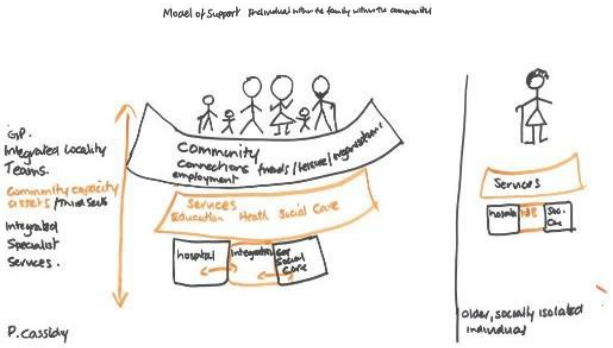


This document has been produced following a high-level, desk-top analysis of the system maps created by staff in Falkirk HSCP following a stakeholder engagement process.

We have used our understanding of the system to inform our observations. During the review we asked the following questions:

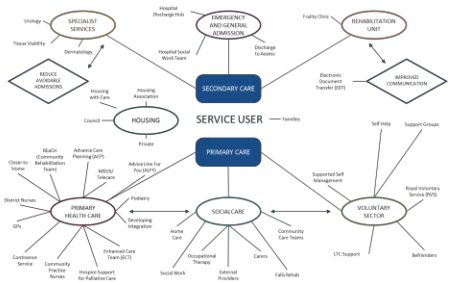
- What is prioritised on the maps ?
- Where are the gaps?
- What questions do the system maps raise?

This document should be read in conjunction with the whole system maps and the reablement service system maps.



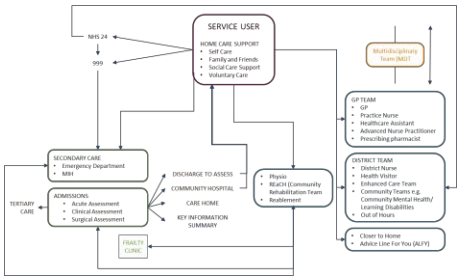
- Highlights the importance of community and wellbeing
- Depicts assets such as friends and leisure opportunities
- Acknowledges the role of the third sector
- Highlights the importance of connectedness and social isolation
- Depicts the centrality of the HSCP
- Indicates the fluidity of the system
- Provides an overview and vision for the HSCP rather than granular detail of services

- The patient is at the centre of the system
- Provides a high level of detail about the range of health and social care services available (especially from an AHP perspective)
- Some acknowledgement of the role of the third sector
- No depiction of the flow between services
- No indication of which areas are prioritised

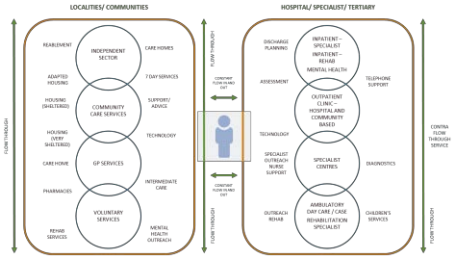


- Provides an oversight of the whole system with services clustered into high level groups (predominantly a medical view of the system)
- A high level of detail provided about primary care – (would others agree these areas are owned by/ interface with primary care?)
- Some acknowledgement of third sector
- Enablers such as improved communication are called out in addition to services
- A gap in relation to unscheduled care

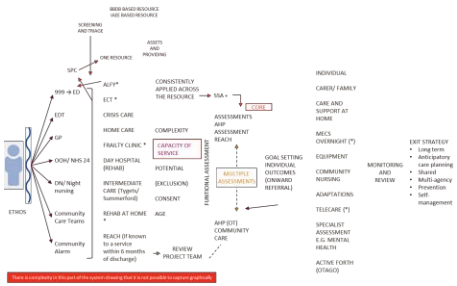
This map is an amalgamation of two individual maps



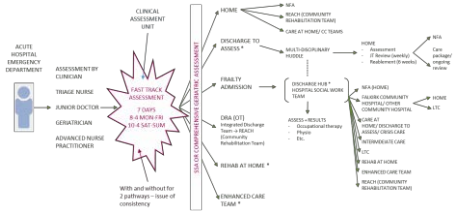
- Attempts to describe the flow between services but perhaps does not reflect the full complexity of the system
- Reflects a section of the reablement process/ intermediate care
- A gap in relation to third sector, housing and prevention



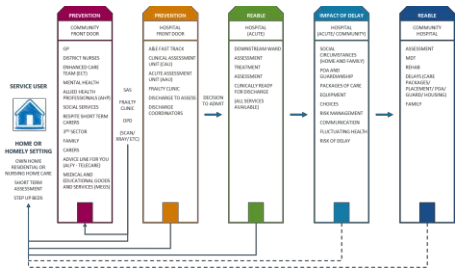
- An idealised view of the system should operate
- Highlights the importance of localities/ clusters
- A gap in relation to unscheduled care/ focuses on planned services



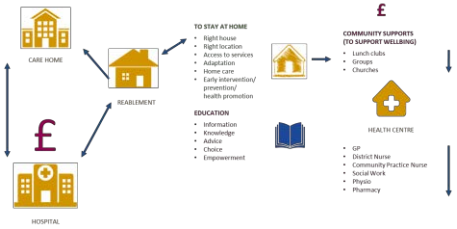
- There is a level of complexity that is difficult to describe
- There are layers of services each with different criteria
- Highlights an exit strategy with a focus on advanced care planning, prevention and self-management – how does this loop back to try and keep people out of the system
- Highlights barriers such as multiple assessments and consistent application of criteria
- Indicates the need to set outcome for individuals



- Depicts a part of the reablement service which sits more with the acute sector
- Depicts a detailed process at the front-door – choices and approaches
- Raises the question: discharge to assess, frailty admission, etc. are separate process – how can we bring these concepts together to ensure the approach is working as effectively as possible?



- Uses thematic heading and ways of working
- Identifies some barriers which can lead to delays
- Highlights potential enablers
- There is a gap in relation to community assets – what precedes the front-door? E.g. neighbours/community



- £ signs indicate the financial pressures faced by the system and also suggest that the resources sit with acute – need to shift the balance of resources and care
- Highlights enablers such as education
- Highlights the importance of informal community supports such as faith groups in ensuring wellbeing

- Highlights the importance of housing
- Depicts the pillars that support service delivery – not just about services and processes

The Improvement Hub (ihub) is part of Healthcare Improvement Scotland

Edinburgh Office
Gyle Square

1 South Gyle Crescent
Edinburgh

EH12 9EB

0131 623 4300

Glasgow Office
Delta House

50 West Nile Street
Glasgow

G1 2NP

0141 225 6999

Healthcare Improvement Scotland

ihub
supporting health and social care

Appendix C: Service user and carer engagement

Figure 3: Service user and carer roadmap

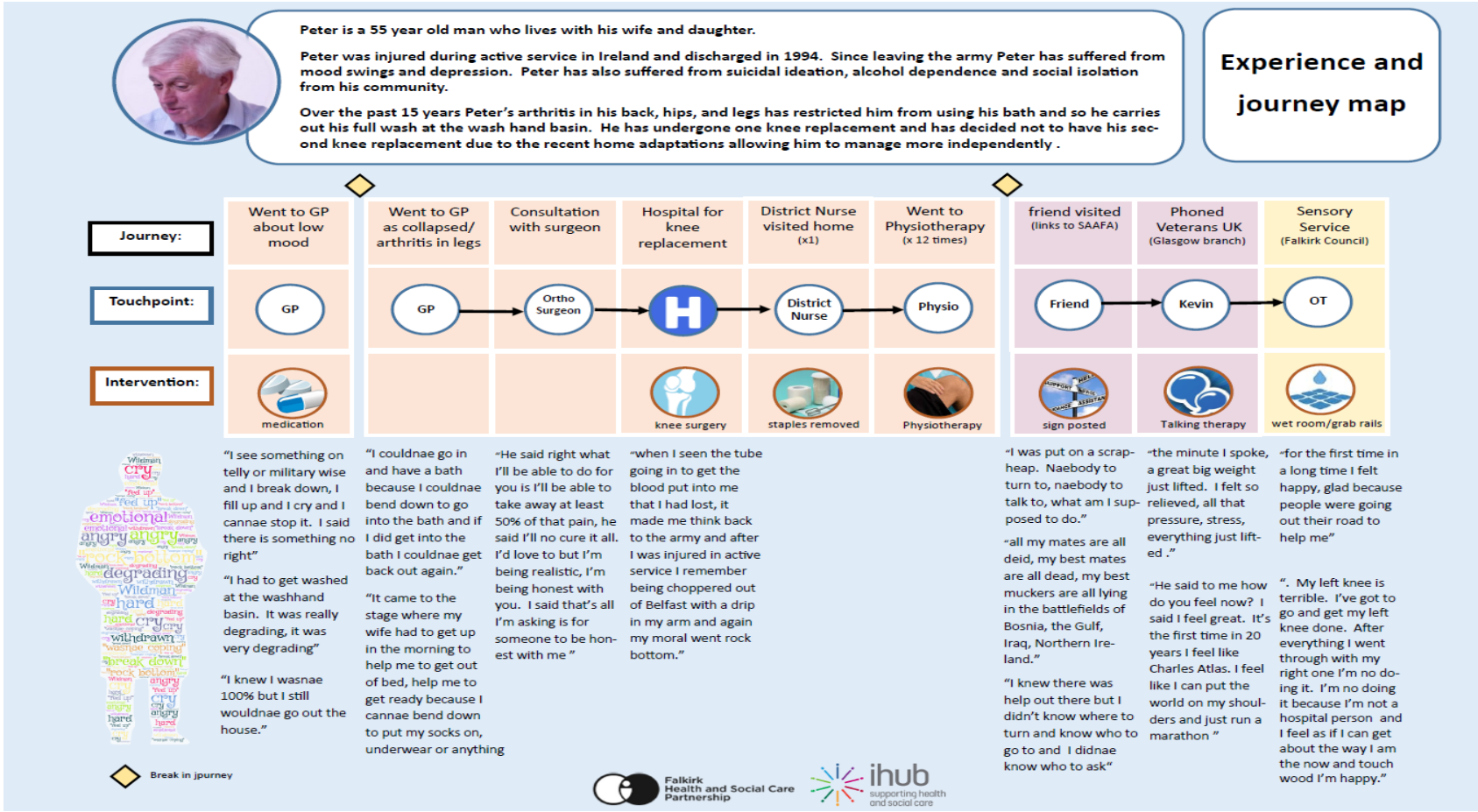


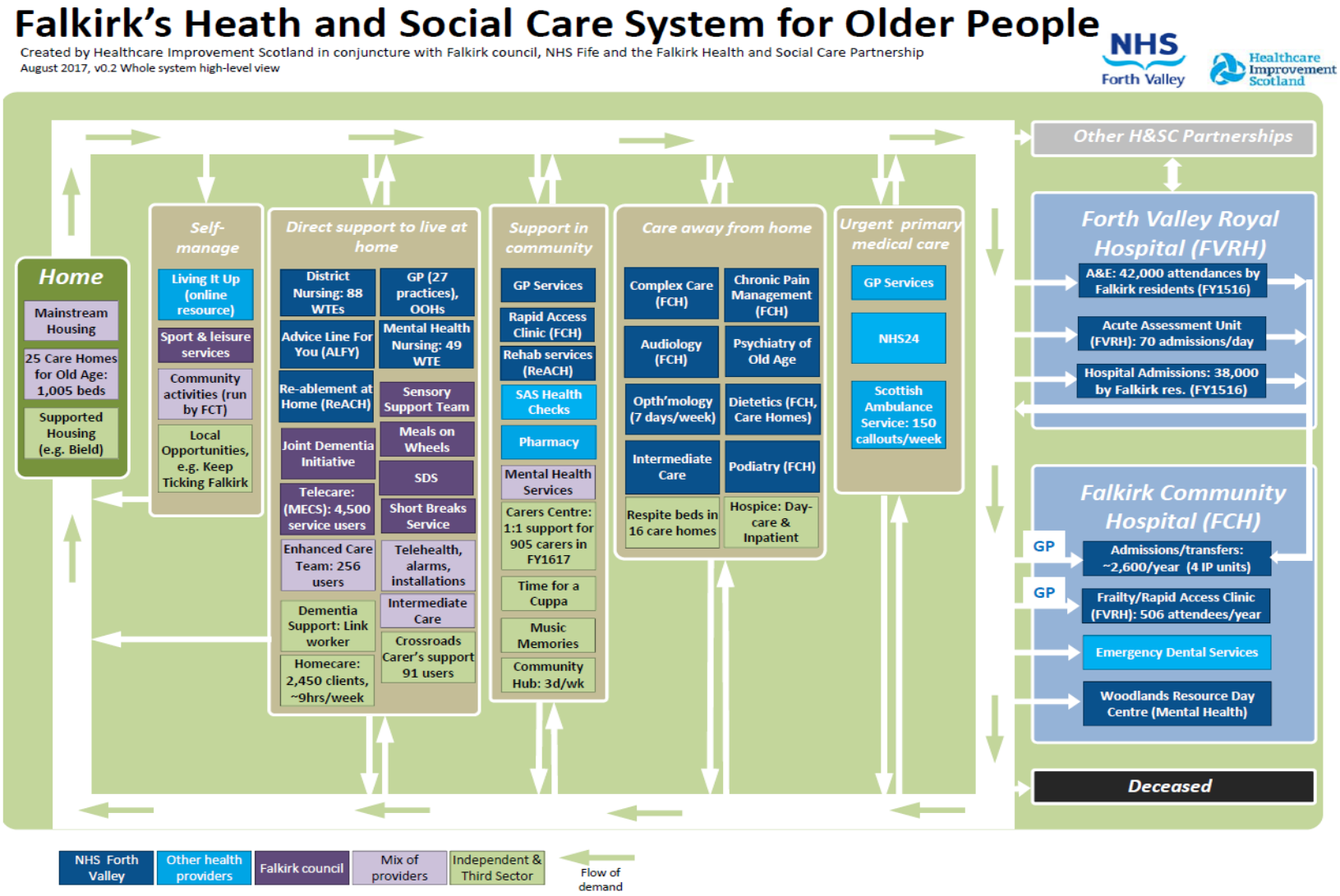
Figure 4: Detailed themes developed from sense-making method

	SUP001	SUP003	SUP005	SUP008	SUP013
Knowing what support is available	"But nobody cares to tell you, you've got to find out yourself. I phoned social services and I never heard from them."		Discharge from hospital = letter. ➔ Phone no. district nurse. "We had to make connection with them."	Lack of consistent key contact.	
Turning points	"This is disaster… about 6/8 months ago I took another stroke and my eyes em, and that's when all the social services."	Appreciation of honesty and info from consultant.	ALFY helpline - raised toilet seat. When spoke to ALFY it "really got going."		
Relationships	"Everyone's been really helpful and good. I've not had any problems with anybody." "They were quite nice nurses, I got to know them quite well 'cause it was always the same ones."	Previous history affecting ability to communicate issues to healthcare workers. Feelings of being unsupported. Socially isolated.	Called Polmont Nurse: Admitted up in air "All a bit unsettled". GP "Oh we don't know anything about you." When did get a nurse didn't know them. Nurse attitude when came: not interested/ quite curt.		Getting letters re: being sectioned is traumatising. On discharge told… stress could have triggered the event, or maybe a brain tumour, didn't know, they'd do scans and stuff. A&E Consultant was calm and to the point. The staff in ward 1 spoke to me a lot, it was fantastic. Psychiatrist wasn't helpful. Thought he was making it up.
Touch points		No psychological support offered - only medical.			

	SUP001	SUP003	SUP005	SUP008	SUP013
Lack of clarity		Didn't know where to look for help.	After discharge LTE told need (No provision): - dressing - raised toilet seat "As far as aware" physio got in touch with doctor. Confusion over point of contact - Called GP not District Nurse.		
Access issue			Ability to pay for treatment influenced care - Physio location. District Nurse phone number was "dead". No District Nurse in Doctors practice - they kept shifting.	Mental health GP. Lack of understanding. Key contact or contact number.	
Confidence in system	She says "you're too honest, if you'd said you didn't get out you would have a home visit." "It's not really handy they will only do it if you're house bound."		Hospital said District Nurse would be in touch. Didn't happen until phoned ALFY. "Nothing happened. Nobody came."		Told to come along to meeting by one staff member then turned up and told different by other staff member.
Family and carer expertise		Healthcare workers not appreciating history affecting psychological state.		Carers experience from the wife (carer + husband) ➔ activity orientated support Long term condition,	"Surprise in coming home" No communication with family prior to discharge.

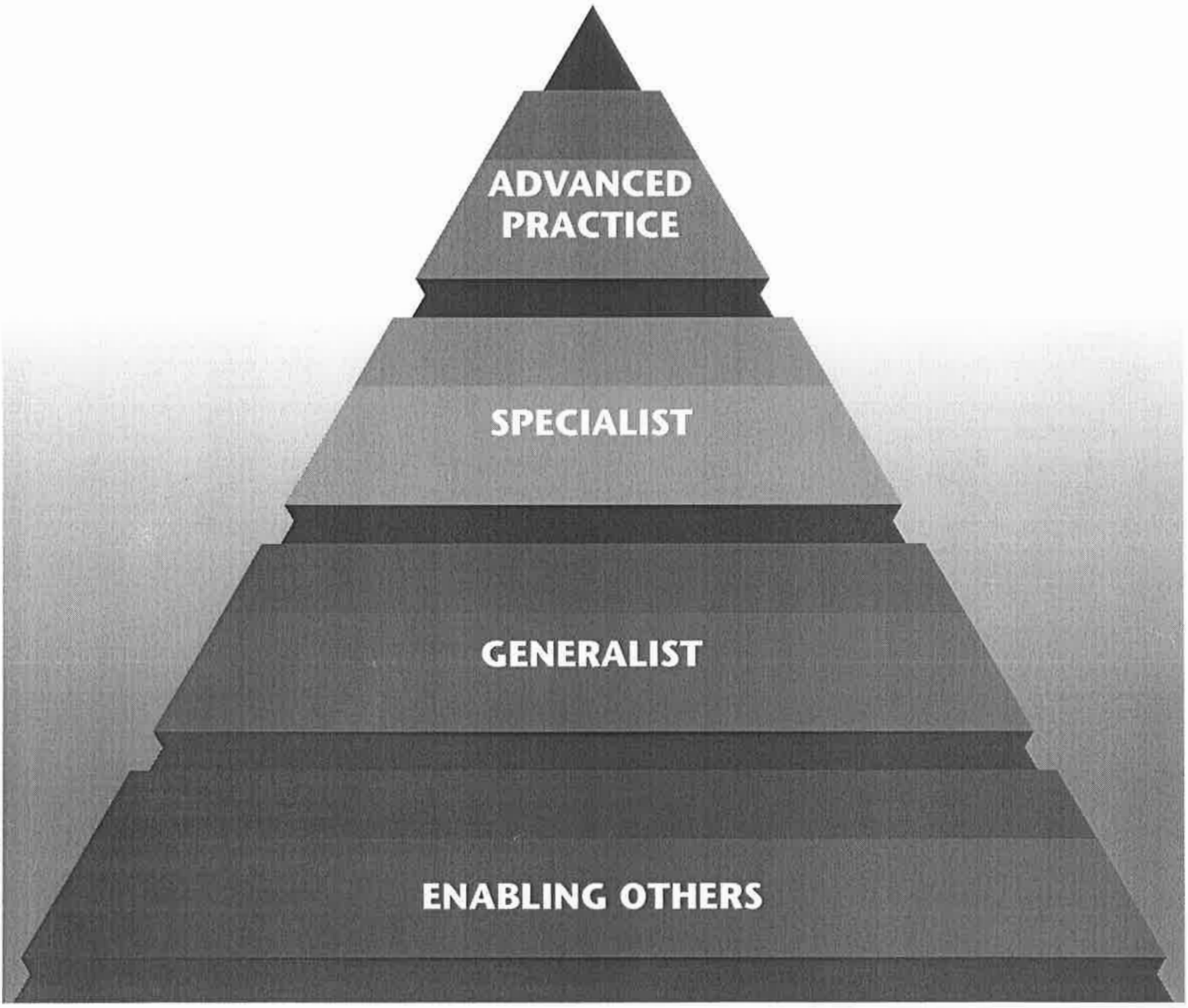
	SUP001	SUP003	SUP005	SUP008	SUP013
				mental health and physical illness.	
Patients not give opportunity to self-manage	"It [walk-in shower] makes me more independent."			Bad experience with mental health nurse - cancelled and no alternative.	Following d/c… He did what he was told to do (to get better) which was very little.
Gaps					Queried what support is available outside? Told there is none. NHS 24 didn't really know what to do. By third episode care absolutely failed us miserably. Weekend, late night experience.
Access to health care 24/7 7/7	"They took me into the hospital overnight to make sure I was OK." "I pressed the buzzer and they were there in 10 minutes."	Sought help at lowest point. Change in life circumstances and health - "rock bottom."	No support over the weekend.		"Traumatic … eight of them to give him an injection to knock him out." Became a complaint after third experience. Happened around five o'clock or sometime when everywhere was shutting. "It all kind of went around about the houses."

Appendix D: ihub whole system mapping



ASPIRE

Allied Health Professions Supporting and Promoting Improvement, Rehabilitation and Enabling Others



AHP Strategy 2017 – 2021

CONTENTS

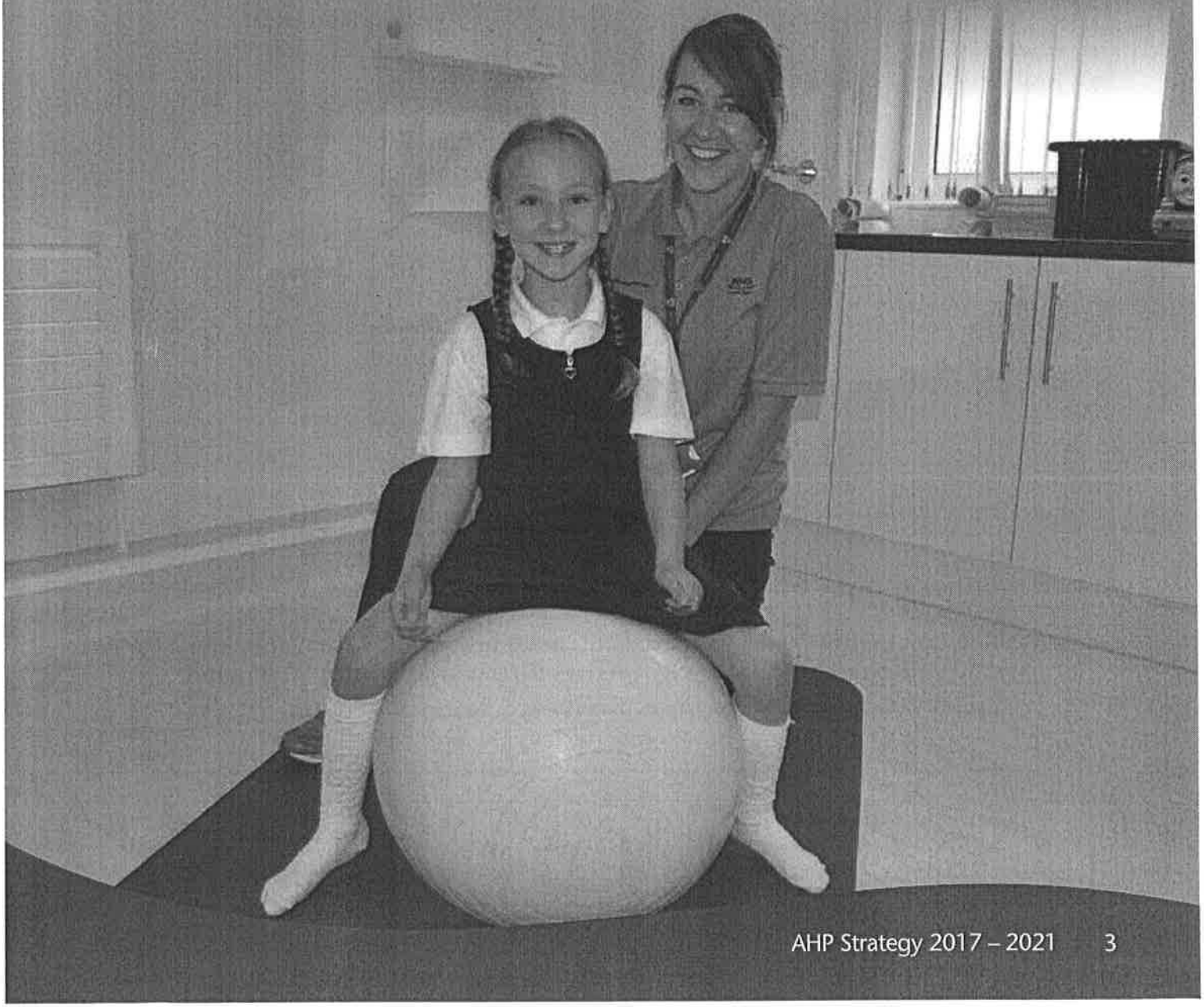
INTRODUCTION

Shaping the Future, the NHS Forth Valley Healthcare Strategy 2016-2021 sets out a vision for the way services will be delivered over the next few years and beyond.

It focuses on care being provided closer to home, working in partnership with staff, patients, local authorities and community organisations to avoid emergency admissions and reduce A & E attendances. The focus is on person centred care, recognising that people have differing needs, circumstances and expectations of care. It also encourages and supports people to take personal responsibility for managing their own health and health conditions.

Against this backdrop, the allied health professions (AHPs) explored the contribution they make in respect of *Shaping the Future, Active and Independent Living Programme* (AILP) the national strategy for AHPs, and the *Strategic Plans* of each Health and Social Care Partnership. AHPs have subsequently developed a generic framework that can be used by all services to describe delivery models for the future.

The challenge now is to use this document to explore the opportunities that exist to optimise the role that AHPs play in prevention and early intervention as well as diagnosis, treatment and the rehabilitation of people of all ages across health, education and social care.



Allied Health Professions: Who are they and what do they do?

Within NHSFV - 550 AHPs (452 wte)

Arts therapies . . . . . .(2.8wte)
Dietetics . . . . . (31.5 wte)
Occupational therapy . . . . . (101.3 wte)
Orthoptics . . . . . (4.2 wte)
Orthotics . . . . . (2.8 wte)
Physiotherapy . . . . . (132.3 wte)
Podiatry . . . . . (30.6 wte)
Radiography . . . . . (75.5 wte)
Speech & Language Therapy . . . . (57.2 wte)
AHP Multi-skilled . . . . . (13.8 wte)

And a number of occupational therapists within the three Local Authorities

Working in:

- Hospitals
- Health centres
- GP practice
- Patient's own homes
- Care homes
- Schools and Nurseries
- Colleges / university
- Prisons x3
- Hostels
- Workplaces
- Leisure Centres & Gyms
- Community Centres
- Day centres
- Third sector establishments

Performance area	Performance
Sickness abscence	average 2.7% against 4% target
eKSF	Ave performance of 80% against and 80% target

Managed within:

- Acute care group
- Children's care group
- Outpatient care group
- Mental Health care group
- Rehabilitation care group
- Imaging Services (Radiography)
- Ophthalmology services (Orthoptics)
- Psychological Therapies (Arts therapies)

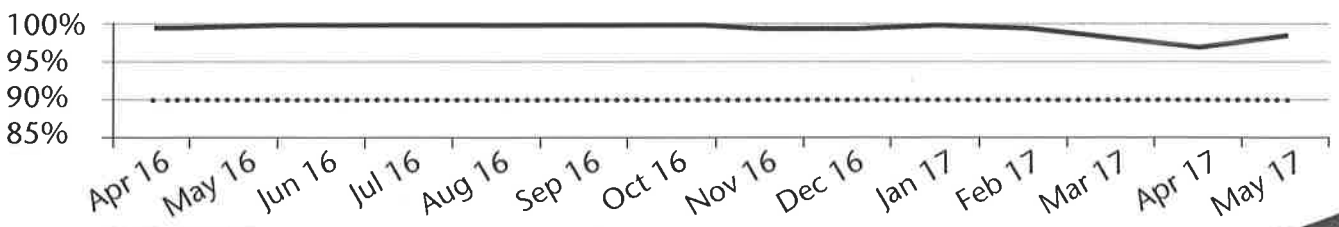
Each year:

- New patients: 73,000
- Total contacts: 406,000
- 157 000 radiography attendances

Working with:

- Social work
- Integrated Teams
- Education colleagues
- 3rd sector organisations
- Carer centres
- MECS services
- Looked after children
- Criminal justice
- Carers
- Police Scotland
- Scottish Ambulance Service
- Housing
- National Organisations
- Scottish Fire & Rescue

Waiting times performance: % of patients waiting for an AHP first appointment at 18 weeks or less (Community Services Directorate) against 90% target:



AHP Contribution to Local and National Priorities

A number of national strategies and delivery plans emphasise the 2020 vision of care closer to home, focussing on prevention, early intervention and self management.

The contribution made by AHPs to these local and national priorities can be seen in the table below. All services are already working to fulfil most if not all of the objectives.

Main Priorities	Outpatient Care Group				Mental Health Care Group			Children's Care Group				Rehab Care Group		Acute Care Group		
	Physiotherapy	Podiatry	Dietetics	Orthotics	Old Age Psychiatry	Learning Disability	Mental Health	Speech & Language Therapy	Occupational Therapy	Physiotherapy	Orthotics	Speech & Language Therapy Adult	Community teams including in-patient community settings	Physiotherapy	Occupational Therapy	Dietetics
Focus on prevention, early intervention and planning ahead	+	++	+++	+	+	++	+	++	+	+	+	++	++	+	+	+
Patient experience	+	+	++	++	+	+	+	+	+	+		++	++	+	+	+
Person centred care, working towards personal outcomes	++	++	+++	++	+++	+++	+++	++	++	++	+	+++	+++	+	+	+
Tackling inequalities			+++		++	+	+++	++	+			++	+	+	+	+
Taking personal responsibility, autonomy, self management	+++	++	++	++	++	+	+	++	++	++	+	++	++	+	+	+
Working in partnership	+	++	+++		+	+++	+++	++	++	++		++	+++	++	++	++
Working closer to home, - focus on functional improvement	++	+	+	+	+	+	++		++	+	+	+	+++	+	+	+
Reducing variation, minimising delays	+++	++	++	+++	+	+	++	++	++	++	+	+++	+++	++	++	++
Improving access to services	++	++	++	+++	+	++	+	++	++	++	+	+++	+++	+	+	+
Having leadership to support quality improvement	+	+	++	+	++	++	++	++	+	+		++	++	+	+	+
Maximising the use of technology where appropriate						++		+	+	+		+++	+++			+

+ - illustrates the extent to which the service focuses on these main priorities (+ has a focus on this priority, ++ has a significant focus on this priority, +++ this priority area is a key focus for the service)

Allied Health Professionals: Service Delivery for the future

In order to capture the diversity of work by allied health professions a generic model of service delivery has been developed. The model is presented as a pyramid and the first aspect, *service delivery*, has been given considerable thought and attention. The remaining three components require further work and form the basis of a workplan for AHPs, currently under way.

The four components of the AHP Model of Service Delivery are:

1. **AHP service delivery**
2. **Measuring impact**
3. **Workforce planning and workforce development**
4. **Care assurance arrangements for safe, effective person centred services supported by contemporary professional leadership**

The model of service delivery is underpinned by a set of principles.
AHP services will ensure that:

Interventions:

- Are person-centred, effective, evidence-based with a focus on delivering positive outcomes
- Will enable people to live independently, supporting self-management and the health and wellbeing of both them and their carers.
- Focus on prevention, early intervention and anticipatory care rather than crisis-led interventions
- Are able to work within a clear integrated infrastructure with appropriate protocols and procedures.
- Are able to deliver core and specialist assessment and interventions within clear pathways.
- Maximise use of technology.
- Are outcome focussed, so that impact is clear and measurable

Access to services

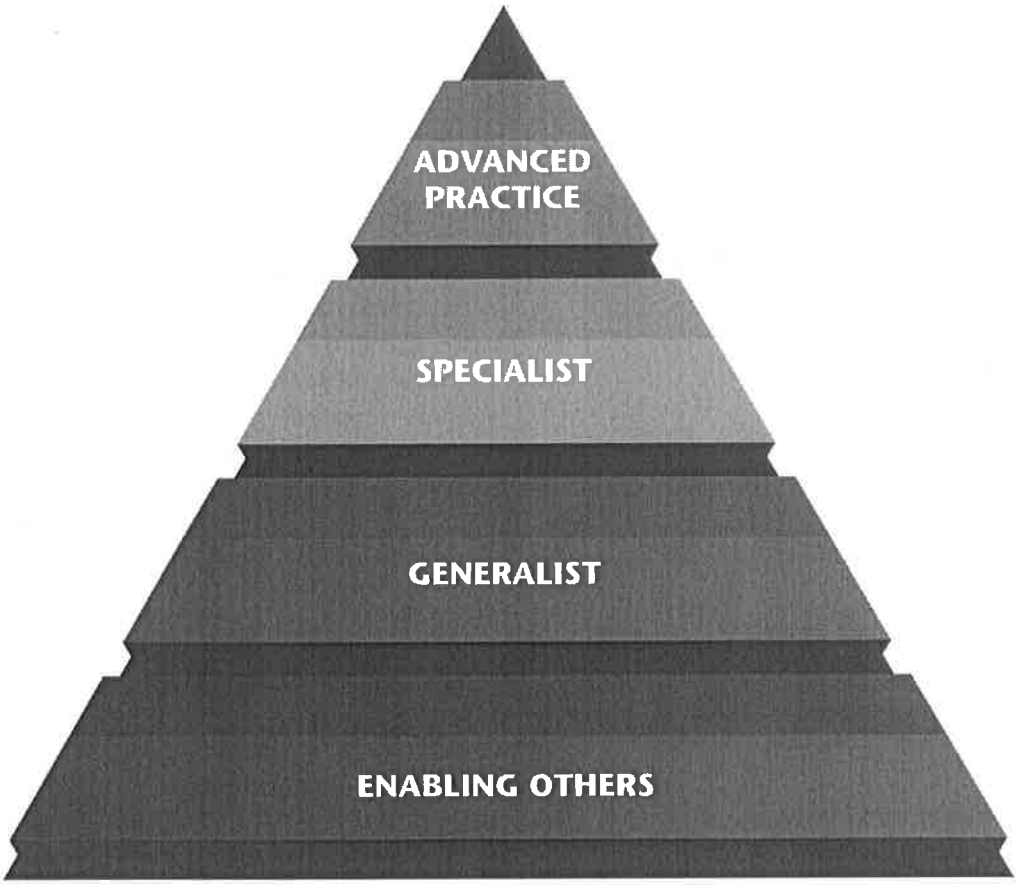
- Is equitable and based on patient need
- Is timely, where and when required eg to facilitate discharge from hospital and prevent admissions
- Ensures appropriate and timely access to specialist services

The AHP workforce

- is flexible enough to ensure that patients are seen by the most appropriate person with the expertise to assess, treat and review them
- is skilled and competent to train and empower others to deliver appropriate interventions.
- has the skills, training and experience to ensure assessment and intervention processes are person-centred and completed with minimum numbers of professionals being involved.
- work closely with health, social care and third sector partners, delivering within available resources.
- has appropriate level of clinical and professional leadership.

1. AHP Model of Service Delivery

Shown as one side of a pyramid, the AHP service delivery model illustrates the tiered work that currently takes place by AHPs in Forth Valley, and also shows where there are opportunities for AHPs to contribute more fully to local and national strategies in future.



Enabling others – Universal approach to sharing knowledge and building capability and capacity in others; training, educating and enabling others to positively impact on the health of the 'communities' where they live or work eg milk allergy management sessions for GPs and health visitors, training social care staff in dementia, training volunteers to provide Top Toes (social footcare service); whole school approach to improving children's spoken language, reablement training to social care support staff

Application of Generalist practice - managing a wide range of clinical presentations using broad professional knowledge and skills across a wide range of settings. For community staff this is likely to be services that are delivered within localities and lends itself to competency based, interdisciplinary working, where staff cross professional boundaries where they have the competencies to do so.

Application of Specialist practice - delivering specialist input to patients with more complex needs

Application of Advanced Practice and beyond - managing the most complex patients, and taking on increasingly skilled work that may have previously been undertaken by medical colleagues eg management of spasticity, diagnosis of learning difficulty; extended scope physiotherapists in GP practice; carrying out video-fluoroscopy;

2. Measuring impact

To deliver the four tiers above requires AHPs to work,

- with named patients directly (face to face, phone)
- with named patients indirectly (liaising with partners, drawing up self-management plans and rehabilitation programmes)
- at a universal /enabling others level, where work cannot be attributed to a named patient.

The extent to which AHPs can record and report data has improved greatly over the past 2 years, with all services now using electronic systems although the data currently captured is mainly activity data and waiting times. It is therefore difficult to demonstrate impact. Also as interventions become more complex and patients are more likely to be seen by teams, it becomes more challenging to determine the impact of any one component, service, profession or intervention.

A national workstream is looking at AHP operational measures to ensure consistent recording of nationally-agreed targets. More work is required locally to ensure that systems are in place to capture these measures and report them in a consistent and meaningful way.

3. Workforce planning and workforce development

In order to deliver new ways of working, the workforce needs to be suitably equipped with affordable workforce plans. This will ensure that the contribution of AHPs to health and social care integration and delivery of the Healthcare Strategy can be maximised. A clear plan of how to prepare, support and develop the workforce through a process of workforce transformation is also required.

These plans will give consideration to the required skill mix and spread of professions across health and social care to meet priorities and resources and will reflect the educational, support and development needs of the workforce to deliver services for the future. This work will be progressed at the earliest opportunity.

4. Assuring safe, effective and person centred care

The range of partners that AHPs work with, the diverse environments in which they work and the different interventions that take place within each of the four tiers demonstrates the increasingly complex ways in which AHPs work. As a result, service delivery is no longer linear. Roles and responsibilities can be shared across organisations, not only public sector organisations, and the need for clear governance arrangements becomes increasingly important to ensure safe patient care and professional practice.

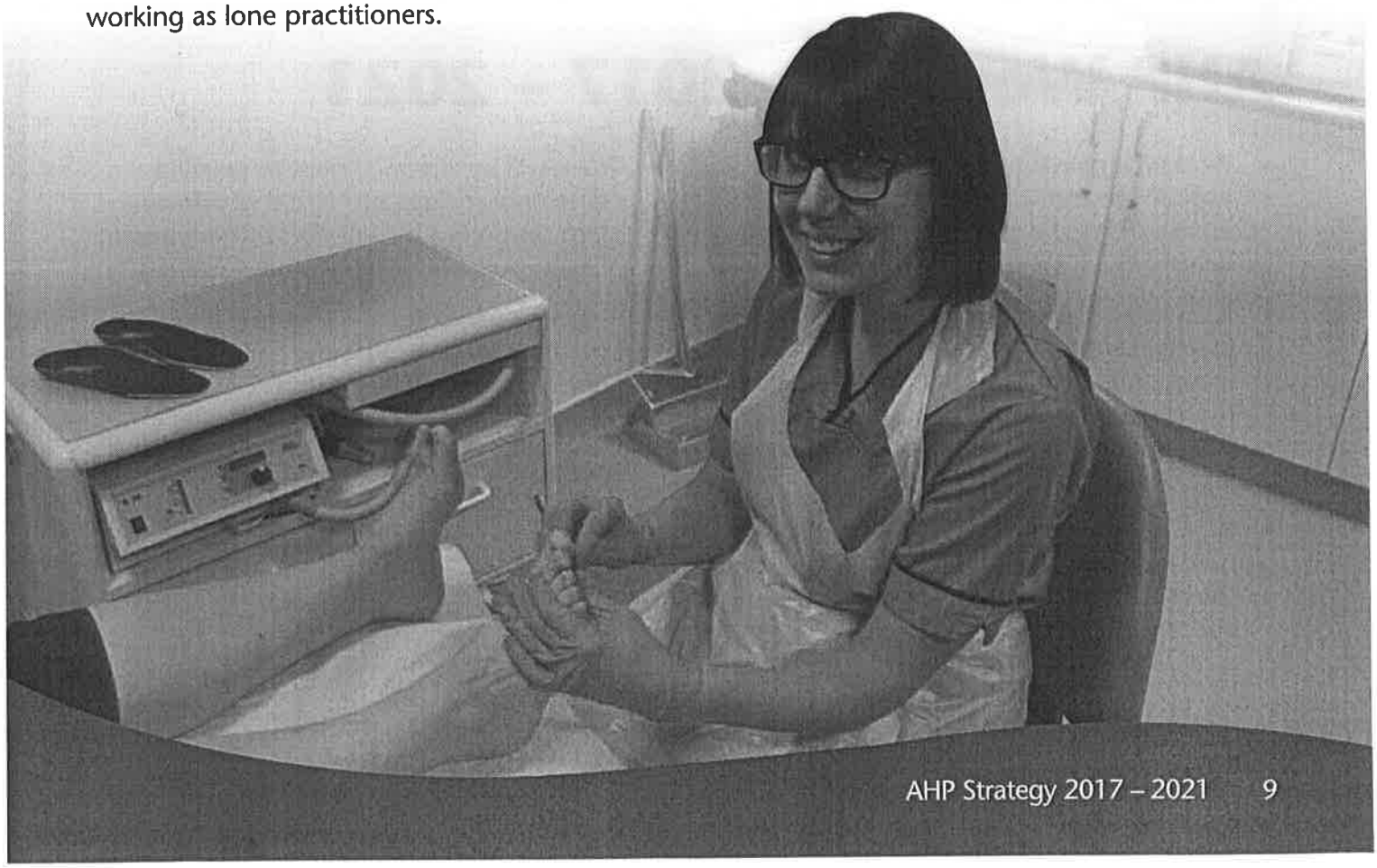
Application of Advanced Practice and beyond - as staff work at the upper limits of practice and at the upper range of their skill set there is a need for strong support to provide assurance for work at this level. Where staff are taking on new and more advanced roles that may have been previously undertaken by medical colleagues, there is also a requirement for specific protocols which may need to be supported by other professionals or by colleagues outwith the Board, especially when working as lone practitioners.

Application of Specialist practice - as staff work with patients with increasingly complex needs, arrangements need to be in place ensure staff are professionally competent and fit to practise.

Application of Generalist practice- service delivery at this level may lend itself to a more competency-based, interdisciplinary approach. Transparent arrangements for care assurance will be required to ensure staff work within their levels of competency and that patients are safe.

Enabling others - the increasing role of AHPs as enablers, facilitators and teachers requires a new approach to governance that not only makes sure staff have the necessary skills and competencies to undertake this role but also to ensure that standards of practice in those they have trained is maintained over time.

This means that care assurance arrangements need to reflect new ways of working and should be supported by professional leadership arrangements that reflect contemporary practice.



Summary

This document highlights outcomes from a programme of work that took place during 2016. As part of this work, a model of service delivery was identified that can be adopted by all allied health professions within Forth Valley, capturing both diversity and commonality. It provides a framework to articulate not only the current contribution to delivery of Shaping the Future, Active and Independent Living Programme and Strategic Plans but also describes future opportunities to maximise the innovation, enthusiasm and drive of AHPs within NHS Forth Valley.

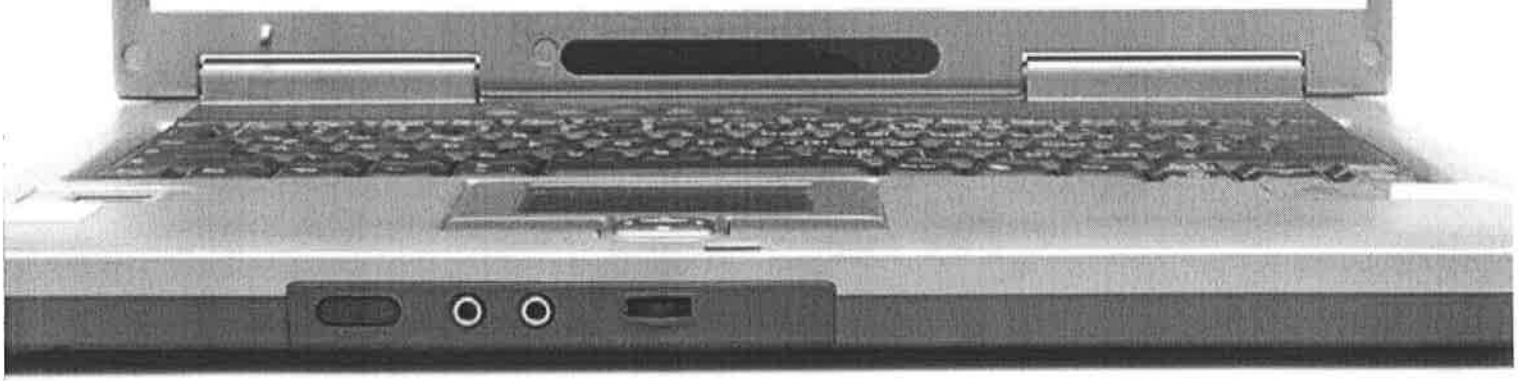
AHP Workplan 2017 – 2021

- Workstreams will be set up to further explore innovative opportunities for AHP service delivery within each tier of the 4 tiered model, including advanced practice.
- Each new service delivery model will be expected to demonstrate how it has incorporated the cross cutting themes (eg personal responsibility, prevention, early intervention, use of technology and improving health and well being)
- Each workstream will ensure that relevant operational measures are in place to support the recording and reporting of consistent and meaningful data
- There will be a requirement to develop contemporary and affordable workforce plans supported by workforce development plans to support delivery of new models
- A specific workstream will consider care assurance for AHPs for safe, effective and person centred service delivery
- Professional leadership arrangements will be strengthened to support the above

Examples of current AHP practice

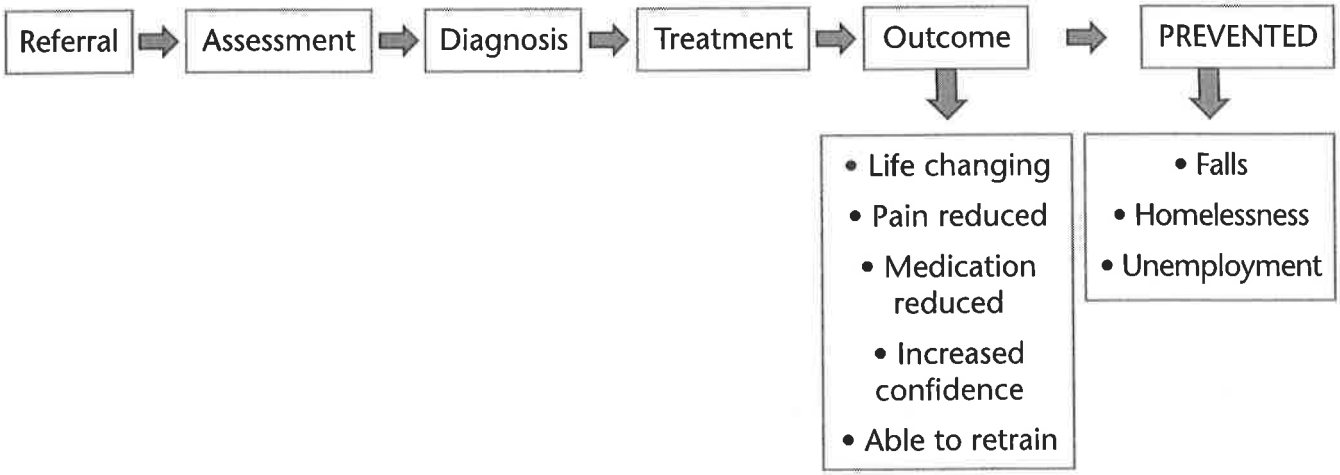
All services have used the 4 tier model to describe their current service delivery in Forth Valley and there are also a number of logic models that have been developed that demonstrate both outcomes and impact of the AHP intervention (see example). These can be found using the link

https://nhsforthvalley.com/wp-content/uploads/2014/06/AHP-Professional-Leadership-Section-2.pdf



Orthotics

A 34 year old gentleman injured in military service was referred to the orthotic service via his GP. Several operations to both knees had left him in constant pain with his knees constantly giving way causing him to fall. He was on high amounts of medication for the pain, unemployed, considering sitting in a wheelchair permanently and about to be made homeless by the time he accessed the Orthotics Service. He was assessed in clinic and prescribed functional knee braces for both knees. He reported the treatment he had received radically changed his life- his pain was reduced therefore his medication reduced so he could think clearly again. He could walk without pain and instability so the falls reduced. His new mobility and confidence encouraged him to enrol onto a course to train for a new profession to be able to support his family again.



NHS Forth Valley

Stirling Council

Clackmannanshire Council

Falkirk Health and Social Care Partnership

Paper for Health Boards and Integrated Joint Boards – West of Scotland

Planning and Delivering Care and Treatment across the West of Scotland

Purpose

This paper sets out the requirement for the West of Scotland to produce a first Regional Delivery Plan for March 2018 and seek the support of Health Boards and Integrated Joint Boards to work collaboratively to achieve the best outcomes delivered sustainably for the citizens across the West.

Background

The Health and Social Care Delivery Plan published in December 2016 set out the importance of delivering;

- Better care
- Better health
- Better value

The Health and Social Care Plan signalled the need to look at services on a population basis and to plan and deliver services that were sustainable, evidence based and outcomes focussed. We can provide better patient outcomes and more efficient, consistent and sustainable services for citizens through NHS Boards, Integration Joint Boards and other partners working more collaboratively and effectively to plan and deliver services.

At regional level, the Scottish Government has commissioned Regional Delivery Plans to be developed, encompassing a whole-system approach to the delivery of health and social care for each of the 3 regions (North, East and West). For the West of Scotland this involves planning for the population of 2.7m covered by 5 NHS Boards, 16 Local Authorities and 15 Health and Social Care Partnerships as well as the Golden Jubilee Foundation. The national NHS Boards are also developing a single plan that sets out the national services where improvement should be focused, including, where appropriate, a ‘Once for Scotland’ approach in areas such as digital services, clinical demand management and support services.

To take forward the national and regional approach, 5 Chief Executives have been appointed to the role of National or Regional Implementation leads.

Developing a Regional Plan

To progress a Regional Delivery Plan it is essential to link this to national planning for specialist services, local planning within Health Boards and locality planning within Integrated Joint Boards to ensure we plan effectively for the wider population.

It is recognised and understood that the existing Boards retain their governance responsibilities, however, to achieve this ambition:

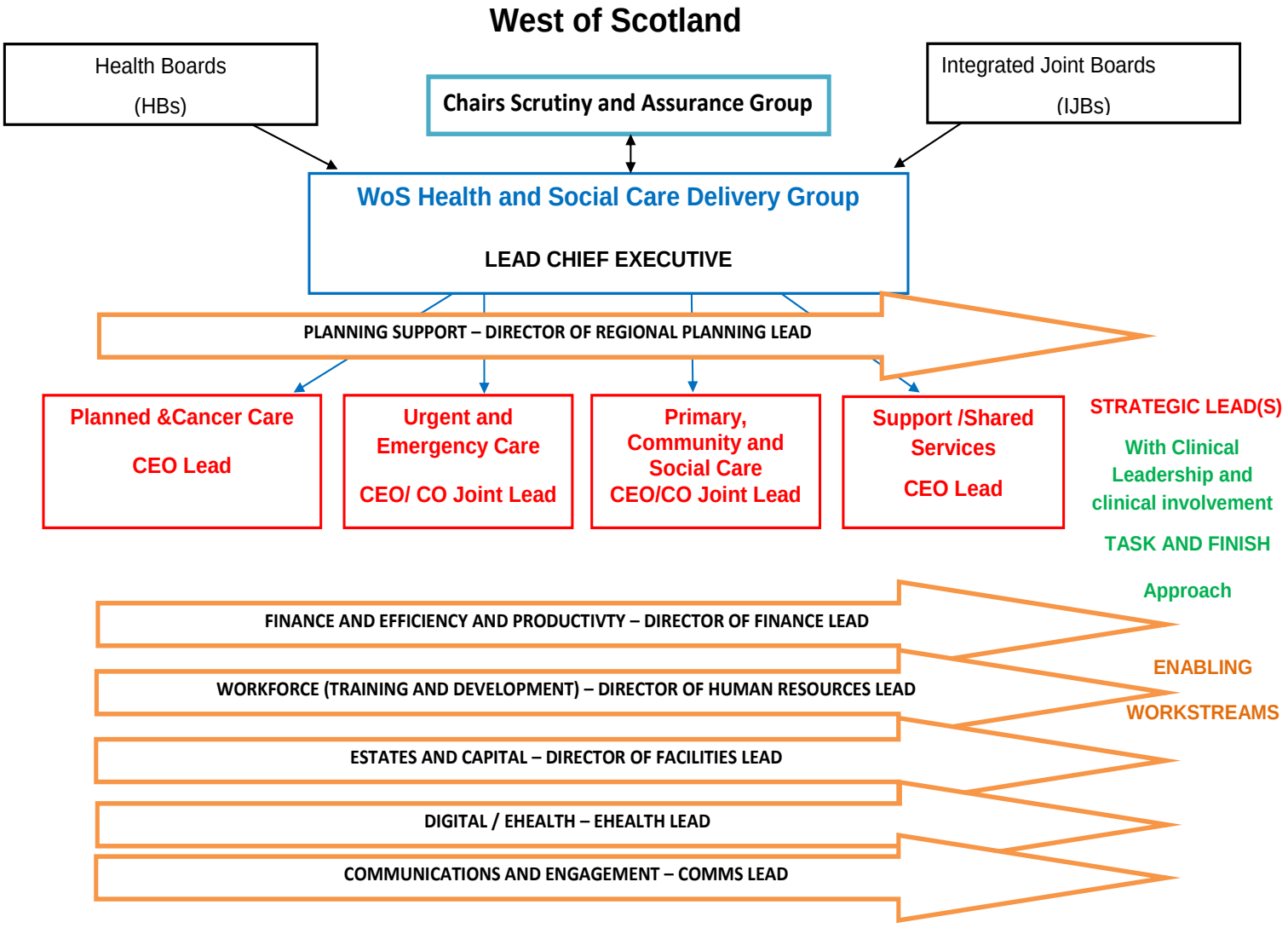
- it is essential that Health Boards and Integrated Joint Boards across the West of Scotland support a collaborative approach
- we need to recognise that boundaries cannot be barriers to delivering evidence based outcomes
- there needs to be transparency in our discussions
- we need to accept a collective accountability for the wider population, evidenced through our decisions and actions.

In taking forward this work, it is important that we are guided by some key principles, namely;

- Maximising health gain
- Anticipation and prevention
- Reducing inequality
- Quality, evidence and outcome
- Sustainability

This is an evolving process which will be achieved by working together across the different organisations in a whole systems approach to set out the story for the West of Scotland, describing the current challenges and consider the opportunities to transform care models to meet the future requirements of our population and improve health.

Current programme structure



Scottish Government
Riaghaltas na h-Alba
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Appendix 7

Carers (Scotland) Act 2016: Consultation on Draft Regulations

RESPONDENT INFORMATION FORM

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

Are you responding as an individual or an organisation?

☐ Individual

x☐ Organisation

Full name or organisation's name

Falkirk Health and Social Care Partnership and Falkirk Council Children's Service

Phone number 01324 506400

Address

HSCP Denny Town House, Glasgow Road Denny FK6 5DL
Falkirk Children's Services Sealock House, 2 Inchyra Road, Grangemouth FK3 9XB

Postcode

Email Margaret.petherbridge@falkirk.gov.uk

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

x☐ Publish response with name

☐ Publish response only (without name)

☐ Do not publish response

Information for organisations:

The option 'Publish response only (without name)' is available for individual respondents only. If this option is selected, the organisation name will still be published.

If you choose the option 'Do not publish response', your organisation name may still be listed as having responded to the consultation in, for example, the analysis report.

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

x☐ Yes

☐ No

Review of Adult Carer Support Plans

Question 1
The circumstances in which plans must be reviewed are specified in regulation 2 of the draft Carers (Scotland) Act 2016 (Review of Adult Carer Support Plans and Young Carer Statements) Regulations 2017. It will be for the responsible local authority to decide whether to review an adult carer support plan in other circumstances not specified in the draft regulations. The draft regulations specify the following circumstances in which an adult carer support plan must be reviewed: a) The cared-for person moves to live in a different local authority area; b) The adult carer moves to live in a different local authority area; c) The cared-for person moves into various listed types of long-term residential care; d) Any other change in the adult carer or cared-for person's circumstances which, in the view of the local authority, has had a material impact on the care provided by the adult carer to the cared-for person. Do you agree with the circumstances listed in the draft regulation?

Q1 Response
Yes

Question 2
Are there additional circumstances not listed in the draft regulations that should be specified as always triggering a review of an adult carer support plan?

Q2 Response
Yes. Plans should be reviewed annually and carers should be able to request a review is they feel their circumstances have changed.

Question 3
Is the suggested approach outlined above appropriate, with regard to review of an adult carer support plan following the discharge of the cared-for person from hospital?

Q3 Response
Yes – agree with the suggested approach, including whether the carer is a child or an adult.

Statutory Guidance provides for a more flexible approach to support planning in partnership with carers. This enables the conversation to centre on individual outcomes, support needs and circumstances.

Question 4
Are there particular circumstances surrounding the discharge of the cared-for person from hospital (as at Section 28 of the Carers Act) that should always trigger a review of an adult carer support plan (e.g. based on the duration of the hospital stay, or changes in the care needs of the cared-for person post-discharge)? Please provide details of any suggested circumstances.

Q4 Response
As indicated above the carer's circumstances and support needs are very individual. A review should always be considered and the opportunity for review discussed with the carer. Any review should take point at the most appropriate time for the carer.

Young Carer Statements

Question 5
The circumstances in which a young carer statement must be reviewed are specified in regulation 3 of the draft Carers (Scotland) Act 2016 (Review of Adult Carer Support Plans and Young Carer Statements) Regulations 2017.
The circumstances in which a young carer statement must be reviewed are: a) The cared-for person moves to live in a different local authority area; b) The young carer moves to live in a different health board or local authority area; c) A young carer at a state school outwith the local authority area where they live leaves that school and moves school to a third local authority area; d) The young carer, if a pupil at a grant-aided or independent school leaves the school; e) The cared-for person moves into various types of long-term residential accommodation; f) Any other change in the young carer or cared-for person's circumstances which, in the view of the responsible authority, has had a material impact on the care provided by the young carer to the cared-for person. Do you agree with the circumstances listed in the draft regulation?

Q5 Response
Yes - This should be widened to include any care establishment or school out with the home area. Many looked after children who are cared for people will be in foster care, kinship care or residential care. Some will also be young carers.

Question 6
Are there any circumstances not listed in the draft regulations that should always trigger a review of the young carer statement (apart from transition of the young carer from children's services to adult services)?

Q6 Response
Yes
When young carer becomes accommodated by the local authority.
Where the child requests a review. Children should view statements as supportive and something that they are actively involved in preparing. They should therefore have the right to request a review consistent with the principles of UNCRC which underpins Scottish policy in supporting children. Children have the right to request reviews with regard to other areas of state intervention.
The young carer may be subject to other review processes – planning meetings in schools, looked after reviews, ASN reviews, or Child Protection Case Conferences. Research and studies are consistent in highlighting that children do not like to participate in systems designed around organisational needs. Therefore the review of the young carer statement should be conducted in a way that puts the young carer's participation at its heart. It should be integrated with other processes, where

the young carer wishes this, to reduce the burden of meetings and reviews for children.

The 2014 Act sets out the statutory requirements for a Child's Plan and the Guidance needs to state how the statement relates to this plan. The Guidance should make clear that review of statements needs to be undertaken in the context of the Getting It Right for Every Child approach in which there is one plan for the child coordinated by a lead professional. The Statements should be integrated with the statutory Child's Plan if the young carer has one.

Question 7
In particular, we are interested in views about whether it would be helpful for the discharge of the cared-for person from hospital (as at section 28 of the Carers Act) to be added as another circumstance that requires the review of a young carer statement.
Is the suggested approach outlined above appropriate with regard to review of a young carer statement following the discharge of the cared-for person from hospital?

Q7 Response
Yes - Statutory Guidance provides for a more flexible approach to support planning in partnership with young carers (and, where appropriate, their families). This enables the conversation to centre on individual outcomes, support needs and circumstances.

The GIRFEC approach allows for 'Team around the Child' meetings/planning meetings which can be set up quickly and involve all those relevant to the child or young person. This offers an efficient and co-ordinated method for reviewing a young carer statement, taking account of any other circumstances.

Question 8
Are there particular circumstances surrounding the discharge of the cared-for person from hospital that should always trigger a review of a young carer statement (e.g. based on the duration of the hospital stay, or changes in the care needs of the cared-for person post-discharge)? Please provide details of any suggested circumstances.

Q8 Response
No, but the Guidance should state that a review of the plan should always be considered and discussed with the young carer. The important issue here is that the decision about reviews are made in full discussion with the young carer

Short Breaks Services Statements

Question 9
Do the draft regulations (alongside the Carers Act) provide an adequate requirement for the preparation, publication and review of short breaks services statements?

Q9 Response
Yes. Regulations should be kept to a minimum and Guidance should provide the detail in order that it can be appropriately amended to reflect best practice as the Act is implemented.

Question 10
Do you agree with the information that the Carers Act and the draft regulations require to be included in a short breaks services statement? Please use the comments box to explain why if you are suggesting that additional information should be included.

Q10 Response
Yes – the purpose of the Short Breaks Services Statement should be clear and should ensure carers know who to contact for further information.

Question 11
Do you agree with the approach summarised above to cover support for breaks from caring and short breaks services under statutory guidance? Please explain the reasons for your answer.

Q11 Response
Yes - we agree with the approach to using statutory guidance to outline the value of enabling carers to benefit from leisure pursuits as part of a package of support.
Including specific detail in guidance rather than in regulations is preferable as this allows for a more flexible approach in line with individual outcomes. It is preferable to leave the short break/respite options as open as possible to ensure that support can be provided flexibly and imaginatively and can be responsive to changing need i.e. it should not be prescriptive but able to embrace a wide range of options, including for young carers to be able to access to local activities with their peers.