Agenda Item: **7**

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Chief Officer Report**
Meeting:	**Integration Joint Board**
Date:	**1 December 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 progress to develop a draft structure and the outline timeline for the implementation of an integrated management and locality structure, including the required support services

2.2 note the increased demand of the current workload on the existing management team

2.3 request the Chief Officer and the Chief Finance Officer develop a costed proposal for additional support to be agreed with the Chair and Vice Chair and Chief Executives. The proposal will identify available funding.

2.4 note the launch of the agreed terms for the General Medical Services Contract and associated documents

2.5 note the requirement, if the contract is agreed, to develop an HSCP Primary Care Improvement plan by the end of July 2018

2.6 note update reports on the General Medical Services contract will be provided to future meetings

2.7 note the contract award for the Discharge to Assess provider from 1 December for 24 weeks with the potential to extend for a further 24 weeks

2.8 remit key HSCP officers to work with the Alcohol and Drug Partnership (ADP) to prepare a proposal setting out how the ADP will link with the IJB going forward

2.9 remit the Clinical and Care Governance Group to consider the findings of the Social Work Complaints Review Committee's and report back any issues to the Leadership Team and IJB as required

2.10 note the work to refresh the publication scheme to comply with the new version issued by the Scottish Information Commissioner

2.11 agree to complete a Board self-evaluation checklist, with findings initially reported to the Chair, Vice-Chair and Chief Officer

2.12 note the HSCP consultation response to the Carers Charter submitted by the Chief Officer

2.13 note the HSCP response to the Health and Sport Committee on care home sustainability

2.14 remit the Chief Officer, Medical Director and performance colleagues to prepare and submit an interim response to the Ministerial Strategic Group for Health and Community Care and present this to the IJB meeting in February for approval.

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

4.1 **Development of an Integrated Structure and Support Services Arrangements**
The Director of Nursing has led the work with the Chief Officer and General Managers to develop a proposed implementation plan for an integrated health and social care structure and detailed project plan. This is included as a separate agenda item 12.

4.2 There is also potential for the Health and Social Care Partnership (HSCP) to host additional services which are not in scope. There are successful models elsewhere in Scotland. To date this has not formed part of the local discussions.

4.3 It is imperative that the future structure is effective and efficient, particularly in relation to the management cost. Accordingly the NHS Board, Falkirk Council and HSCP may wish to consider how to streamline the operational management costs of other out of scope community based services within the HSCP structure.

4.4 Members of the Board will be aware from other items on the agenda, of the considerable workload arising from the existing work to deliver the strategic plan, the change programme including the review of Home Care and the development of integrated locality teams. Additional work required to implement the General Medical Services (GMS) contract and to develop the Primary Care Transformation Programme Improvement Plan, alongside the amendment to the Integration Scheme as outlined in section 14 make the outstanding requirement for a support services agreement more urgent. The current management resource is not sufficient to deliver the scale of change required.

The management team requires more support for planning, project management, performance communications, community capacity building and engagement. It is proposed that the Chief Officer and the Chief Finance Officer develop a costed proposal for additional support for agreement with the Chair, Vice Chair and Chief Executive. The proposal will identify available funding.

5. SERVICE DEVELOPMENTS

5.1 **New General Medical Services (GMS) Contract**
Scottish Government and the Scottish General Practitioners Committee (SGPC) of the British Medical Association (BMA) have agreed terms of the 2018 General Medical Services Contract offer. The contract offer was launched on the 13 November. The Scottish Government letter is attached as Appendix 1.

5.2 A poll of the BMA membership will be held during December to seek their agreement to the new contract. The results of that poll will be announced in early January 2018 and presuming a positive response, allowing the new Regulations to be laid in February. This will enable the contract to come into effect in April 2018.

5.3 An essential part of the proposed contract is to see general practice more integrated with wider healthcare services to better reflect the role of Integration Joint Boards as the planners, commissioners, and in many cases, through HSCP arrangements, those responsible for the delivery of primary care services.

5.4 A Statement of Intent has been drawn up and is attached as Appendix 2. This outlines the collaborative approach required between Scottish Government, NHS Boards, Integration Authorities (IA) and GPs.

5.5 A co-produced draft Memorandum of Understanding (MOU) between the IA, the SGPC of the BMA, NHS Boards and the Scottish Government is being developed. This sets out an agreed approach that, if accepted by the profession, will support the implementation of the GMS contract in Scotland from April 2018. The changes that would be delivered through this new contract are focussed on redesigning the balance and flow of work between GPs as the Expert Medical Generalist (EMG) and other professional staff working within a multi-disciplinary team. The draft MOU sets out :

- general principles underpinning primary care in Scotland
- respective roles and responsibilities of
    - Integration Authorities (typically delivered through the Health and Social Care Partnership delivery organisations)

    - NHS Boards as parties to General Medical Services contracts, service delivery agents and NHS employers
    - SGPC as the Negotiating Committee of the BMA for the GMS contract in Scotland
    - Scottish Government setting the strategic, legal, and financial framework for general medical services in Scotland
- resourcing (financial and workforce)
- the establishment of HSCP Primary Care Improvement Plans; alongside NHS Boards arrangements for local delivery of the new Scottish GMS contract in line with the Scottish GMS contract offer document ("Scottish Blue Book")
- governance arrangements for oversight of implementation of the new Scottish GMS contract and the HSCP Primary Care Improvement Plans, if the new contract is formally endorsed by SGPC.

5.6 SGPC will be holding a series of road shows across Scotland to provide briefings. The Forth Valley Road Show for GPs is scheduled for 20 November. Senior staff from both IJBs and the Health Board will meet with SGPC colleagues to discuss the new contract on the same day.

5.7 If the terms of the contract are agreed the Partnership and Health Board will be required to develop an HSCP Primary Care Improvement Plan by the end of July 2018. This will also require to be incorporated into the Strategic Plan.

5.8 This will be a key piece of work which will need commitment and collaboration across the Forth Valley partnerships to deliver within the timeframe alongside the other significant work streams. The Chief Officer will liaise with the Interim Chief Executive of NHS Forth Valley to agree how we will proceed. The IJB will be provided with an update report at the next meeting on 4 February.

5.9 **Alcohol and Drug Partnership**

At the IJB's October meeting, a presentation was delivered by the Chair of the Falkirk Alcohol and Drug Partnership (ADP) and the Forth Valley ADP Co-ordinator. The presentation set out the role of the ADPs and the challenges facing Forth Valley and Falkirk in terms of drug and alcohol use. The presentation also set out the links between the work of the ADP and the priorities in the Falkirk Strategic Outcomes and Local Delivery Plan (SOLD), developed by the Community Planning Partnership for 2016-2020. The current improvement plan for the ADP was subsequently circulated to IJB members. This improvement plan includes actions that came from the ADP review carried out by the Care Inspectorate across Scotland to support self evaluation of National Quality Principles.

5.10 The Scottish Government issued funding allocation letters for ADPs in August 2017 noting that from April 2016, responsibility for the deliver of both in patient and community based addictions services was transferred to IJBs. The letter highlighted that there is an expectation that the IJB and ADP will work together in maintaining agreed service levels. A key area to be addressed in light of the changes to responsibilities, is how the work of the ADP links to the IJB, including what the appropriate governance mechanisms are for looking at service delivery models, commissioning decisions, reviewing performance and budget considerations. The FVADP has recognised that this piece of work needs to be

carried out. It is proposed that the ADP, in collaboration with officers from the Health and Social Care Partnership, are requested to prepare a proposal setting out how the ADP will link with the IJB going forward. If approved, it is expected that this paper would come to the April meeting of the IJB.

5.11 **Podiatry Service**
The IJB received a report on 16 June 2017 and approved the proposed redesign of podiatry services. This was subject to the outcome of the proposed pilot and patient feedback.

5.12 The podiatry service is managed as an area wide service across Forth Valley and therefore the implementation of the Personal Foot care Guidance will be piloted simultaneously across both partnerships. The pilot site for Falkirk will be Stenhousemuir Health Centre as this is one of the larger podiatry sites with a greater number of patients suitable for redirection than the smaller sites.

5.13 The podiatry proposal for Clackmannanshire and Stirling IJB was agreed at the meeting held on 30 August 2017. The pilots across both partnerships will commence in February 2018. A scoping exercise has been undertaken with the podiatry staff to identify their training needs in relation to the successful redirection of patients from the NHS Podiatry Service and a training package is being developed to support staff through this transition. A manual exercise to identify patients who are suitable for redirection has also been completed.

5.14 NHS Forth Valley communications team are involved and will issue a media release prior to the start of the pilots and a letter which will be given to those patients suitable for redirection.

5.15 The IJB are asked to note the pilot start date and that a report will be presented to a future IJB on the outcome of the pilot.

5.16 **Active and Independent Living Programme (AILP) group: Uninjured faller pathway with Scottish Ambulance Service (SAS)**
Since the last update in September 2017, the local group taking forward the work to develop a pathway with SAS and local services to avoid unnecessary conveyance to hospital for uninjured fallers, has commenced testing of the pathway from 2 October 2017.

5.17 Achievements during this period have been:

- pathway tested with an increasing number of crew members
- decision-making support tool has been reviewed and decision made to not use
- pathway film script agreed, cost selected with dates to start voice recordings and animation type agreed – This will form the basis of training and education for SAS staff
- SAS continue to carry out ‘deeper dives’ followed by one to one sessions with crew members.

5.18 Activity for coming month:

- continue to increase the number of crews using the pathway
- complete audio recordings for filming of pathway
- develop Feedback Form from community services to SAS and agree process for feedback
- continue to use 'deeper dive' information in one to one sessions with crews
- selection of 6 people – 2 who have been conveyed to hospital, 2 who have remained at home and 2 who were conveyed and turned around at Emergency department. This information will provide group with valuable information to continue ongoing work.

5.19 The local working group continues to meet monthly and receive support from the Improvement Adviser from the Active and Independent Living programme. Monthly WebEx sessions are run for all partners taking part in this national programme to facilitate learning and sharing of good practice.

5.20 The chair of the local group provides monthly progress reports to the national centre. These reports are also shared with Andrew Murray as Lead for Unscheduled Care, to ensure that he is aware of progress which will feed into the Unscheduled Care Group. The progress updates are also shared with the Chief Officers of both partnerships.

5.21 **Safe and Together Approach – Domestic Abuse Informed Practice**
Funding to deliver multi agency awareness raising and training for Falkirk strategic leads, managers, supervisors and practitioners was secured via Falkirk Health and Social Care Partnership. Falkirk currently sits above the national average in the number of reported incidents of domestic abuse to Police Scotland per 1000 of the population. Research and practice experience reflects that not all incidents are reported.

5.22 The need for improvement was identified arising from an audit of multi agency practice in 2015 in response to domestic abuse. In particular a need for: a common framework and shared language across services that included psychological abuse and patterns of behaviour rather than a focus on incidents and, a need to shift the focus from victim /survivor being expected to protect their children to holding the perpetrator to account for their behaviour and for their parenting.

5.23 An overview of the approach, its core components and principles followed by core and managers/supervisors training was delivered between 13–17 November 2017. Participants who attended the core training are expected to embed the approach in their day to day practice and also to support and mentor others. Participants were involved in pre and post course evaluation and their practice will continue to be evaluated at six monthly intervals to determine impact upon service delivery and service users outcomes. Monthly practitioner engagement sessions will be facilitated to provide opportunities to share experience and inform future practice and wider roll out of the approach. This will include Social Work Adult Services.

5.24 110 participants attended the awareness raising event representing a wide range of adult and children's services. This included services focussed on prevention, early, targeted, statutory and court mandated intervention. 29 participants attended the core training and 27 participants attended the managers/supervisors training. There was representation from Local Authority Children's Services, Police Scotland, NHS FV, voluntary sector and Children's Panel.

5.25 Embedding the Safe and Together approach has been identified as a priority for Children's Services multi-agency learning and development alongside extending the use of the Neglect Toolkit. It is recognised that domestic abuse and neglect all too often co-exist.

6. HSCP CHANGE PROGRAMME

6.1 **Priority setting framework**
Following the briefing session for Board Members on 3 November 2017, a similar session is being organised for the Strategic Planning Group in the early New Year.

6.2 **Primary Care Transformation Programme**
The Primary Care Transformation Programme was presented and agreed by Falkirk IJB in August 2017. Since the last update report the detailed proposals generated through the General Practice sustainability work stream in Falkirk West and the Urgent Care Out of Hours work stream have been progressed and implementation activity is underway.

6.3 The following presents a summary of the work that has taken place:

6.3.1 Urgent Care Out of Hours
The first phase of the urgent care out of hours programme is focussing on developing a more sustainable multidisciplinary team to deliver necessary urgent primary care through evenings, overnight and weekends across Forth Valley. The following activities have been achieved in the last period.

- Dr Chris Mair and Dr Karyn Webster have been appointed as joint clinical leads for the service
- the overnight, acute hospital based, mental health advanced nurse practitioners are now working with the GPs to test out a model which will direct NHS 24 triaged telephone calls for people with mental health needs directly to the mental health nurses. This is a test of change associated with the overnight acute mental health model and will be evaluated over the next three months
- the recruitment process has commenced for 5 urgent out of hours care advanced nurse practitioner training posts. This will be the key change in terms of providing highly skilled clinical capacity to the service and reducing the reliance GPs
- the out of hours working group is also scoping the practical options for commencing work with the Scottish Ambulance Service and the role of the paramedic specialist practitioner.

6.3.2 General Practice Sustainability: Falkirk West Locality

The introduction of 4 primary care mental health nurses across the Falkirk West practices will create significant first point of contact capacity within general practice and build on the existing and evolving model of community based support for mental health. These posts are in recruitment and hoped to be in place by 1 March 2018. This work will integrate with the Falkirk partnership mental health commissioning group. The new GP contract potentially presents further opportunities for mental health, including increasing the reach of social prescribing.

6.3.3 In addition

- reports were submitted to Health Improvement Scotland in September
- we are soon to introduce Florence, simple text based telehealth for blood pressure monitoring to the first 4 GP practices in Falkirk. This has the potential to introduce an already tested technology approach to self care into primary care which will improve quality, personal and clinical experience and reduce resource use for a high volume clinical task
- the programme is supporting cluster quality improvement across Forth Valley through a variety of mean including smaller scale tests of change.

6.4 **Frailty at the Front Door Collaborative**

NHS Forth Valley and the two HSCP's will be one of three NHS Boards to work with iHub to improve the way frailty is coordinated at the front door of acute care through a collaborative approach. The work is at the early stages with an induction event scheduled for 7 December 2017. The Board will receive an update on the development of the collaborative at future meetings.

6.5 **Discharge to Assess**

Following a tender and evaluation process, an award has been issued to a provider that will enable the continuation of the Discharge to Assess project.

7. DELAYED DISCHARGE

The Delayed Discharge update is included in the Performance Framework Report, as a separate agenda item 11.

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 Financial Report at agenda item 8.

9. SERVICE PLANNING

9.1 **Winter Plan**

The NHS Forth Valley Winter Plan is attached as a separate agenda item 14.

9.2 **Regional Planning**

The West of Scotland Health and Social Care Delivery Board is required to develop a regional transformation plan over the next 6 -12 months. This will set 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. 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.

9.3 The West of Scotland Health and Social Care Delivery Board has taken forward work in the following areas:

- Producing a "Developing a Regional Plan: position paper and discussion document" in September 2017. Attached as Appendix 3. The paper describes the collective ambition of the West of Scotland to improve the health and care for people across the Region. It has a particular focus on keeping people well, early intervention and developing better, more integrated care organised around the individual needs of the patients we serve. It builds on the many examples of excellent care already provided across the Region and reflects our local aspiration to deliver the *National Health and Social Care Delivery Plan* providing better health, better care and better value. The Regional Delivery Plan will support both the Local Delivery and Health and Social Care Strategic Commissioning Plans and taken together with these plans will describe a strategy for the health and social care for the Region's 2.7m population as a whole.

- Producing a population health needs assessment for the West of Scotland – this is currently being progressed; a significant number of analyses have been identified and undertaken which will support the work over the coming months to consider the service model and provision for health and care services for the region. Beyond the work to consider the population age, gender deprivation levels and the implications of this both in relation to health and social care provision, use and funding levels, work is considering the use of services, life expectancy and health outcomes; reviewing the trends in this over the last decade or longer.

- Producing a demand and activity report – this is currently being progressed.

- Producing a "Developing a Regional Workforce" plan – initial work has considered the NHS workforce as workforce information is more developed. Workforce data from social care will be available from the Health and Social Care Partnerships as work is completed to refine Phase 2 of the national workforce plan.

- Producing a communications plan – this has been developed to support the implementation of the West of Scotland Delivery Plan. It sets out the approach that will be taken to engage with key stakeholders on the plan, to communicate the national and historical context within which the plan has been developed and to highlight the benefits that will be realised for patients, communities and staff. It also outlines the measures that will be taken by the West of Scotland Communications Teams to ensure consistency of message, co-ordination of

timescales and a single ‘once for the West of Scotland’ approach to maximise effective use of resources and avoid duplication.

9.4 The IJB will receive regular reports on the West of Scotland Regional Delivery Plan.

10. IJB GOVERNANCE

10.1 **Social Work Complaints Review Committee (CRC)**
Falkirk Council recently convened two Social Work Complaints Review Committee’s to consider complaints made against Social Work Adults Service. This was in line with the Social Work Complaints Handling Procedure as the complaints were made before 31 March 2017. They were therefore dealt with under the previous 3 stage complaints procedure; the third stage being the CRC. The findings of the CRC now need to be considered by the service to ensure the appropriate management actions are taken and lessons learned.

10.2 It is proposed that the Falkirk Clinical and Care Governance Group are remitted to consider the findings of the CRC and report back any issues to the Leadership Team and IJB as required.

10.3 **IJB Self Evaluation**
In response to a proposal by the Chair, an IJB self-evaluation checklist has been developed for completion by each Board member. Board self-evaluation is an important part of good corporate governance which helps to ensure that the Board is focused on what it is trying to deliver. The process can support members to honestly and objectively:

- reflect on how well they are meeting their responsibilities as individuals and collectively as a Board
- consider their performance
- step back from the Boards everyday business and identify and address fundamental issues
- demonstrate leadership by conducting a review and
- identify arears for improvement in how the Boards work is undertaken.

10.4 It is proposed that each Board member complete the form. The responses will then be collated into a report prepared for the Chair, Vice-Chair and Chief Officer. A summary report with recommendations will be presented to a future Board meeting for consideration.

10.5 **IJB Publication Scheme**
The Board is a public body for the purposes of the Freedom of Information (Scotland) Act 2002 (FOISA). The Board must have a publication scheme in place, so that members of the public can see what recorded information is already publicly available, and find out how to access that information. A publication scheme, based on the Model Publication Scheme (MPS) for local authorities, from the Scottish Information Commissioner (SIC) has been available on the Board’s web page since 1 April 2016.

10.6 There is a requirement to refresh the publication scheme to comply with the new version issued by the SIC. This will ensure the IJB continues to meet its duties under section 23(1) of FOISA and is attached at Appendix 4 for information.

10.7 In line with the existing arrangements made in the 2015 MPS, adaptions have been made to include the 2017 updates. The changes outlined below follow the guidance and updates, where required, are provided:

Class	Additional Requirements
Class 3: How we take decisions and what we have decided	Environmental Impact Assessment Reports undertaken in compliance with the Town and Country Planning (Environmental Impact Assessment)(Scotland) Regulations 2017
Class 6: How we procure goods and services from external providers	Various additional information, including: ▪ any information published in accordance with the Procurement Reform (Scotland) Act 2014, the Procurement (Scotland) Regulations 2016 and the Public Contracts (Scotland) Regulations 2015 ▪ Register of contracts awarded, which have gone through formal tendering, including name of supplier, period of contract and value ▪ Links to procurement information the authority publishes on the Public Contracts Scotland website
Class 7: How we are performing	▪ Mainstreaming Equality Reports produced under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, as amended ▪ Employee and board equality monitoring reports, produced under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, as amended

11. PUBLICATIONS

11.1 **Audit Scotland NHS in Scotland 2017**
Audit Scotland published a report on the NHS in Scotland in October 2017. With the NHS in Scotland turning 70 next year, the report makes clear the necessity for the organisation to continue to evolve so as to meet the changing needs of the population and withstand the pressures facing the service.

11.2 The report examines key issues the NHS during 2016-17 and how well it is adapting for the future. Significant activity is underway to achieve the Scottish government's vision that everyone should "live longer, healthier lives at home". Crucial building blocks are still to be put in place if healthcare in Scotland is to be transformed.

11.3 The key messages from the report are:

- Finance – NHS Scotland has an annual budget of around £13 billion, 43% of the overall Scottish budget in 2016-17
- Significant pressures – demand for healthcare services continues to increase, with growing numbers of people waiting longer to be seen
- Future planning – the way healthcare is planned, managed and delivered at all levels in Scotland must change if the quality of care is to be maintained
- Long-term – a clear, long-term financial framework is a critical part of setting out how change will happen and when; short-term planning has hindered development
- Involvement – a different way of involving staff and the public in how they access, use and deliver health and care services is needed to help make the necessary difficult decisions.

11.4 The Audit Scotland report contains a number of recommendations mainly for the Scottish Government to take forward, albeit some will require partnership working with NHS boards and integrations authorities. Recommendations focus on three areas: providing the foundations for delivery of the 2020 vision; improving governance, accountability and transparency; and promoting cultural changes which are necessary to move to new ways of providing and accessing healthcare services. This will be monitored through the Leadership Team as required.

11.5 **Independent Sector Nursing Data 2017 report**

Scottish Care published the Independent Sector Nursing Data 2017 report in November 2017. The report provides an overview of nursing in the independent social care sector; the highlights and challenges of nursing in care homes and illustrates the nurse recruitment and retention crisis currently being faced.

11.6 The report is based on survey data from 91 care organisations, representing 317 individual services and approximately 2,400 nurses from the sector. It provides some headline facts and figures about the sector in relation to the recruitment and retention of nurses:

- 64% of nurses in care homes are over the age of 45
- average vacancy levels across sector 31% (28% in 2016)
- 91% of providers are finding it hard to fill nursing posts compared to 68% in 2015.
- 54% of providers think it is harder this year than last year
- turnover of nursing staff is now 43% compared to 29% in 2016
- 46% of providers have increased their use of agency staff in the last three months
- the biggest problem identified in the report is an insufficient supply of nurses.

11.7 The Board will note there is a separate agenda item relating to Bield and their recent announcement to close care homes across Scotland. The sustainability of care home provision is both a national and local concern, which is also being considered by the Health and Sport Committee. There is also work ongoing with COSLA and Scotland Excel on work to develop a National Care Home Contract (NCHC). Further updates will be provided to the Board as required.

12. CONSULTATIONS

12.1 **Carers (Scotland) Act 2016: Carers Charter**
The Scottish Government were seeking views on the draft Carers Charter being made under the Carers (Scotland) Act 2016. The consultation closed on 22 October 2017 and the Falkirk HSCP response is attached at Appendix 5 for information.

12.2 **Care Home Sustainability - Health and Sport Committee**
Following the announcement from Bield Housing Association, the Health and Sport Committee has agreed to carry out a one-off evidence session on care home sustainability. The oral evidence session will take place on Tuesday 12 December and organisations have been invited to give evidence, including Scottish Care, COSLA, Care Inspectorate, Bield, Scottish Federation of Housing Associations and Lothian and Fife Integration Joint Board's. Prior to this session taking place, the Committee issued a short targeted call for views. The Falkirk HSCP response is attached at Appendix 6 for information.

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13. CORRESPONDENCE

13.1 **Carers (Scotland) Act 2016 - Implementation**
The Scottish Government issued a letter on 17 November 2017 requiring amendments to the IJB Integration Schemes to accommodate the alterations necessary for the implementation of the Carers Act. The consultation and legal requirements to alter the scheme need to be completed by 2 March 2018. This places a considerable workload on the HSCP restricted resources and the Partnership Carers Act Implementation Group.

13.2 **Understanding Progress Under Integration**
The Scottish Government wrote to Chief Officers on 22 November 2017 to provide an update on work to develop a plan for sharing progress updates on integration with the Ministerial Strategic Group for Health and Community Care (MSG).

13.3 A small working group of lead officers for strategic commissioning and performance in Integration Authorities, Chief Finance Officers, data analysts and SG officials has been established. The group has suggested the following outline framework for sharing regular progress updates with the MSG based on four key elements:

- quarterly data on the six indicators but in time building on these indicators for example to reflect the contribution of primary and social care
- comparison between progress in Integration Authorities and projections set out in local plans
- overarching narrative summary, drawing out emerging themes from across Integration Authorities
- local illustrations, inviting individual Integration Authorities to contextualise their progress with a presentation to the group and opportunity for discussion.

13.4 A paper providing an update on progress will be presented to the next MSG meeting on 13 December, drawing on the recent annual performance reports, with one or two partnerships to present at the meeting.

13.5 Additionally, Integration Authorities have been asked to provide the MSG with an updated overview of local objectives and ambitions relating to the six indicators for 2018/19 by 31 January 2018. The Scottish Government will then provide an overview, with input and support from the working group and partnerships, for MSG meeting on 21 March 2018.

13.6 The Board are asked to remit the Chief Officer, Medical Director and performance colleagues to prepare and submit an interim response for 31 January and present this to the IJB meeting in February for approval.

13.7 **Digital Health And Care Strategy Development Update**
The Chief Officer received correspondence from the Scottish Government, dated 25 September 2017. This notes the intention to publish a Digital Health and Social Care Strategy by the end of the year.

13.8 The strategy will bring together all IT, digital services, tele-health and tele-care, business and clinical intelligence, predictive analytics, digital innovation and data use interests in health and social care. It will reflect the ambitions of the overall Digital Strategy for Scotland, and we are working closely with the Local Government Digital Office to ensure alignment with their plans.

13.9 The letter also provides an update on progress with work including:

- The establishment of a Strategic Oversight Group with wide representation including from across the health and social care services, academia and the third sector. The purpose of this Group is to act as the key steering body for the development of the strategy and to connect to and communicate with their own networks
- Establishment of an External Expert Panel to provide world-leading advice and expertise in to the Strategy's development. The Chair of the Panel is the internationally acclaimed Professor David Bates of Harvard School of Public Health
- Joint work with Local Government Digital Office to conduct a review of the technical landscape in order to ensure greater consistency and applicability of technology use, improve interoperability, reduce costs through greater.

13.10 NHS Forth Valley's local eHealth Strategy is in the process of being refreshed and there have been 2 wider stakeholder events (with cross sector involvement) to help shape priorities. The revised Strategy, which is expected to go to the Health Board for consideration in April next year, will also pick up on national developments and priorities emerging from the National Strategy publication. The IJB will receive an update at a future meeting on the national strategy and the work being taken forward to develop a local Digital Health and Care Strategy.

14 CONCLUSIONS

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
Through updating the Model Publication Scheme the Board is fulfilling the legal requirements set out in the Freedom of Information (Scotland) Act 2002.

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.

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Approved for submission by: Patricia Cassidy, Chief Officer

Author: Suzanne Thomson, Programme Manager – Falkirk HSCP
Date: 10 November 2017

List of Background Papers:

Directorate of Population Health
Primary Care Division

T: 0131-244 2761
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The Scottish Government

By Email:

Chief Officers

13 November 2017

Dear colleague

2018 SCOTTISH GENERAL MEDICAL SERVICES CONTRACT OFFER

The Scottish Government and the Scottish General Practitioners' Committee of the British Medical Association have agreed the terms of the 2018 General Medical Services contract offer.

This contract offer is being launched today, and can be found at http://www.gov.scot/Publications/2017/11/1343 .

A new GMS contract is a critical part of our plans to transform primary care services in Scotland. The benefit of these proposals include:

- Improving access for patients;
- Addressing health inequalities and improving population health, including mental health;
- Providing financial stability for GPs;
- Reducing GP workload through the expansion of the primary care multidisciplinary team;
- Increasing support for GPs and GP infrastructure;
- Increasing transparency on general practice funding, activities and workforce to assist strategic planning, commissioning and delivery of primary care services; and
- Making general practice a more attractive profession for existing GPs, junior doctors and undergradute medical students.

A poll of the BMA membership will be held during December to seek their agreement to the new contract. The results of that poll will be announced in early January 2018, allowing the new Regulations to be laid in February, which will enable the contract to come into effect in April 2018.

I am extremely grateful to Integration Joint Board Chief Officers for their substantial contribution to the production of this contract offer and to the supporting framework for

implementation, as expressed in the proposed Memorandum of Understanding (updated copy attached). An essential part of the proposed contract is to see general practice more integrated with wider healthcare services to better reflect the role of Integration Joint Boards as the planners, commissioners, and in many cases, through HSCP arrangements, those responsible for the delivery of primary care services.

I recognise that these proposed changes cannot be seen in isolation and come at a time of very significant wider change and significant pressure. That is why the collaborative approach to the oversight and implementation of these measures, both the narrower contractual changes and wider service redesign, are so important.

Leading this scale of change at this time will not be easy and there will be significant challenges locally and nationally in the months and years ahead but that is why the agreement with the BMA to see many of the changes happen over 3 years and for priorities and pace to be set locally is so critical. This will require more engagement with GPs locally and will depend on a relationship of mutual respect, but again we see that as a very positive opportunity in building the wider system clinical leadership we need from GPs.

Ensuring stable GP income, while reducing GP workload and risk are priorities in the contract offer. But these changes have to be seen more widely in the context of whole system planning and delivery including critically the interface between primary and secondary care, and with social care. Equally we recognise that these changes don't address all issues – including shifting the balance of care, and long term infrastructure challenges – but they represent a very substantial foundation for next steps.

I hope you will feel able to commend this offer to GPs locally. It represents a very positive deal at a difficult time. The SG negotiating team is available to help explain the offer and we will be travelling around Scotland in the next couple of weeks to meet and discuss. Please don't hesitate to contact me if you feel there are issues that require specific clarification or discussion.

Best wishes,

Richard Foggo
Deputy Director and Head of Primary Care Division
Health

Andrew Scott
Director of Population

To Whom It May Concern

Statement of Intent: Delivering the new General Medical Services (GMS) Contract in Scotland

A co-produced *draft* Memorandum of Understanding (MOU) between the Integration Authorities (IA), the Scottish General Practitioners' Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government is being developed setting out an agreed approach that, if accepted by the profession, will support the implementation of the General Medical Services (GMS) contract in Scotland from April 2018.

The changes that would be delivered through this new contract are focussed on redesigning the balance and flow of work between GPs as the Expert Medical Generalist (EMG) and other professional staff working within a multi-disciplinary team.

The draft MOU sets out:

- general principles underpinning primary care in Scotland;
- respective roles and responsibilities of:
    - Integration Authorities (typically delivered through the Health and Social Care Partnership delivery organisations);
    - NHS Boards as parties to General Medical Services contracts, service delivery agents and NHS employers;
    - SGPC as the Negotiating Committee of the BMA for the GMS contract in Scotland;
    - Scottish Government setting the strategic, legal, and financial framework for general medical services in Scotland.
- resourcing (financial and workforce);
- the establishment of HSCP Primary Care Improvement Plans; alongside NHS Boards arrangements for local delivery of the new Scottish GMS contract in line with the Scottish GMS contract offer document ("Scottish Blue Book"); and
- governance arrangements for oversight of implementation of the new Scottish GMS contract and the HSCP Primary Care Improvement Plans.

If the new contract is formally endorsed by SGPC, Health and Social Care Partnership Chief Officers and NHS Board Chief Executives have agreed to recommend to their respective Boards that the terms of the MOU be endorsed and that HSCP Primary Care Improvement Plans then be established as part of each HSCP Strategic Planning processes; and be implemented alongside the NHS Board arrangements for delivering the GMS contract in Scotland. The Plans will be developed collaboratively with advice and support from GPs; and explicitly agreed with the local GP Subcommittee of the Area Medical Committee (and in the context of the arrangements for delivering the new GMS contract explicitly agreed with the Local Medical Committee), and be in place by the end of July 2018. Further details on these arrangements can be found in the draft Memorandum.

This clear joint statement of intent provides reassurance that partners are committed to working collaboratively and positively in the period to March 2021 and beyond to deliver real change in local health and care systems that will reduce workload and risk for GPs and ensure effective multi-disciplinary team working for the benefit of patients.

Signed on behalf of the Scottish General Practitioners' Committee of the British Medical Association

Alan McDevitt, Chair, Scottish GP Committee of the British Medical Association

10 November 2017

Signed on behalf of Health and Social Care Partnership Chief Officers

David Williams, Chief Officer, Glasgow HSCP and Chair, Chief Officers, Health and Social Care Scotland

10 November 2017

Signed on behalf of NHS Board Chief Executives

Jeff Ace, Chief Executive, NHS Dumfries & Galloway and Chair, Chief Executives, NHS Scotland

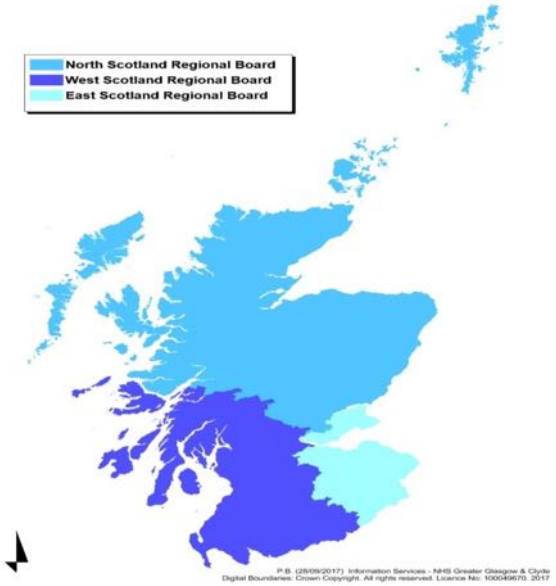
10 November 2017

Signed on behalf of the Scottish Government

Paul Gray, Chief Executive, NHS Scotland

10 November 2017

West of Scotland



Developing a Regional Plan

Position Paper and Discussion Document
September 2017

1. Introduction

This paper describes the collective ambition of the West of Scotland to improve the health and care for people across the Region. It has a particular focus on keeping people well, early intervention and developing better, more integrated care organised around the individual needs of the patients we serve. It builds on the many examples of excellent care already provided across the Region and reflects our local aspiration to deliver the *National Health and Social Care Delivery Plan* providing better health, better care and better value.

The paper is structured as follows:

- Summary of our overall approach
- Our guiding principles
- The leadership of the Programme
- The national policy context
- The regional context
- The case for change
- The emerging common purpose
- Early thinking on new models of care
- The regional plan to take this work forward to March
- Next steps
- Statements of intent

Delivering this vision will require action at every level of the health and care system across the Region. Our starting point is to recognise that circa 90%of care is provided in an out of hospital setting. Our approach will therefore build first and foremost on the needs of local communities whilst also recognising the need to plan for the most seriously ill who will require more specialised hospital based services.

Our approach is to collectively plan to improve the health and wellbeing of our 2.7m population, reducing inequalities and improving health outcomes for our citizens. It will be grounded in effective and meaningful partnership between health care, local authority services, primarily social care, the third sector, patients and communities. The Regional Delivery Plan will support both the Local Delivery and Health and Social Care Strategic Commissioning Plans and taken together with these plans will describe a strategy for the health and social care for the Region's population as a whole.

2. Executive Summary

Regional planning in the West of Scotland with the focus on acute and tertiary services has served us well for many years. These arrangements are no longer fit for purpose, as the task to prepare a Regional Delivery Plan requires a different and more inclusive approach. Therefore, we are putting in place new arrangements to co-ordinate planning across the Region.

The NHS in the West of Scotland has demonstrated significant improvements over the last 20 years; however there is further work to be taken forward to meet the challenges of the next 20years. Preventable illness is widespread and health **inequalities deep-rooted**.

New technologies and treatment options are emerging, and **patients' needs are changing**. We face particular pressures in providing care to an increasingly older population recognising they will need more joined up integrated care to stay well and lead a full life.

In the West of Scotland, we have a shared understanding of the challenges we face and have developed a **compelling Case for Change** as a basis for action.

We have developed a **shared vision and a common purpose** which describes our future offer for our patients and communities. Our ambition is to join up care around the patient breaking down traditional barriers in how care is provided between family doctors and hospitals, between physical and mental health and between health and social care. This future will see far more care delivered locally nearer to people's homes but with some services in specialist centres.

We are committed to **Local Care Models** based on a deep understanding of the different needs of segments of the population, a consistent set of clinical standards and with services integrated and co-ordinated from a patient view.

Whilst most people can be cared for by better more joined up local care, we recognise the most seriously ill need more specialised hospital care. We are committed to developing a region-wide framework to support the development of **New Models of Acute Care** based on a stratified network of services.

To deliver this vision we have put in place comprehensive programme arrangements including **System Leadership through a Regional Programme Board** and have set out a **Forward Programme Plan** (October to March) to deliver the first strategic plan in March 2018.

3. Guiding Principles

In drafting this document and developing the plan, we are proposing to apply the following principles:

- Prevention is better than cure
- Care should be designed around the needs of the whole population removing boundaries in planning and delivering care
- Focus on reducing health inequalities by working together on the wider determinants of health
- Care should be provided as locally as possible and only centralised where absolutely necessary
- Care should be integrated across health and social care working in true partnership with patients, carers and the voluntary sector
- We should make the best possible use of resources achieving value for patients, communities and the tax payer.

4. Leadership of the Programme

The West of Scotland comprises a number of partner organisations supporting the provision of health and care services including 5 Territorial Boards, 15 Health and Social Care Partnerships, 16 Local Authorities, 5 National Boards and a number of Third Sector Organisations.

West of Scotland Partners

Health and Social Care Partnerships (15) / Local Councils (16)[1]	• Inverclyde • East Renfrewshire • West Dunbartonshire • North Ayrshire • North Lanarkshire • Dumfries &Galloway • Falkirk • Glasgow City	• Renfrewshire • East Dunbartonshire • East Ayrshire • South Ayrshire • South Lanarkshire • Stirling & Clackmannanshire[1] • Argyll and Bute
NHS Territorial Boards (5)	• Ayrshire & Arran • Forth Valley • Lanarkshire	• Dumfries & Galloway • Greater Glasgow &Clyde
NHS National Boards (5)	• Scottish Ambulance Service • NHS 24 • Golden Jubilee Foundation	• National Education Scotland • National Shared Services

1 Local Councils are typically 1:1 with HSCPs with the exception of Stirling and Clackmannanshire which has 2 Councils and 1 HSCP
Source: Regional Team

Recognising the importance of all the key stakeholders in developing a plan for the future in the West of Scotland work, we began working with Boards and their executive and non executive members, the Integrated Joint Board chief officers and their voting members, and other senior managers and senior clinical leaders' to begin to create a shared agenda. We recognise that we have further work to do engage with and include Local Authorities, Integration Joint Boards and the third sector in the development of this plan, particularly around the social care element of this work. This will be progressed over the next few months.

Some of this work has been facilitated by external organisations to encourage a more transformational approach both to developing the regional delivery plan and the ways in which we will need to work across the different parts of the system to achieve success, learning from experience both within the United Kingdom and across other parts of the world.

Stakeholder Engagement

Our first set of meetings aimed to set out the question we believe we needed to answer as a region. This can be described as:

How do care services need to be configured in the West of Scotland to be safe, sustainable, equitable, effective and affordable to meet the needs of the 2.7m population going forward to 2035 and support the delivery of the Health and Social Care Plan?

The workshop engaged more than 65 people in shaping approach




An engagement session on the 20th September 2017 saw representatives from the NHS Boards, the Integrated Joint Boards come together to consider the emerging story for the region. The session set out for consideration and discussion:

- the key messages arising from the population needs assessment;
- the key messages from the gap analyses on workforce, demand and performance analyses, finance and infrastructure;
- the case for change;
- the common purpose that unites us as a region
- the potential interventions in care models and a stratified model for designing services
- the programme structure to support the development of the Regional Delivery Plan
- the approaches we need to adopt to communication and co-production as we go forward to prepare the first regional delivery plan for March 2018, including the approach to governance and sign off prior to submitting the plan at the end of March 2018.

This session allowed key regional stakeholders to come together to consider and agree the vision for the region and the guiding principles and behaviours that will be crucial to develop and maintain the relationships across the region and to create the arrangements and necessary conditions to engender a whole system approach to achieve the collective goal.

5. National Policy Context

Over the past eighteen months 2 key documents – the Health and Social Care Delivery Plan and the National Clinical Strategy- have been published providing the policy direction and setting out the way forward in Scotland in terms of health and care of our population on top of the existing Quality Strategy that sets out an ambition for quality.

National Health and Social Care Delivery Plan[1], launched in December 2016, describes the approach to be followed to ensure that Health and Social Care is transformed in the next few years. It is action orientated, and sets out a significant list of deliverable objectives which include a focus on regional and national planning of services where appropriate. The delivery plan draws on preceding strategies, pulling them together and setting out the direction of travel and expectation of a modern health and care system to achieve the aspirations mentioned in the strategies.

- 2020 Vision – people live longer, healthier lives at home or in a homely setting
- Health and Social Care Integration[2] which promotes prevention, anticipation and supported self management; working across health and social care to improve patient care
- Daycase treatment as the norm
- Highest standards of quality and Safety (Quality Strategy 2010)
- Person centred care
- Health and Social Care Workforce Plan[3]– considering workforce planning and development
- Investment - matched to reform and transformation
- Digital Strategy[4] - promoting technology and information supporting both patients and care professionals to provide modern models of care

The National Clinical Strategy[5]published in February 2016 set out areas for change:

- Planning and delivery of primary care services around individuals and their communities
- Planning hospital networks at a national, regional or local level based on a population/ availability of appropriately skilled workforce paradigm
- Providing high value, proportionate, effective and sustainable healthcare (linked with Realistic Medicine)
- Transformational change supported by investment in eHealth and technological Advances

The National Clinical Strategy also calls for regional planning of many hospital services to improve patient outcomes; to make maximal use of highly trained clinicians; to fully utilise complex services supported by expensive technology such as robotic surgery; to standardise care to avoid unwarranted variation; and to make services financially sustainable for the future.

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[1] http://www.gov.scot/Resource/0051/00511950.pdf
[2] www.shiftingthebalance.scot.nhs.uk/downloads/1305042182-Integration(Summary position paper)
[3] Integration across Health and Social Care Services in Scotland – Progress, Evidence and Options: www.gov.scot
[4] http://www.ehealth.nhs.scot/strategies/the-person-centred-ehealth-strategy-and-delivery-planstage-one/
[5] www.gov.scot/Publications/2016/02/8699

The King's Fund has considered the evidence of benefit from reconfiguration of acute services and notes that while reconfiguration can lead to improvements in services:

> *"Reconfiguration is an important but insufficient approach to improve quality. It should be used alongside other measures to strengthen delivery of care and to instil an organisational culture of improvement."*[6]

Other national policies and strategies influencing the development of the regional delivery plan include:

- Best Start *(Maternity and Neonatal Services Strategy – 2017)*
- Primary Care Transformation
- Implementing the GP contract
- Mental Health Strategy
- Cancer Strategy (March 2016)
- Getting it Right for Every Child (GIRFEC)
- Realistic Medicine
- Review of Health and Social Care Targets
- Public Health Strategy

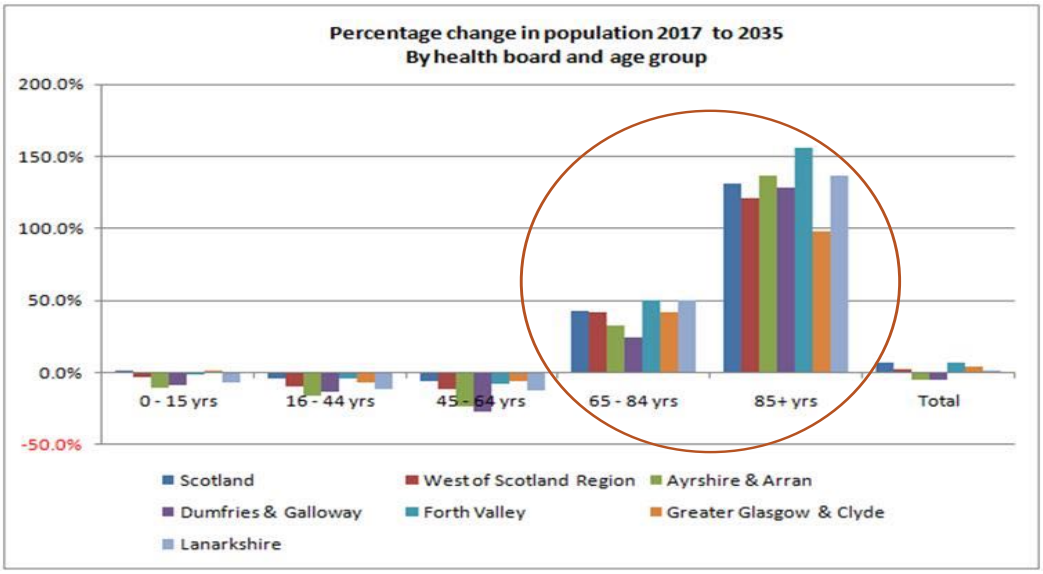
[6] The King's Fund: *Reconfiguration of Clinical Services: What is the evidence?* Candice Imison. November 2014

6. Regional Context

6.1. Understanding the Population

The West of Scotland serves a population of circa 2.7m, covering a wide geographic area of 8,777 square miles, consisting of urban, rural and island communities. A Health Needs Assessment for the West of Scotland is currently being progressed. A significant number of analyses have been identified and undertaken which will support the work over the coming months to consider the service model and provision for health and care services for the region. Beyond the work to consider the population age, gender, deprivation levels and the implications of this both in relation to health and social care provision, use and funding levels, work is considering the use of services, life expectancy and health outcomes; reviewing the trends in this over the last decade or longer.

Population Changes in West of Scotland



Population Needs Assessment: Emerging Findings

- The West of Scotland has some of council areas with highest proportions of oldest residents in terms of population percentage over 65.
- It also has most of the most deprived council areas in terms of summary SIMD score (Glasgow city, West Dunbartonshire, Inverclyde, Renfrewshire, North Lanarkshire, East Ayrshire) and the bulk of the population residing in the most deprived deciles and quintiles.
- Both social deprivation and agedness of the population place major demands on the health and care systems
- The challenges of equitable service provision based on need rather than demand in a geographic area that also has considerable sized areas of affluence results in smaller National Resource Allocation Committee (NRAC) and Scottish Allocation Formula (SAF) shares for hospital & community services.
- Hospital admission rates are observed to be higher in the West of Scotland based on the crude rates. Work is underway to age, sex, deprivation adjust this position to assess the

level of over-utilisation. This poses the question - does the proximity to hospital facilities encourage access particularly where they are relatively well provided for in terms of hospital beds and consultant provision?

- Plateauing of the life expectancy at birth is seen for Scotland as a whole, which is particularly clear for Scottish males, and evidence of unexpected downward shifts in the life expectancy trajectory are visible in some areas within the region. Stalling of rises in life expectancy defying the expectation of ongoing improvements in longevity. This is likely to be multi-factorial
  - including the effects of the high prevalence of obesity, the rising prevalence of Type 2 Diabetes, the stalling decline of smoking prevalence, the contribution made by the rise in alcohol-related deaths, etc
  - the role of austerity and level of investment in health and social care may be impacting, as well as the current organisational model that may hinder the achievement of optimal efficiency.
  - falling access to primary and secondary health services, and social care, for some sections of the population in both remote/ rural areas and urban areas.

  All of these threaten to reverse the progress made by improving structural determinants of health over the past century and increased health service provision over the past 15 years.
- Consistently clear improvements in most health parameters, as well as preservation of, or improvement in, the relative position in the national health league table, are being seen for the residents of the most deprived health board in the West of Scotland, namely Greater Glasgow & Clyde, in terms of standardised death rates from all causes, and standardised mortality ratio for all causes, SMR for cancer mortality for all types, and specifically for the commonest cause of death, namely heart disease.
- Despite having less social deprivation than GG&C, Lanarkshire's relative position in the standardised mortality (all causes) league table has worsened somewhat in recent years and its relative position in the cancer mortality league table for all types combined and for lung cancer in females has also worsened.
- Perhaps more surprisingly, more rural areas in the West of Scotland, even those characterised by relative affluence such as Dumfries & Galloway and Argyll & Bute, have unexpectedly lost ground and those with historical health deficits, such as parts of Ayrshire & Arran, appear to have deteriorated further in very recent years. Age/sex standardised death rates (all causes), standardised mortality ratios (all causes of death), and/or SMR for cancer (all types combined) appear to be rising in recent years, for these three board/council areas, the starting points of the rises varying with the area. Even the more affluent Forth Valley, appears to have lost ground with respect to its relative position in the cancer (all types) SMR league table, since its enviable position before 1990.

To ensure that the limited resources available are used equitably, that is, determined by genuine need, and fairly distributed against both geographical and socio-economic gradients, it will be important to consider the service provision across the region.

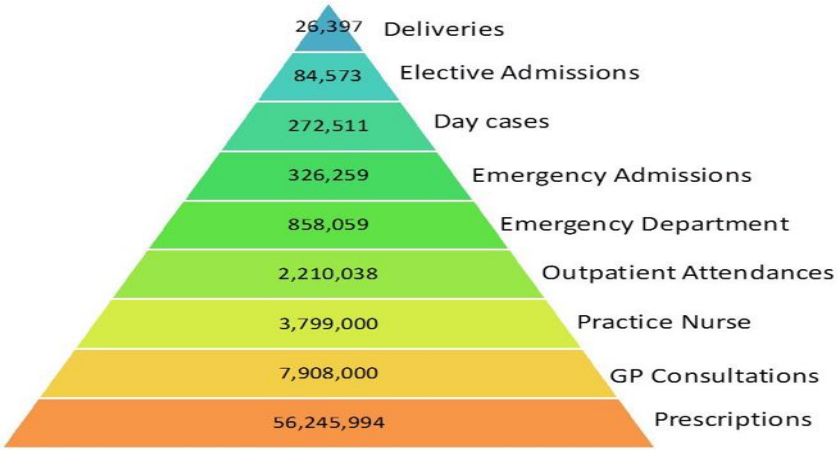
6.2. Demand Capacity Review

As with the Health Needs Assessment, analyses are being undertaken to consider the demand for and use of services. The focus to date has been primarily on health but this will be extended to include the social care provision for the plan submitted in March. This work has been reviewing a number of areas including analyses of: activity by admission category and by specialty; changes in activity; beds, bed days used and length of stay; projected position by 2020, 2025 and 2035; performance data including waiting times and waiting list information, outpatient measures and day case rates.

Information setting out the position for the West of Scotland is available in a supporting paper however some of the high level messages of this work to date are set out below:

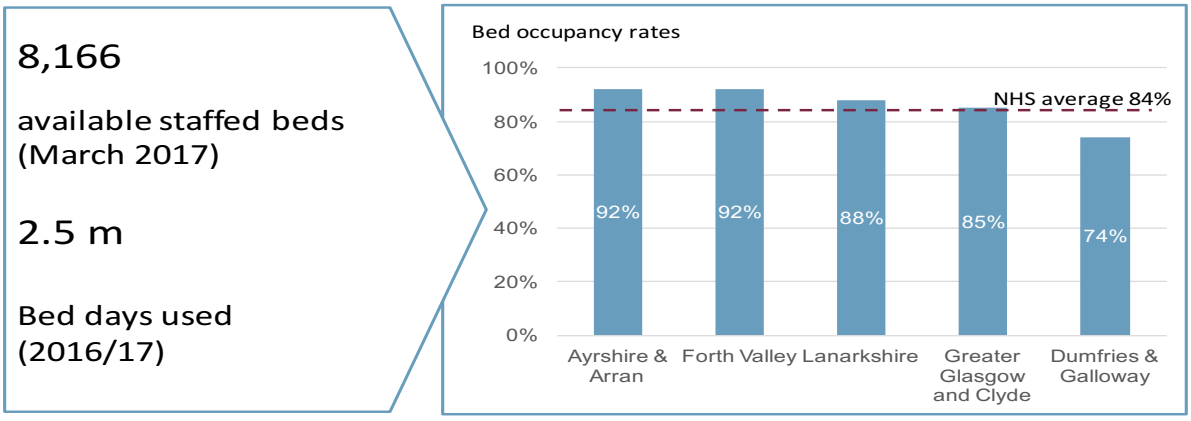
West of Scotland Activity

The diagram below sets out some of the key areas of activity, indicating the different levels of activity, providing some context in terms of where the services are provided.



Work has also been undertaken to consider the bed numbers and bed days being used to support the hospital service provision across the region. The inserted information below shows the current position based on the expected percentage growth of the population based on how the current service is used by different age bands of the population and the potential future scenarios if there is no change.

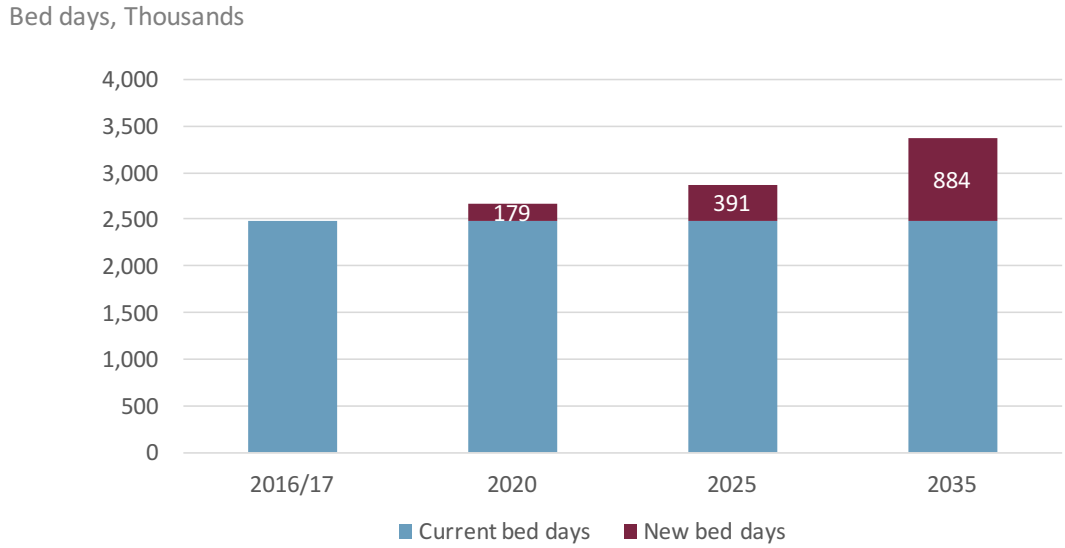
Current acute bed status in West of Scotland



Projected changes in activity and bed days, based on demographic growth only

Of particular note is the rise in bed days in addition to the 200,000 currently to be saved. With the current model of care, we expect there to be demand for an additional 880,000 acute bed days by 2035– 2,850 beds assuming an 85% occupancy rate.

Projected changes in occupied bed days due to demographic changes only



Source: Regional team analysis

6.3. Workforce Challenges

The NHS in Scotland must adapt its workforce models to be in the best position to deliver excellent and sustainable treatment and care in a rapidly changing Health and Social Care landscape. Workforce planning must take account of the national workforce planning work and consider the workforce challenges across the health and social care sector. West of Scotland Health Boards have been working together to develop a position which accurately describes the workforce within the region and identifies the principle workforce issues which must be addressed in order to deliver new regional models of clinical care:

- Workforce availability
- Workforce adaptability

- Workforce affordability

The West of Scotland Health Boards currently employ 62,630 wte / 72,620 head count, which accounts for approximately 45% of the NHS workforce in Scotland. Each Board has reviewed the ISD dataset to identify specific factors, where applicable, in terms of risks and challenges, opportunities and options to create an overall high level regional workforce position.

A supporting paper on the work to date is attached in the appendix. The high level message is that there are five key 'hot spot' job families/professions across the region:

- Medical – challenges in demand, supply and sustainability across a spectrum of grades, specialties and including general practice;
- Nursing – specifically challenges in smaller branches/cohorts associated with the overarching demography of the workforce and the potential risk this presents in terms of retirement profiles e.g. health visitors, district nurses, paediatrics, midwifery, mental health and associated issues with demand and supply. The demand for Advanced Nurse Practitioners (ANPs) was also specifically flagged. This mirrors the medical position both in acute settings but also increasingly within GP practices. There remain questions about the capacity of higher education institutes to meet demand;
- Radiographers – mismatch in supply of radiographers compounded by the increasing demand for services and existing problems with radiology staffing;
- Pharmacy technicians – significant increase in demand not being matched by supply;
- Healthcare science – demographics of the workforce, particularly in senior roles, are influencing the current provision couples with longstanding national issues with supply;

Issues informing the need for change are currently being quantified in terms of medical staffing as this proves challenging in providing equitable access to specialist opinion to support care in a number of Boards and specific specialties within the region. Currently there are circa 269 vacancies at consultant level (119 vacant for 6 months or more). This exercise will in time cover all staff groups.

It is recognised that the workforce of the future will not be "more of the same". The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will be required to work to the "top of their licence" with work aligned to their skills. It is likely that the workforce may require to be re-profiled to match the increased workload demand in the community and the higher acuity in acute care. The Directors of Nursing are leading work through the West of Scotland Advanced Nurse Practitioner Academy to ensure consistency of competency and level of practice across the West of Scotland, sharing resources where appropriate. This is enabling the West of Scotland to get assurance with regard to growth of this important senior group. They are also looking at non-medical care models to develop new and extended Advanced NMAHP roles such as caseload holders, clinical leads as alternatives to medical models for particularly hard to fill specialties.

As part of the development of the first plan for March 2018 work will be undertaken to understand the total workforce supporting health and care services within the West of Scotland.

6.4. Infrastructure

Based on the report prepared by Health Facilities Scotland the West of Scotland faces significant challenges in relation to the infrastructure within health. The Report indicates that

around 50% of the estate is modern, offering good functional accommodation however 50% of the estate has significant challenges. This is summarised below:

Modern estate

- Queen Elizabeth University Hospital & Royal Hospital for Children
- Stobhill and Victorla ACHs Glasgow
- New Dumfries and Galloway Hospital
- Forth Valley Royal Hospital
- 2 PFIs / PPP facilities – Hairmyres, Wishaw (Lanarkshire)
- Golden Jubilee Hospital
- New community care estate such as Eastwood Health and Care Centre and other similar primary care facilities

Estate with significant challenges

- Backlog maintenance around 1/3rd of national total
- Physical condition, age and functional suitability challenges a number of sites
- 3 similarly sized hospitals south west of Glasgow, with a growing need for investment RAH, Crosshouse Hospital and Ayr Hospital
- East side of Glasgow - GRI and Monklands will struggle to provide functionally appropriate accommodation. There are also challenges around the need to improve engineering services infrastructure to support these sites.
- Outlying areas of the region need investment in buildings and engineering services; specifically IRH, Vale of Leven and Falkirk Community Hospital
- Some GP practices

The current position offers both a challenge and an opportunity to build the future infrastructure based on the needs of the population organizing care in the most appropriate setting and using the workforce to best effect to provide the right care level within the hospital or community settings.

- £1bn - £2.5bn investment required
- Investment strategy combining replacement, refurbishment and rationalisation likely to offer most effective and affordable solution
- Health and Care Facilities and requirements as well as national work on primary care being undertaken by Health Facilities Scotland will also be included in the March 18 plan
- Medical Equipment and technology investments are currently being reviewed
- Offers new opportunities to consider different infrastructure to support future services

  The Regional Delivery Plan must bring a co-ordination to the planning of and investment in infrastructure that supports the care models developed.

6.5. Finance

The financial plans submitted by the West of Scotland Health Boards for 2017/18 show a combined recurring deficit of £237m.

	Greater Glasgow & Clyde £m	Ayrshire & Arran £m	Forth Valley £m	Lanarkshire £m	Dumfries & Galloway £m	Total £m
New Resources:						
Baseline increase	31.1	10.0	7.3	23.5	4.2	76.1
Social Care Fund	(23.7)	(7.7)	(5.3)	(13.4)	(3.0)	(53.1)
New Medicines Fund	(7.9)	(2.6)	(1.5)	(3.7)	(1.8)	(17.5)
Income from other Boards	2.4					2.4
Other (including NRAC)	0.0	1.5	5.4		1.7	8.6
Total new resources	**1.9**	**1.2**	**5.9**	**6.4**	**1.1**	**16.5**
Additional Expenditure:						
Recurring over/(under) commitment b/fwd	29.6	17.7	7.5	9.5	4.8	69.1
Pay inflation estimate	20.0	4.8	3.3	7.2	3.6	38.9
Other Costs (incl medical staffing)	6.0	3.1	4.4	8.7	4.5	26.7
Supplies inflation estimate	6.0	5.0	4.7	4.8	0.4	20.9
Primary Care prescribing	8.5	5.6	2.9	1.4	1.2	19.6
Acute prescribing	21.0	0.3	2.4	8.6	0.7	33.0
Other prescribing			2.5			2.5
Capital charge inflation	1.0					1.0
Apprentice levy	8.0	1.5		2.0	0.8	12.3
Rates revaluation	11.0	0.3	1.2		0.5	13.0
Pension cost (RRL to AME)	3.5					3.5
National services	1.5	0.4	0.1	0.3		2.3
Premises costs	3.2	0.9				4.1
Out of Hours and other regional costs	5.0	0.4	0.9			6.3
Total additional expenditure	**124.3**	**40.0**	**29.9**	**42.5**	**16.5**	**253.2**
Financial gap to be closed	**(122.4)**	**(38.8)**	**(24.0)**	**(36.1)**	**(15.4)**	**(236.7)**

Work is currently under way to complete a forward look for the next three years but this is difficult given uncertainties around future funding assumptions regarding Scottish Government funding uplifts and pay policy. To set a context for the financial parameters of the regional plan, a three year forward projection is being developed based on the following assumptions:

- **Annual Scottish Budget allocations** – assumes that the basis in which funding was allocated for 2017/18 continues for 2018/19 and 2019/20 (annual uplift to meet cost pressures <1%).
- **Transfer resource** – share of the transfer of £250m from Acute to IJBs in line with national target to reduce bed days by 400,000. This will also provide 50% of the commitment to increase primary care funding by £500m by the end of the current parliamentary term. The other 50% being funded directly by Scottish Government Commitment to 50:50 split between primary / community care and acute costs by end of the current parliamentary term also factored into three year forward projections.
- **Projected Cost Base** – assumes 10% inflationary increase (3%pa) on 2016/17 budgets over the next three years (conservative estimate).
- **Earmarked allocations** – assumes that these will be spent of new commitments and therefore no net benefit to overall financial position.
- **New medicines and diagnostic costs** - assume increase for secondary care medicines and diagnostics in line with recent historic patterns.

- **Capital**– no change in formula funding allocation to be prioritised towards backlog maintenance and essential equipment replacement.
- Changes to pay policy will impact future modelling

7. Case for change

Everyone deserves to lead a full and healthy life and to receive the best possible care when they become ill. The West of Scotland has many areas of excellent care of which we should be proud of but we know that we could do more both to prevent ill health and to improve outcomes.

Over the last few years we have seen improvements in the services and infrastructure for patient care. For example:

- We opened the Queen Elizabeth University Hospital and Royal Children's Hospital in Glasgow. We will shortly open a new hospital in Dumfries and Galloway.
- We have reorganised our community services, placing responsibility for local health and social care services under the joint leadership of the NHS and Local Authorities.
- We have successfully provided a number of regional services such as interventional cardiology, based in 2 facilities at Hairmyres in Lanarkshire and the Heart and Lung Centre at the Golden Jubilee Foundation; Forensic medium-secure care at Rowanbank Clinic, Glasgow. The Beatson West of Scotland Cancer Centre on the Gartnaval Campus in Glasgow which we have recently extended by developing a satellite cancer unit at Monklands in Lanarkshire; and most recently the Regional Robotic Prostatectomy Service at the Queen Elizabeth Hospital.
- There is ongoing work to reorganise and improve specialist services across the West of Scotland including major trauma, systemic anti-cancer therapy, urology and ophthalmology. Each of these services seeks to improve patient outcomes by organising care in the most effective way; providing the timely access to specialist care and through standardising approaches to optimise care.
- Integrated Joint Boards have progressed change in local care through the Integrated Care Fund and Primary Care Transformation.

Staff work hard so that we can continue to care for people under greater and growing pressures on the services. Despite all of this work, there is an emerging set of facts that we believe will not make it possible for the care services to stay on the current path without causing significant issues for our patients and staff as well as circumstances which we believe will make the current service model unsustainable even in the short term. This set of emerging facts, tested with senior colleagues involved in leading care services in the West of Scotland, who have confirmed their support for this, can be grouped around 8 major themes:

- **Our population is changing and so are their care needs** - Our population is getting older quicker, partially as a result of work we have done to improve how long people live. This brings its own challenges as older people generally need more health and social care. Particularly of significance is the growth in over 85's albeit we are seeing that life expectancy is remaining flat and for some areas reducing.

- **We need to improve people's health** – In the West of Scotland we have high levels of obesity, smoking, drinking and drug use. There is also widespread poverty in parts of the Region. There is strong evidence that these factors contribute significantly to people's need for care, in how long people live and in how many of these years are lived in good health.

- **Hospital is not always the best place for care** – People are currently in hospitals who need care that would be better provided outside of hospitals. There is strong evidence that people staying in hospital longer than necessary makes them deteriorate and lose their independence. In some parts of West of Scotland we lack co-ordination of care for people who require multi professional input, particularly those with long-term conditions, mental health and older people and this also results in unnecessary visits or admissions to hospitals. Our care staff in the community do not have access to specialised services and this means they have no choice but to refer people to hospitals.

- **We want to provide the best possible care**– There are differences in how we deliver care across the region and variation in practice. It is important that we use the learning from each part of the service to support us to deliver the best care models and address variation in morbidity and mortality rates. This is partially because our most experienced and highly specialised staff are spread too thinly across the West of Scotland reducing the experience given to junior staff in the management of complex cases that allow them to build up the skills to provide the most appropriate level of support in emergency care. Hospitals are also struggling with waiting times for operations and treatments. This is in part because due to emergency care pressures which can impact on the provision of planned care in the same hospital resulting in elective cancellations reducing the capacity available to support planed care.

- **We need to use our workforce effectively** - There are difficulties in recruiting and retaining staff at all levels and settings of care making it hard to provide the best levels of care. The age profile of our staffing in some professions and general practice also gives cause for concern in terms of maintaining sustainable services. Some local organisations already have high levels of vacancies and are using temporary staff which is proven to cause clinical risks as well as costing the care services more.

- **Our buildings are not fit for purpose**– About half of the hospital buildings in the West of Scotland need major repair work or replacement that would cost somewhere between £1-2.5 billion. At the same time, much of the care that could be provided in the community does not have suitable locations or accommodation to provide these services.

- **Opportunities afforded by technology** – Technology has changed many industries for the better and there are many opportunities for the West of Scotland to use technology to improve our service, both in terms of how we organise and deliver care and in the interventions we offer.

- **We need to make the best possible use of available health and social care funding –** This year we expect to have a deficit of £237m across the West of Scotland. Whilst some Boards will manage this in 2017/18 we must address the underlying issues and transform our service model to deliver quality and sustainable services.

In bringing these 8 themes together it is clear that status quo is not an option in terms of providing sustainable and safe services across the region. Leaders of the

West of Scotland care systems believe we must make radical changes in how we provide care or we will fail our population and our staff. There is recognition that regional working across Board boundaries with our citizens to develop service models that meet the populations' needs is essential. This approach will be important to make most effective use of the resources, particularly workforce, if we are to ensure the population have access to the appropriate level of care and to use the funding available to best effect.

Evidence from other systems demonstrates the need to have upfront investment to support delivering the service transformation. In considering the way forward the region recognises the importance of: developing digitally enabled services to modernise how care is delivered; and ensuring adequate capital investment is available to create the most effective configuration of facilities across the health and care system to provide the right models of care to support transformation.

Recognising the existing governance arrangements and accountabilities of the NHS Boards, the Health and Social Care Partnerships/ Integrated Joint Boards and Local Authorities, work will be progressed to consider how each of the organisations can work effectively together to deliver their local plans but also to optimise the opportunities from working regionally to create sustainable care models for the local populations. To achieve this ambition a common purpose has been developed. The next section sets out what our common purpose might be as region to address this case for change.

8. Developing the Way Forward

8.1. Shared Vision and Common Purpose

We are working together as a region towards four aims:

- Improving health and wellbeing;
- Increasing care and quality;
- Delivering on finance and efficiency; and
- Better workplace with a focus on staff.

In the submission in March, we will set out a shared vision and common purpose for the West of Scotland to achieve these aims and directly address our case for change. Our current draft of this is:

While we will be united as a region in addressing this common purpose, not all of the work to plan or deliver these objectives will be done at a regional level. For example, the Integration Joint Boards (IJBs) have primary responsibility for joining up health and social care in their communities, while there are national programmes who are planning for shared services across the nation. Existing Board Strategies and Health and Social Care Strategic Commissioning Plans set out work that will continue to be progressed locally. This work will influence and be influenced by the development of the regional delivery plan. By March we will define how this common purpose will be planned and delivered at local, regional and

national levels with a guiding principle that we should be as local as possible and as regional as necessary where there is a compelling case for regional or national work.

In developing this plan, one of the challenges will be defining the role of the region in care that is delivered outside of hospital. From discussions amongst leaders of the care system we believe there will be a regional role in facilitating sharing of best practices, developing common and consistent elements of care models across the region, determining how best to ensure the money is available to implement these new ways of care, and making sure the IJBs are supported with the necessary workforce, facilities and technology to do their work.

Inevitably there will be tension between organisations within the region as we try to balance achieving individual organisation goals and regional goals that may sometimes pull in opposite directions. If we are to achieve this common purpose as a region, our service leaders will need to role model behaviours that will support the different organisations to work together successfully. Our workshop participants on the 20th identified behaviours they felt would be important including trust, respect, acting with principle and integrity, acting collegiately and ultimately working for the best interests of all the 2.7m people who live in the West of Scotland.

8.2. Care Models

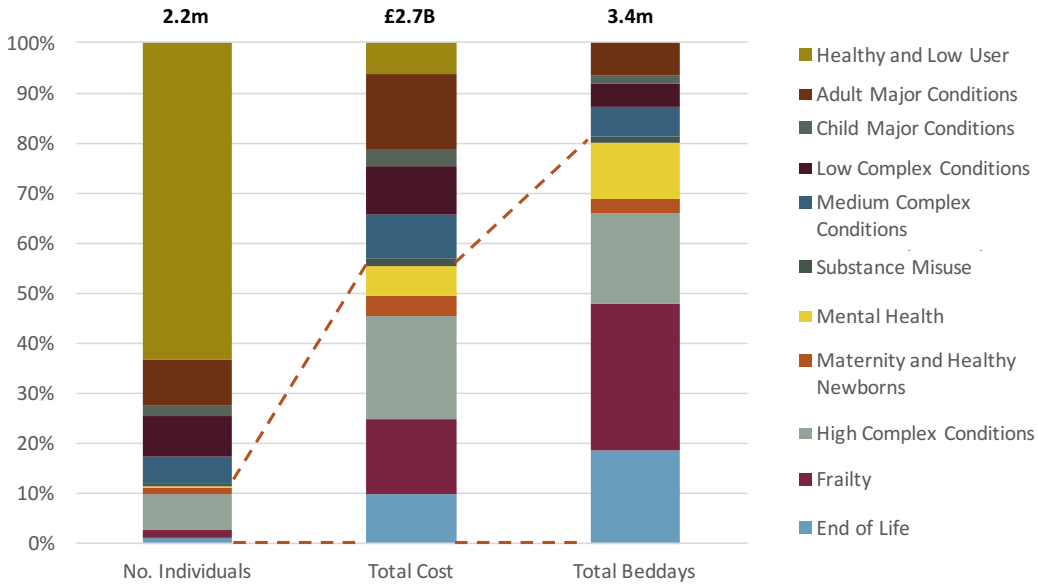
In the West of Scotland we intend to develop our future care models in four ways, outlined in the exhibit below.

Understanding the needs of different segments of the population	Addressing as much care as possible proactively and locally	Designing hospital care to deliver safe and sustainable services	Putting in place the key enablers
• Use ISD data to have fact-based discussion on population segments • Identify specific patients and segments to make targeted interventions to care plans and care models	• Integrated services covering primary care, community care, social care, mental health, access to specialist diagnostics • Services integrated and co-ordinated from patient view • Increased funding and capacity outside hospital • Effective multi-disciplinary team working	• Establishing clear standards for safe delivery of services – Interdependencies – Workforce – Volumes • Establishing different levels of hospital services • Networking hospitals for sustainable high-skilled services	• Digital • Workforce • Estates • Organisational development • Financial Allocation Model • Governance • Communications & engagement

Understanding the needs of different segments on the population

ISD Scotland have developed data that shows how different segments of the population use the care services in very different ways. For example, people with serious mental health needs are estimated to cost £19k in hospital care per person per year, people with frailty issues cost £11K per person per year while mostly healthy people cost £115 per person per year.

In the West of Scotland 12% of the population consume over 55% of the health spend and 80% of beddays



Source: ISD

Individuals and groups of our population clearly have very different needs and we in the West of Scotland are committed to organise the system around these different needs.

Addressing as much care as possible proactively and locally

Integration Joint Boards have primary responsibility for this area and are making progress in developing and delivering on their plans. At a regional level we are exploring the potential for some common elements of care models that can be described regionally and delivered locally. For example, one region in England made this offer of local care to its older population with complex needs:

- **Care planning and navigation** – People will be supported to develop a personalised care and wellbeing plan. Dedicated professionals from a variety of health and social care backgrounds will co-ordinate the care and support from the rest of the multi-disciplinary team (MDT) and the wider health, social care and voluntary sector.

- **Supporting people to improve their health and wellbeing** - Supporting people and carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention / engagement.

- **Healthy living environment** – Ensuring a healthy living environment to preserve long-term health & wellbeing (e.g. falls prevention, housing improvements and alterations).

- **Integrated health and social care multi-disciplinary team** – Providing person-centred, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to people who have personalised care plans based on their needs.

- **Single point of access** – A number called by the person, the GP, community services and acute staff, or indeed any other professional, to support people with their care by gaining more efficient, coordinated access to services.

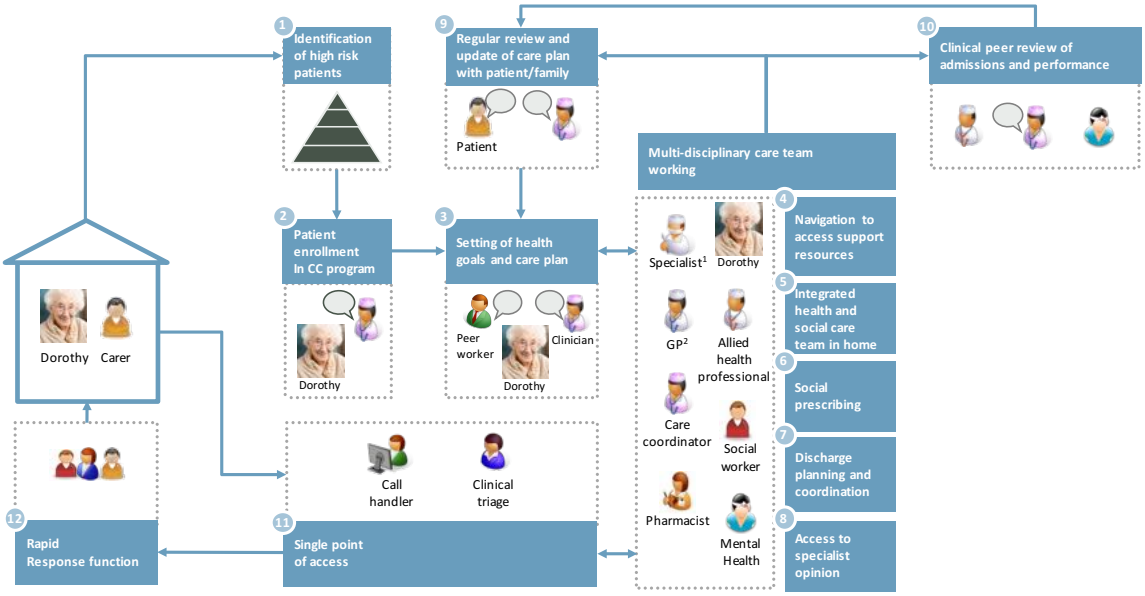
- **Rapid response** – The ability within an MDT to respond rapidly to people with complex needs who are experiencing urgent health or social care needs that left unattended would result in a hospital admission.

- **Discharge planning and reablement** – A pro-active, anticipatory service designed to target those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating and to support their recovery.

- **Access to expert opinion and timely access to diagnostics** - The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics. Access to full and timely diagnostic services and diagnostic results will reduce the need for multiple outpatient appointments.

Such a model for anticipatory care could look like the following chart:

Example flows of an anticipatory Local Care model



1 Specialists in both inpatient or outpatient settings
2 Includes primary care physicians, advanced practice nurses, physicians assistants
Source: Carnall Farrar

It is important to recognise that this type of local care model will require a mix of different primary care professionals working as a multidisciplinary team and is in part designed to make best and most sustainable use of the GP as the expert generalist to improve outcomes. The chart below draws out the range of skills that may be needed.

We are exploring ways to strengthen the teams around GPs, particularly for population segments that need coordinated care in the community

Multi-disciplinary team model for older people with complex needs

In the regional workshop, we agreed that we would seek to put a model or models like this in place across the West of Scotland recognising that there could be significant variation in how we might implement it locally. As a region, we intend to as a minimum:

- Share best practice across Integration Joint Boards
- Estimate the impact of local care models so that we can design the future need for beds
- Agree on the regional need for investment to make the business case together
- Ensure the enablers of local care in place, including workforce, technology and facilities
- Communicate to the population of West of Scotland an expectation of what can be provided locally and where hospital care is needed.

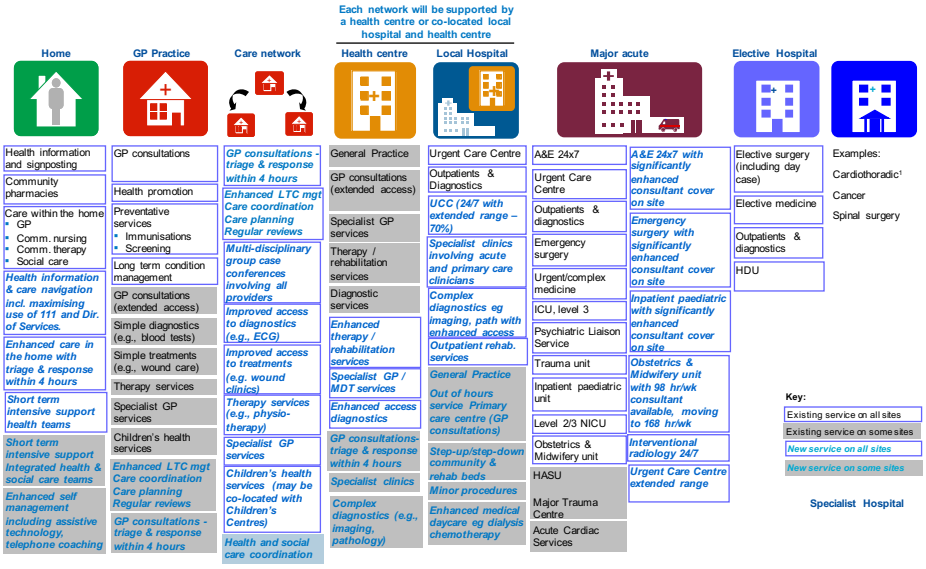
Designing hospital care to deliver safe and sustainable services

As a region, we have explored taking a tiered approach to hospital care, with clearly defined services at each site based on the needs of the population, meeting clinical standards, having the minimum volumes needed to build and maintain staff skills, and the availability of skilled staff for each specialty.

In practice, this would mean moving low volume specialties around different hospital sites; with some higher level hospitals will specialist services. Other hospitals would not have every service but would work through networks.

An example of how a tiered approach might look in the acute sector, as well as how some care services currently provided in acute may move to other models or setting of care models is outlined in the exhibit below.

Illustration of region-wide framework for local and acute care models



In the engagement workshop, it was agreed to explore this approach for the March submission and detail the factors and process that would be considered in such a decision, including assessing different options for clinical safety, availability of workforce, the amount of time it would take patients and families to get to services, capital investment needed, and operating costs.

Putting in place the key enablers

To deliver these care models, many enablers will need to be in place. The exhibit below outlines our early thinking on the different enablers that will need to be planned for in our March plan:

1 Workforce	People will be at the heart of the system that we are building, they are our greatest asset. The new care model will require staff and partners to work differently and will also require new roles to be developed.
2 Organisational development	Training, upskilling and behavioural change are crucial to enable leaders, professionals and teams to work together differently to deliver the new care model.
3 Estates	Estates resources need to be understood. The new care model will be enabled by the creation of a regional capital strategy, considering additional space required; repair, repurposing or disposal of existing space. Exploration of estate and infrastructure for both health and local authorities will be essential to optimise use of facilities and capital funding investment.
4 Information	The new care model will need to be enabled by integrated patient data to allow clinicians and care professionals to plan, and deliver the care needed for our population. Information is also crucial to enable long term, innovative solutions and drive productivity improvements.
5 Financial model	The current financial models and service level agreement arrangements across organisations within the region require to be reviewed as they contribute to the fragmentation in the system, and do not support integrated population based care. A new approach is needed to align organisations around a common purpose, provision of services across the region, nurture collaboration, drive cost savings and support system-wide decision making.
6 Governance	To support the integrated system and achieving a shared vision, appropriate governance is essential to enable the organisations to work together effectively as the system transitions into a new delivery model. This will require clear roles and responsibilities, with engagement from the right stakeholders.
7 Comms and engagement	The public and staff need to be engaged throughout and consulted appropriately. A detailed and robust internal and external communications and engagement plan is required, backed up by the resources to execute it.

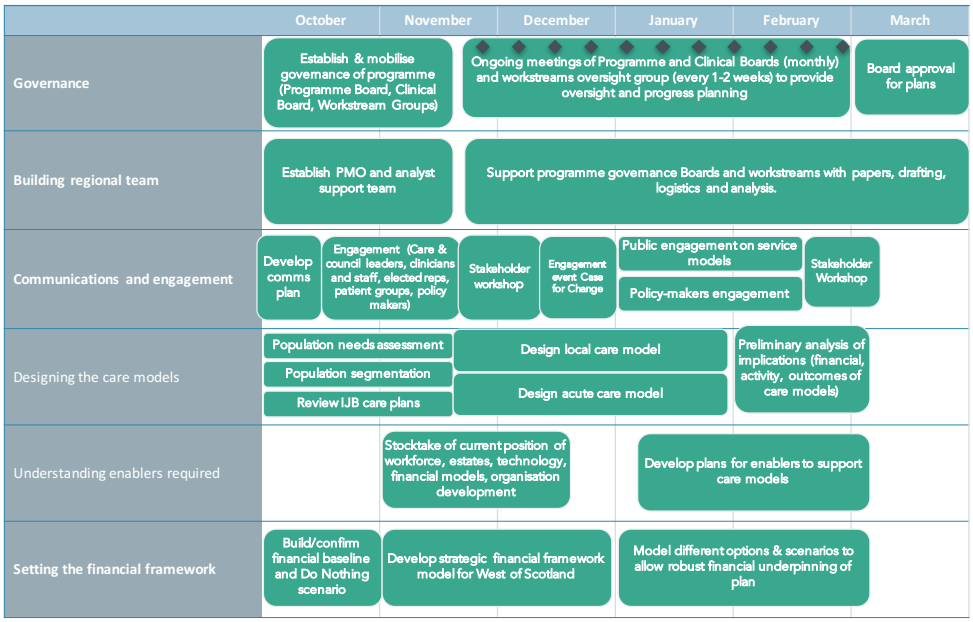
Taken together, we believe these proposals for designing our care models are consistent with the National Clinical strategy, particularly when planning local services around individuals, population segments and their communities, and planning hospital networks at the appropriate level recognising availability of skilled workforce.

9. West of Scotland Structure and Planning Approach to Deliver the Regional Plan

To deliver our regional plan by end-March, we have developed a workplan that covers:

- Governance
- Building the regional team
- Communications and engagement
- Designing the care models
- Understanding enablers required
- Setting the financial framework

This work and the timeline is illustrated below and detailed further in the rest of this section.



9.1. Governance

We are putting in place the following governance arrangements:

- NHS Board Chairs form an assurance and scrutiny group. It is anticipated that this group will develop to include representation from IJB chairs.
- West of Scotland Health and Social Care Delivery Group. This group is chaired by the Regional Implementation Lead. Membership includes CEOs, Chief Officers, Partnership, Employee Director Rep, and leads for Nursing, Medical, HR. We are also engaging with COSLA/SOLACE on including representation from Local Authorities.
- We are exploring the establishment of a Clinical Board/Senate whose scope could include: 1) deepening and owning the case for change, 2) providing clinical input into care model decisions and 3) providing clinical leadership to the process and signal clinical backing of the regional work.

9.2. Building the regional team

Developing the plan and preparing for implementation is going to require building a regional team to support this, the scale of which will depend upon the final scope of work agreed for the region.

The overall effort will be led by the Lead Chief Executive (John Burns) and the Director of Regional Planning (Sharon Adamson). We will be mobilising 5 strategic work streams led by a Chief executive or joint leadership with a Chief Officer to develop detailed plans for each area:

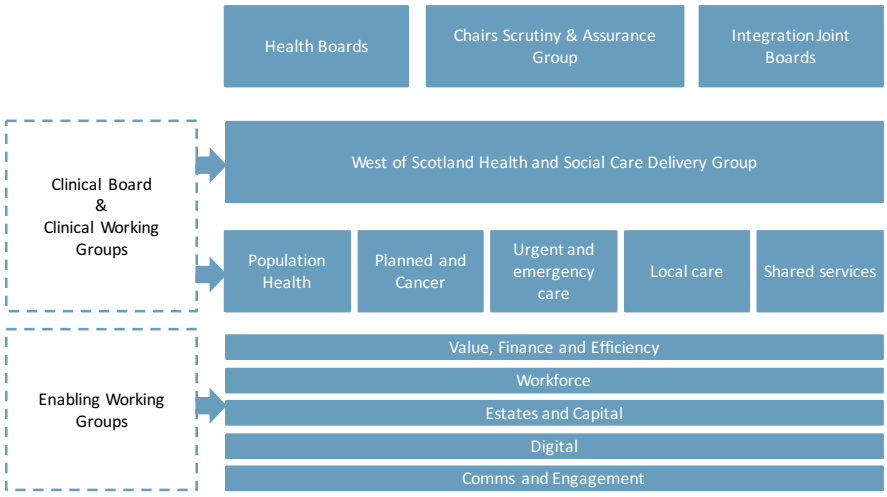
- Population Health
- Planned and Cancer Care
- Urgent and Emergency Care
- Local care
- Shared Services (including links to National Work e.g., Once for Scotland)

Supporting this work is a number of enabling work groups:

- Finance
- Workforce
- Estates and Capital
- Digital
- Communications and Engagement

The chart below maps out our current thinking on the arrangement of governance and workstreams for the West of Scotland:

West of Scotland Region – Programme Structure



Furthermore, there is work underway from the previously agreed regional priorities that will continue and will inform the new regional delivery arrangements, including reviews of:

- Urology
- Ophthalmology
- Trauma and Orthopaedics

- Major Trauma
- Maternity and Neonatal
- Systemic Anti- Cancer Therapy Provision
- Interventional radiology

9.3. Communications and Engagement

All of the areas outlined above need to inform the change in conversations across the system with the public, with the various staff involved, the different organisations and the roles that we all need to play in achieving this, thereby setting the expectations of how we will behave and act to encourage success.

There has been considerable engagement work undertaken by the Health and Social Care Partnerships in developing their Strategic Commissioning Plans. Engagement findings from the National Clinical Strategy and through the National Conversations work also offer views that can inform the approach we are taking and can be built upon as we develop the regional delivery plan.

Critical to success is describing the functional relationships required to progress this and achieve success, recognising the importance of conversations rather than plans in driving change. As part of this we need to provide an environment that supports the enacting of change.

Initial Engagement will look at:

- Developing and sharing key messages around regional planning and the case for change; considering what Scottish Government will lead and what will be regional and local
- Ongoing Engagement
  - Identifying key stakeholders – internal and external, targeting our approaches to support different stakeholders needs
  - Setting out the messages around the population health need, considering service models and the views of the public on service requirements
  - Setting out the emerging thinking on the future service models and implications to provision

9.4. Designing the Care Models and Understanding the Enablers Required

As outlined in section 8.2 above we believe there are four elements to designing interventions that will be transformative and allow us to meet our four aims as a region:

- Understanding the needs of different segments of the population (both now and how it will change over time) in order to identify those that need targeted interventions to care models.

- Addressing as much care as possible proactively and locally in primary, community and social care.
- Designing our acute and community hospitals around the need for safe and sustainable acute care following the local care intervention.
- Putting in place the enablers to allow these interventions to be successfully implemented.

We have quite rich data from ISD around population segmentation and are working with public health colleagues on a population needs assessment for the region. Based on this work, we propose to do a quick effort to prioritise population segments where we would look for better care models to improve their care.

We will then look to produce with IJB colleagues, informed by their existing plans as well as local and international best practice, the common elements of local care models that the population of the West of Scotland can expect to be delivered by IJBs. We expect to have by end-March a clear description of how local care models will be experienced by people in the West of Scotland, an analysis of activity shifts between acute and local care, a business case for the system from these investments, as well as an implementation plan for these models of care.

In parallel with this local care model work, we will be building activity and financial models that will allow us to understand the implications of local care models on the bed requirements and service configuration in the acute sector. By end-March, we expect to have a view on what this will mean in terms of:

- Centres of excellence, particularly for low-volume, high-complexity care
- Organisation of elective and emergency services
- A model for different levels of hospitals and the services they will provide
- An alternative model for providing excellent urgent and emergency care

When designing care models, we will also develop a view on the implications for enablers of these care models, including:

- The implications for estates and infrastructure across the public services, including how best to use the existing estate across hospital sites, primary care and social care.
- Understanding the skills and competencies, as well as numbers, of staff required to support the emerging models, creating a position to influence training and education for the future.
- Understanding of how the future developments in technology might influence the care and models required to better inform the planning beyond 2025 and the potential impact on the different parts of the system. This will consider the opportunities digital health offers, linking with national work.

9.5. Setting the financial framework

In parallel with the care model work, we intend to build a regional financial framework that will:

1) set out the current baseline for the region and the do nothing scenario over a longer period than we have currently projected.
2) allow us to model the impact of care model interventions and changes to key revenue and cost assumptions.
3) Determine a different approach to the finance models to support more effective cross system working
4) outline the business case for interventions at a locality level, board level and regional level.

10. Next steps

With the other regions and the National Boards, we have identified a set of next steps that we should also address collaboratively which the national boards will lead to support the development of the regional delivery plans.

10.1. Collaborative Contribution from the National NHS Boards

As part of developing our regional delivery plans we will also consider the services, functions and support that are best delivered on a national basis; and which can contribute towards the management of demographic financial and workforce pressures. To that end we will work closely with the National Boards over the next few months to refine, develop and prioritise the initial propositions that they have set out.

10.2. Service Transformation – Demand Management

With NHS24 and the Scottish Ambulance Service we will develop plans to

- implement, at scale, the proposals for practice level GP Triage
- reduce the volume of out of hour callers to NHS24 and 999 callers requiring further support from primary and secondary care;
- develop a triage service for return appointment patients and outreach telehealth clinics;
- roll out computerised CBT and improved pathways for those contacting NHS24 and the Scottish Ambulance Service in mental distress.

10.3. Supporting Recruitment, Retention and Improving the Employment Experience

We will work with NES, NSS and others to co-ordinate national and international campaigns to promote careers in health and care in Scotland and to link careers advice and marketing support to the new NHSScotland national recruitment system.

We will also continue to work to improve the employment experience for all our workforce; including rolling out the arrangements to reduce the number of employers of Doctors and Dentists in Training.

We will work with NES, NSS, SSSC, the Care Inspectorate and others to develop an accessible, user designed data platform which provides access to data on the existing and the 'in-training' workforce and to analytical tools which can help to inform the development of different workforce scenarios supporting local, regional and national planning.

10.4. Digital Transformation

It is essential that we transform our digital landscape to enable the public and healthcare staff to access information, resources and services from smart phone technology in the same way as they access retail, transport, and similar services in other spheres of their lives. Part of the work we will progress is to ensure that we can use technological advances in robotics and artificial intelligence to meet the challenges that face us now, and in the future.

Working with the National Boards we will seek to create clarity about technical and usability standards that will support intuitive applications that are capable of delivery across boundaries and which support the scale up and spread of proven innovations to ensure the benefits of technology are accessed across the whole system at pace.

10.5. Once for Scotland

We will continue to work with the National Boards to develop new models of delivery for services such as procurement, radiology, aseptic pharmacy, laboratories and clinical engineering.

We will also work with the National Boards to implement the strategy for NHSScotland Business Systems, which is predicated on moving to Cloud based, Software as a Service models for a joined up approach to Finance, HR and Payroll (moving away from legacy systems and from managing these systems in individual silos). This will provide a core infrastructure which will facilitate the development of shared business services in our regional structures.

11. Statements of Intent

In advance of the submitting the regional delivery plan in March 2018, we intend to:

1. Develop and publish a clinical case for change.
2. Come together as regional leaders of our health and care system and set out a comprehensive programme to deliver our vision and common purpose.
3. Develop a region-wide planning process that will describe what will be planned and delivered by whom at national, regional and local level.
4. Assess the care needs of our population, taking into account the different needs of individuals and segments of the population.
5. Develop local care models for the highest priority population segments and model the impact of these interventions on future acute capacity requirements.
6. Develop a stratified model of local and acute care setting out the different levels of service provision in the different facilities across the region; understanding the implications for future service configuration.
7. Hold engagement sessions with our population, frontline staff and policy-makers to inform them of the regional delivery plan and allow them to shape and coproduce it with us.
8. Develop a view of the impact of this plan on the future capital investment requirements for the region, including hospital and out-of-hospital infrastructure.
9. Assess the impact of this plan on our workforce and outline our future workforce strategy; informing future training and education requirements.
10. Evaluate the impact of the implementation of this strategy on finance and activity and outline a financial plan to support implementation.

Appendices

1. Population Health Needs Assessment Summary Information
2. Demand and activity
3. Workforce
4. Communications and Engagement Plan

Falkirk
Health and Social Care
Partnership

FALKIRK INTEGRATION JOINT BOARD

GUIDE TO INFORMATION AVAILABLE THROUGH THE MODEL PUBLICATION SCHEME 2017

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- publish the classes of information that they make routinely available
- tell the public how to access the information and what it might cost.

Falkirk Integration Joint Board has adopted the Model Publication Scheme 2017 produced by the Scottish Information Commissioner.

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The purpose of this Guide to Information is to:

- allow you to see what information is available (and what is not available) in relation to each class
- state what charges (if any) may be applied
- explain how you can find the information easily
- provide contact details for enquiries and to get help with accessing the information
- explain how to request information we hold that has not been published

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Contact us

You can contact us for assistance with any aspect of this publication scheme:

Falkirk Health and Social Care Partnership
Information Governance Department
NHS Forth Valley
Colquhoun Street
Stirling
FK7 7PX

Telephone: 01786 433284
Email: FV-UHB.FalkirkIJBFOI@nhs.net

We will also be pleased to advise you how to ask for information that we do not publish or how to complain if you are dissatisfied with any aspect of this publication scheme.

The classes of information that we publish

We publish information that we hold within the following classes. Once information is published under a class we will continue to make it available for the current and previous two financial years.

Where information has been updated or superseded, only the current version will be available. If you would like to see previous versions, you are welcome to make a request to us for that information.

CLASS 1: ABOUT US
Class description: Information about Falkirk Integration Joint Board who we are, where to find us, how to contact us, how we are managed and our external relations.

The information we publish under this class and how to access it
Who we are
Integration scheme
How to contact us

CLASS 2: HOW WE DELIVER OUR FUNCTIONS AND SERVICES
Class description: Information about our work, our strategy and policies for delivering functions and services and information for our service users.

The information we publish under this class and how to access it
Our vision and outcomes
Our strategic plan

CLASS 3: HOW WE TAKE DECISIONS AND WHAT WE HAVE DECIDED
Class description: Information about the decisions we take, how we make decisions and how we involve others.

The information we publish under this class and how to access it
Our decisions, including the minutes of the Integration Joint Board meetings Integration Joint Board Audit Committee Standing Orders

CLASS 4: WHAT WE SPEND AND HOW WE SPEND IT
Class description: Information about our strategy for, and management of, financial resources (in sufficient detail to explain how we plan to spend public money and what has actually been spent).

The information we publish under this class and how to access it
Details of our spending will be published through our IJB Board Papers

CLASS 5: HOW WE MANAGE OUR HUMAN, PHYSICAL AND INFORMATION RESOURCES
Class description: Information about how we manage our human, physical and information resources.

The information we publish under this class and how to access it
Information Resources: Access to Information including FOI and Subject Access Request

CLASS 6: HOW WE PROCURE GOODS AND SERVICES FROM EXTERNAL PROVIDERS
Class description: Information about how we procure goods and services, and our contracts with external providers.

The information we publish under this class and how to access it
Falkirk IJB does not directly procure goods and services, therefore does not hold or publish any information under this Class. Procurement is undertaken by Falkirk Council and NHS Forth Valley.

CLASS 7: HOW WE ARE PERFORMING
Class description: Information about how we perform as an organisation, and how well we deliver our functions and services.

The information we publish under this class and how to access it
Annual Performance Report Performance Management Framework Equality Outcomes and Mainstreaming Report Equality and Poverty Impact Assessment

CLASS 8: OUR COMMERCIAL PUBLICATIONS
Class description: Information packaged and made available for sale on a commercial basis and sold at market value through a retail outlet e.g. bookshop, museum or research journal.

The information we publish under this class and how to access it
Note: nothing published

CLASS 9: OPEN DATA
Class description: Open data made available by us as described by the Scottish Government's Open Data Strategy and Resource Pack, available under an open licence.

The information we publish under this class and how to access it
Note: nothing published

Carers (Scotland) Act 2016: Consultation on a Carers' Charter

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

☒ 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
Falkirk Children's Services Sealock House, 2 Inchyra Road, Grangemouth FK3 9XB

Postcode

FK6 5DL

Email

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

☒ 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?

☒ Yes

☐ No

QUESTIONS

Content of a Carers' Charter

Section 36

Intention of the Carers' Charter

To set out the rights of carers as provided for under the Carers (Scotland) Act 2016. The document is intended to provide a summary of the rights of carers under the Carers (Scotland) Act 2016 in a readily accessible and understandable format for both young and adult carers alike.

The draft Charter for your consideration can be found in the accompanying attachments.

Questions

1) Is the information presented in Chapter 1 – "Am I a carer?" clear? Please indicate in the comments box any information that should be added, removed, or particular parts of the chapter which would benefit by being presented differently.

No

Comments

Although technically correct carers find this description confusing. The document is tailored to answer questions in the way the Draft Regulations and Act are framed.

The development of a Carers Charter that is accessible and easily understood should be the aim, with more detailed supporting and technical notes for staff and other groups.

Specific points below:

Don't think this is clear enough for example. It needs to be clear that:

- Person under 18 – carer is exercising their responsibility as a parent or guardian due to the fact the young person is a child and outlining that this would include foster carers and kinship carers.

- Rather than say you have a contract it would be better to say you are paid to provide the care

- Think it needs to be clear that the care is provided as a consequence of ill health or disability including alcohol and substance related issues

2) Is the information presented in Chapter 2 – "Adult carer support plan" clear? Please indicate in the comments box any information that should be added, removed, or particular parts of the chapter which would benefit by being presented differently.

No

Comments

Think the language is too professional – the concept of outcomes is sometimes difficult for people. Would prefer this was explained for example:

- What matters to you in your own life and what would help you to carry out your caring role? What would support you to have a life outside of caring and help you take care of your own health and wellbeing

The glossary states that the responsible authority is the body responsible for preparing young carer statements. It is also the body that responsible for preparing adult carer support plans. It needs to be made clear that the local authority may delegate responsibility via the Integration Joint Board to the Health and Social Care Partnership. This is not highlighted under the description of Integration Authority in the glossary. Should it be listed as Integration Authority or should it be Health and Social Care Partnership? Could cause confusion if this is not right.

Suggest a rewording – instead of 'the local authority …….should normally provide a copy of the plan to you and to any other person at your request……'

3) Is the information presented in Chapter 3 – "Young carer statement" clear? Please indicate in the comments box any information that should be added, removed, or particular parts of the chapter which would benefit by being presented differently.

No

Comments

Think the language is too technically based and more appropriate for professionals – the concept of outcomes is sometimes difficult for people. Would prefer this was explained e.g.

- What matters to you in your own life and what would help you to carry out your caring role where that is appropriate? What would support you to have a life outside of caring and help you take care of your own health and wellbeing

In terms of who is responsible – if the young carer attends a grant aided school or independent school this is particularly confusing. It is important that it is easy to understand and that it aligns with the named person provision of the Children and Young Person (Scotland) Act 2014. Otherwise a young person could have a number of people/agencies involved with conflicting or overlapping duties.

Suggest a rewording – instead of 'the local authority …….should normally provide a copy of the young carer statement to you and to any other person at your request……'

The development of age appropriate versions should be considered including a separate charter for young carers.

4) Is the information presented in Chapter 4 – "Support as a carer" clear? Please indicate in the comments box any information that should be added, removed, or particular parts of the chapter which would benefit by being presented differently.

No

Comments

Addition - It should do this in a way that gives you as much choice and control as you would like, providing this support is safe and legal

'If your identified needs do not meet your local authority's eligibility criteria, you may still qualify for other services and support then your local authority may still offer to provide ….'

This could be through for example:

- A local carer centre;
- A local voluntary organisation; or
- Other local or national services

Additional information may be needed if the carer does not live in the responsible authority's area and they need to be able to access support in the area they live.

NB Draft guidance states:
64. As a matter of best practice, responsible local authorities who have identified a carer in their area who resides in a different local authority area, should liaise with that local authority to ensure that the carer has access to an ACSP and any requisite support that would benefit them and to which they are entitled to. This is also confusing in terms of responsibility. Guidance needs to clearly align to the Charter and the Act)

5) Is the information presented in Chapter 5 – "Carer involvement in services" clear? Please indicate in the comments box any information that should be added, removed, or particular parts of the chapter which would benefit by being presented differently.

No

Comments

Again the language could be simplified. It might be useful to add 'Carers Strategy' to the glossary with a brief explanation of what this is. Not all carers will be familiar with this.

The change in language from section to section in terms of 'responsible authority' 'Integration Authority' 'health board' etc. may be confusing for some people. Consistency and full explanation in the glossary may help, however plain English

and appropriate formats should be developed to address equality and diversity issues.

6) Is the information presented in Chapter 6 – "Hospital discharge" clear? Please indicate in the comments box any information that should be added, removed, or particular parts of the chapter which would benefit by being presented differently.

No

Comments

The process should be initiated on admission to hospital or other settings so that appropriate involvement of carers can take place in facilitating the admission, transfer and discharge process.

This also needs to be aligned with the statutory duty to identify carers for organisations and staff.

Approaches for carers of individuals with specific or specialist needs should be addressed for example in the case of mental health patients, to a lower security hospital.' – this needs a bit more explanation i.e. will people know what is meant by a 'lower security hospital'.

'You may be able to share knowledge and information with health and social care professionals (including those from the local authority). '

7) Are there any rights of carers under the Carers (Scotland) Act 2016 not captured in this draft of the charter that should be included?

Yes / No

Comments

In general this may be a difficult read for some carers e.g. very young carers, carers with a learning difficulty etc. What plans are in place to provide easy read information for carers who may not fully understand the content of the Charter and therefore their rights under the Act.

A carers right to review and mechanism on how this will be achieved should be addressed.

Also the recent announcements on carers benefits, including where and how they can be accessed should be included at some point

Health & Sports Committee Request for information on Care Home Sustainability

Falkirk Health & Social Care Partnership Response

Prior to this session taking place, the Committee is issuing a short targeted call for views and would be grateful if you could respond to the following questions:

1. What impact does the recent announcement of the closer of 12 residential care homes have on your area?

The impact of the recent announcement by Bield is that we will have a reduction of 32 beds out of nearly 1,000 available locally. This is 3% of available beds. In 2015/16 Care Home vacancies during this financial year were 0.7%, which was the lowest we have had in Falkirk since the process of monitoring this data began in 2008. The impact of the Bield Care Home bed closures is significant in that alternative provision requires to be arranged over a short notice period [around 5 ½ months]. We would clarify that our local data on care home placement availability reflects our operational intelligence gathering and is somewhat at odds with the published data from the National Care Home Census which reports a higher level of supply of placements.

We are arranging individual assessment/review for each resident and the alternative support provision which will follow that care planning process will reflect the specific needs of person. While options will include a move to supported housing where appropriate we do anticipate that a high proportion of residents will need to move to alternative care home provision. This will present challenges in terms of limited supply of care home placements, in a context of high competing demand in particular from people who are in hospital awaiting a move to a care home. There is clearly a risk to performance on delayed discharge. There is also likely to be a financial impact for the Partnership as it is unlikely that those people requiring to move to another care home will be able to be placed in a residential provision as opposed to care home with nursing, the latter provision being likely to incur higher costs, estimated at circa £140k.

2. Are there concerns regarding the sustainability of residential service provision (in your area)? and if so, how could they be addressed?

At beginning of financial year 2017/18 there were 17 independently run care homes in the Falkirk Council area. All independent sector care homes operate under the National Care Home Contract and have a capacity to accommodate 841 older persons. The local authority care homes accommodate 129 older persons. Total beds in Falkirk Council area are 970 split between 758 nursing placements and 212 residential placements. We are aware from benchmarking with comparator Partnership areas that our current weighted rate of care

occupancy for the population aged over 65 is higher than some other areas. This suggests that we have scope on a planned basis over time to enhance our capacity to support more people to be supported at home through improved care at home services, reflecting the opportunities of more integrated service delivery across the spectrum of community health and social care services. Our approach to sustainability of residential provision therefore includes delaying or preventing admissions to the residential sector in order to ensure that the existing provision is better targeted towards and available to those people who have higher levels of need which require care home admission. We are also mindful of the impact over time of demographic change, which requires to be factored into our modelling of future demand for residential service provision.

16 November 2017