AGENDA ITEM 3

DRAFT

FALKIRK TRANSITIONAL BOARD

Minute of Meeting of the Falkirk Transitional Board held in the Municipal Buildings, Falkirk on Friday 2 October 2015 at 9.30am.

Voting Members:	Councillor Allyson Black, Falkirk Council (Chair) Councillor Dennis Goldie, Falkirk Council Councillor Linda Gow, Falkirk Council Jim King, Vice-Chair, NHS Forth Valley (Vice-Chair) Alex Linkston, Chairman, NHS Forth Valley Julia Swan, Non-Executive Member, NHS Forth Valley
Non-voting Members:	Sandra Burt, UNISON Representative, Falkirk Council Tracey Gilles, Medical Representative Jane Grant, Chief Executive, NHS Forth Valley Tom Hart, Employee Director, NHS Forth Valley Kathy McCarroll, Chief Social Work Officer, Falkirk Council Tracey McKigen, Interim Chief Officer Mary Pitcaithly, Chief Executive, Falkirk Council Angela Wallace, Nursing Representative, NHS Forth Valley
Officers:	Fiona Campbell, Head of Policy and ICT Improvement, Falkirk Council Deirdre Cilliers, Head of Social Work Adult Services, Falkirk Council Jack Frawley, Committee Officer, Falkirk Council Colin Moodie, Depute Chief Governance Officer, Falkirk Council Kathy O'Neill, CHP General Manager, NHS Forth Valley Fiona Ramsay, Director of Finance, NHS Forth Valley Bryan Smail, Chief Finance Officer, Falkirk Council Suzanne Thomson, Programme Manager – Health and Social Care Integration, Falkirk Council Elaine Vanhegan, Head of Performance and Governance, NHS Forth Valley

TB50. Apologies

No apologies were received.

TB51. Declarations of Interest

No declarations were made.

TB52. Minute

Decision

The minute of meeting of the Falkirk Transitional Board held on 4 September 2015 was approved.

TB53. Matters Arising

The board sought information on the operational responsibilities of the Chief Officer. The Chief Executive, Falkirk Council advised that initial discussions had taken place and that she anticipated that these would be progressed prior to the next meeting of the board.

Councillor Gow entered the meeting prior to consideration of the following item of business.

TB54. Standing Item: Delayed Discharge

The transitional board considered a report by the CHP General Manager and the Head of Social Work Adult Services providing an update on progress toward meeting the national target that no-one who is ready for discharge should be delayed by more than two weeks. The report provided background information and an update on current performance. The CHP General Manager provided an overview of the report.

Members discussed the provision of care home placements and were advised by Deirdre Cilliers that reablement beds at Summerford were available. Additional placements at Oakbank would not be available until after a meeting with the Care Inspectorate the following week to acquire a variation on registration. Kathy O'Neill advised that 10 hospital patients had been identified as appropriate to take up places in the additional capacity.

The board discussed the figures and pressures that already existed commenting that there would be additional pressure through winter. The board requested a report providing a statement of activities, their impact and timescales for the next meeting.

Members asked about partnership working with Housing Associations. Deirdre Cilliers stated that an agreement was in place to work with a housing association to utilise properties on a temporary basis to offer accommodation to people awaiting home adaptations. This would be used in cases where homes needed large scale adaptations such as tracking hoists.

Decision

The transitional board:-

(1) note the report, and

(2) request a report providing a statement of activities, their impact and timescales for the next meeting.

TB55. Standing Item: Strategic Plan

The transitional board considered a report by the Interim Chief Officer providing an update on strategic planning arrangements. The report provided background information, information on the strategic planning group and information on the requirement to undertake a strategic needs assessment. Appended to the report were the proposed membership of the strategic planning group and the membership of the strategic plan co-ordinating group. The Interim Chief Officer provided the board with an overview of the report and a presentation on strategic planning.

The board discussed consultation methods and how to obtain feedback on what issues mattered to people most. Suzanne Thomson advised that the approach was to build on what was already in the system such as the clinical services review feedback and meeting with the patient panel. There were plans for wider public events and a staff newsletter.

Decision

The transitional board noted the report.

TB56. Welfare Guardianships

The transitional board considered a report by the CHP General Manager and the Head of Social Work Adult Services providing an overview of the welfare guardianship process, highlighting some of the complex issues associated with it, and providing information on the process and factors which cause delays. The Head of Social Work Adult Services provided an overview of the report.

Members discussed the possibility of developing a strategy for people admitted without guardianship to minimise delays. The board also discussed the workload demands on mental health officers, Mary Pitcaithly advised that the Council had committed to providing additional resources for training mental health officers. Deirdre Cilliers stated that additional staff had been trained and accredited and that although they worked in other teams they would add overall capacity.

Decision

The transitional board noted the report.

TB57. Joint Inspection of Older People's Services

The transitional board considered a report by the CHP General Manager and the Head of Social Work Adult Services providing information on the outcome of the joint inspection of adult health and social care services in Falkirk. The report provided background, the key findings of the report, and evaluation and recommendations. The position statement was appended to the report. The CHP General Manager provided an overview of the report.

Members asked about the timescales to report back to the Care Inspectorate and the role of the IJB in future inspections. Kathy O'Neill stated that an action plan would be requested but that the timescale was not yet set. She advised that for future inspections of this kind the IJB would be the responsible body.

Decision

The transitional board agreed to receive a report with the finalised Improvement Action Plan at a future meeting.

TB58. Winter Planning

The transitional board considered a report by the Director of Public Health and Strategic Planning providing an update on the winter planning process. The report provided background information and progress against key actions. The Chief Executive, NHS Forth Valley provided an overview of the report.

Members asked about the role of district nurses in winter planning. Kathy O'Neill stated that for the festive period district nurse rotas are planned in advance to take account of additional demand. She advised that additional community nurses were being recruited to be in post by December.

Decision

The transitional board agreed that:-

(1) the winter plan would be submitted to the Scottish Government by the end of October;

(2) a report would be submitted to the next meeting with the plan, as submitted to the Scottish Government, for consideration, and

(3) the plan would be electronically circulated to the voting members in advance of submission to the Scottish Government to comment on.

TB59. Partnership Funding

The transitional board considered a report by the Director of Finance providing a summary of the financial resources available to the partnership and commitments previously agreed. The Director of Finance provided an overview of the report.

The board discussed financial risks and projects which had already been approved where costs ran through to 2016/17. Members requested that in subsequent reports more information is provided on individual projects, including their contribution to priorities. Fiona Ramsay stated that financial information could be provided and that work was ongoing to provide the additional information. Kathy O'Neill stated that some projects in receipt of bridging funding were extended in their duration to allow sufficient time to evaluate their effectiveness.

Decision

The transitional board noted the report.

TB60. ICF Plan

The transitional board considered a report by the Chief Executive, NHS Forth Valley and the Chief Executive, Falkirk Council providing further information on the Integrated Care Fund (ICF) Spending Plan. The Interim Chief Officer provided an overview of the report.

Members asked why the report had been received late, having previously agreed that reports would be provided five clear days ahead of the meeting. They highlighted that three reports on the agenda had been received late.

The board asked about the timescale for workforce organisational development work. Tracey McKigen advised that she would be meeting with organisational development leads and would advise the board at the next meeting.

Members asked for further information on the data analyst post and how it differed from that from the Scottish Government provided posts. Suzanne Thomson advised that the Scottish Government allocation was until March 2016 to assist with the strategic needs assessment but that work was still required on developing localities and profiles. Further work would be carried out to look into high resource individuals. Approximately 2% of people were using 50% of resources. The post holder would also carry out work to understand the collective impact of projects.

Decision

The transitional board noted the report.

TB61. Membership of the Integration Joint Board

The transitional board considered a report by the Interim Chief Officer providing information on the recruitment of non-voting members to the IJB. The Programme Manager – Health and Social Care Integration provided an overview of the report.

Decision

The transitional board agreed to appoint Karen Herbert and Angela Price as the third sector representatives.

This paper relates to
Agenda Item 5

Title/Subject: **Establishment of Integration Joint Board**

Meeting: **Integration Joint Board**

Date: **6th November 2015**

Submitted By: **Chief Governance Officer**

Action: **For Decision**

1. INTRODUCTION

1.1 On 3rd October 2015, the Falkirk Integration Joint Board for the area of Falkirk Council was established by the Public Bodies (Joint Working) (Integration Joint Boards Establishment) (Scotland) Order 2015. This followed the approval of the Integration Scheme submitted by Falkirk Council "the Council" and NHS Forth Valley "the Health Board". This report sets out the membership of the Board and invites the Board to confirm the appointment of the members set out in section 4. The Board is also invited to confirm the appointment of the Interim Chief Officer as the Chief Officer for the remainder of the term of her contract.

2. RECOMMENDATION

The Board is asked to

(a) note the contents of the report;
(b) appoint those members listed at 4.1 to the Board; and
(c) confirm that the Interim Chief Officer is appointed as Chief Officer for the remainder of her contract.

3. MEMBERSHIP OF THE INTEGRATION JOINT BOARD

3.1 Voting Members

The membership of the Board consists of 3 councillors nominated by the Council and 3 non-executive directors nominated by the Health Board. These are:-

Falkirk Council	Allyson Black	30 April 2017
Falkirk Council	Dennis Goldie	30 April 2017
Falkirk Council	Linda Gow	30 April 2017
NHS Forth Valley	James King	April 2017
NHS Forth Valley	Alex Linkston	April 2017
NHS Forth Valley	Julia Swan	April 2017

3.2 In the Integration Scheme, the Council and the Health Board agreed that the Council would appoint the first chairperson of the Board. The Council has appointed Allyson Black. The Vice Chairperson, appointed by the Health Board, is Jim King. In May 2017 the Health Board will appoint a Chairperson for the period of 2 years and the Council will appoint the Vice Chairperson.

4. NON VOTING MEMBERSHIP

4.1 Membership by virtue of office

The Board includes a number of members who will be members as long as they hold the office noted below.

Chief Officer	Tracey McKigen (Interim)
Section 95 Officer – Chief Finance Officer	Vacant
Chief Social Work Officer	Kathy McCarroll
Chief Executive Falkirk Council	Mary Pitcaithly
Chief Executive NHS Forth Valley	Jane Grant

4.2 As the Interim Chief Officer was appointed prior to the establishment of the Board, it is necessary that the Board appoints her to the office of Chief Officer for the remainder of the term of her contract to ensure that she is a member of the Board as intended by the legislation.

4.3 Health Professionals

The membership also includes 3 medical professionals appointed by the Health Board. These are as follows:-

General Practitioner	Leslie Cruikshank	30 April 2018
Registered Nurse	Angela Wallace	30 April 2018
Medical Practitioner other than a General Practitioner	Tracey Gillies	30 April 2018

4.4 Stakeholders

The Board requires to appoint a number of members in respect of the categories noted below. The processes for identifying the nominees have been subject to discussion and agreement at earlier meetings of the Transitional Board. The proposed members nominated a as result of those processes are:-

Staff of the Constituent Authorities	Sandra Burt (Council) Herbie Schroder (substitute) Tom Hart (Health Board) Lindsey Orr (substitute)	30 April 2018
Service Users	Martin Murray Margo Biggs (substitute)	30 April 2018
Unpaid Carers	Claire Crossan Jack Minnock (substitute)	30 April 2018
Third Sector	Karen Herbert (Third Sector Interface-CVS Falkirk) Angela Price (Falkirk & District Association for Mental Health)	30 April 2018

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Approved for Submission by: Colin Moodie, Depute Chief Governance Officer

Author – Colin Moodie, Depute Chief Governance Officer
Date: 13 October 2015

List of Background Papers

1. Integration Scheme

This paper relates to
Agenda Item 6

Title/Subject:	**Standing Orders**
Meeting:	**Integration Joint Board**
Date:	**6th November 2015**
Submitted By:	**Chief Governance Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1 As a newly established public body, the Integration Joint Board needs to adopt standing orders to govern the conduct of its meeting. A set of standing orders is attached for the board's consideration.

2. RECOMMENDATION

(a) adopt the standing orders appended to the report; and
(b) agree that the standing orders will be reviewed in a year.

3. BACKGROUND

3.1 In terms of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 ("the IJB Order"), the board requires to adopt a set of standing orders. Some of the contents of the standing orders are mandatory in terms of the IJB Order and all of these have been incorporated with one exception which is referred to at 3.4 below.

3.2 The standing orders are based on a draft considered by the Transitional Board at its February meeting and incorporate the changes discussed and agreed at that time. In particular, provision has been made for Deputations and to allow voting members to have motions included on the agenda of board meeings.

3.3 The standing orders incorporate a requirement to conduct meetings with the same level of openness as in local government. The board will also note that there is an emphasis in the standing orders on decision making by consensus. This is because the IJB Order does not allow the standing orders of the board to allow for a second or casting vote. The standing orders are less complex than those of the council or in the health board with a view to them being proportionate to the needs of this board. It is suggested that they are reviewed again after approximately a year in operation to see if any change is required.

3.4 The mandatory provision in the IJB Order which has not been included relates to declarations of interest. It has been recognised by the Government that there is an error in the provision and they are currently consulting on an amendment to the IJB Order to rectify the position. There is a report elsewhere on the agenda which deals with the consultation.

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Approved for Submission by: Colin Moodie, Depute Chief Governance Officer

Author – Colin Moodie, Depute Chief Governance Officer
Date: 19 October 2015

List of Background Papers

1. Draft Standing Orders

FALKIRK INTEGRATION JOINT BOARD
STANDING ORDERS

1. Title

1.1 These are the standing orders of the Falkirk Integration Joint Board made under the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 They will come into force on 6 November 2015.

2. Definitions

In the standing orders, the following terms will have the undernoted meaning:

"Constituent authority" means Falkirk Council or NHS Forth Valley.
"Integration functions" means the functions delegated to the Integration Joint Board pursuant to section 3 of the integration scheme and further described in Annexes 1 and 2 of the scheme.
"Integration scheme" means the document agreed between the constituent authorities in accordance with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.
"Integration Joint Board Order" means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.
"Third sector interface" means the organisation or partnership which is recognised by the Scottish Government and Falkirk Council as the third sector interface for the council area.

3. General Principles

3.1 The following general principles will be given effect to the application of the standing orders:-

1. that the role of the chairperson is to ensure that the business of the meeting is properly dealt with and that clear decisions are reached;

2. that the chairperson will seek to promote and identify consensus among the voting members of the Board;

3. that the chairperson has a responsibility to ensure that the views of all participants are expressed including the advice of officers when this is necessary to inform the decision; and

4. that meetings are conducted in a proper and timely manner with all members sharing responsibility for the proper and expeditious discharge of business.

4. Membership

4.1 The membership of the board shall consist of voting and non-voting members.

4.2 In accordance with the integration scheme, the voting members will consist of three councillors appointed by Falkirk Council and three members of the health board appointed by Forth Valley Health Board. The members appointed by Forth Valley Health Board must be non-executive members except where regulation 3(5) of the IJB Order applies.

4.3 The non-voting members of the board will be as follows:-

(a) The chief social work officer of Falkirk Council;
(b) The chief officer of the board;
(c) The proper officer of the board appointed under section 95 of the Local Government (Scotland) Act 1973;
(d) A registered medical practitioner whose name is included in the list of primary medical services performers prepared by the health board in accordance with regulations made under section 17P of the National Health Service (Scotland) Act 1978;
(e) A registered nurse who is employed by the health board or by a person or body with which the health board has entered into a general medical services contract;
(f) A registered medical practitioner employed by the health board and not providing primary medical services;
(g) The chief executive of Falkirk Council;
(h) The chief executive of Forth Valley Health Board;
(i) A person appointed by the board in respect of the staff of Falkirk Council engaged in the provision of services provided under integration functions;
(j) A person appointed by the board in respect of staff of the Forth Valley Health Board engaged in the provision of services provided under integration functions;
(k) A person appointed by the board in respect of third sector bodies carrying out activities related to health or social care in the Falkirk council area;
(l) A person appointed by the Board in respect of service users residing in the Falkirk council area; and
(m) A person appointed in respect of persons providing unpaid care in the Falkirk council area.

4.4 The persons appointed under 4.3 (d)-(f) shall be appointed by Forth Valley Health Board.

5. Term of Office

5.1 Subject to 5.2, the term of office of a member of the board is to be determined by the constituent authorities but is not to exceed three years.

5.2 The chief social work officer, the chief officer, the proper officer and the chief executives will remain a member for as long as they hold the office in respect of which they are appointed.

5.3 At the end of a term of office determined under 5.1, a member may be re-appointed for a further term of office.

6. Chairperson and Vice Chairperson

6.1 In accordance with the integration scheme, the first chairperson will be appointed by the council and will hold office until 30th April 2017. For the next period, the health board will appoint the chairperson for a period of two years. Thereafter, the appointment will alternate between the constituent authorities with each appointment being for a period of two years.

6.2 The constituent authority which is not entitled to appoint the chairperson in respect of an appointing period must appoint the vice chairperson of the board in respect of that period.

6.3 The health board may only appoint as chairperson or vice chairperson a member of the Board who is a non-executive director of the health board.

7. Substitution

7.1 Voting Members

If a voting member is unable to attend a meeting of the board, the constituent authority which nominated the member is to use its best endeavours to arrange for a suitably experienced substitute who is either a councillor or as the case may be a member of the health board to attend the meeting in place of the voting member. The question of whether the substitute is suitably experienced shall be a matter to be determined by the constituent authority.

7.2 **Non-Voting Members**

If a member who is not a voting member is unable to attend a meeting of the integration joint board, that member may arrange for a suitably experienced substitute to attend the meeting. Where an appointment is made under 4.3 (i)-(m) above, the Board will also appoint a suitably experienced person or persons to act as a substitute in respect of the person appointed.

8. Meetings

8.1 The first meeting of the Board is to be convened at a time and place determined by the chairperson.

8.2 The Board will agree a programme of meetings for each year which will constitute the ordinary meetings of the Board.

8.3 The chairperson may call a meeting of the Board at such other times as he or she thinks fit. Any meeting so called will constitute a special meeting of the Board.

8.4 A request for a meeting of the Board to be called may be made in the form of a requisition specifying the business proposed to be transacted at the meeting and signed by at least two thirds of the voting members, presented to the chairperson.

8.5 If the request is made under paragraph 8.3, the chairperson refuses to call a meeting, or does not call a meeting within seven days after the making of the request, the members who signed the requisition may call a meeting.

8.6 The business which may be transacted at a meeting called under 8.4 is limited to the business specified in the requisition.

9. Notice of Meetings

9.1 Before each meeting of the Board, or a committee of the Board, a Notice of the Meeting specifying the time, place and business to be transacted at it signed by the chairperson, or a member authorised by the chairperson to sign on the chairperson's behalf, is to be sent electronically to every member or sent to the usual place of residence of every member so as to be available to them at least five clear days before the meeting.

9.2 A failure to serve notice of a meeting on a member in accordance with 9.1 shall not affect the validity to anything done at that meeting.

9.3 In the case of a meeting of the Board called by members, the notice has to be signed by the members who requisitioned the meeting in accordance with 8.4 above.

10. The Agenda

10.1 Each item of business to be transacted at a meeting will be noted on the Notice of Meeting. No other item of business will be considered at the meeting unless by reason of special circumstances the chairperson is of the opinion that the item should be considered as a matter of urgency. The nature of the special circumstances will be recorded in the minute of the meeting.

10.2 Each item of business will be accompanied by a report unless special circumstances exist for the non-availability of the report. This provision will not apply where the item of business consists only of a presentation to be made to the Board for information purposes.

10.3 Copies of the Notice of Meeting and the accompanying reports will be open for inspection by members of the public at the offices of the Board at least five clear days before the meeting except:-

1. where the meeting is convened at shorter notice in which case the Notice of Meeting and reports will be available for public inspection from the time the meeting is convened; or
2. where the report relates to an item during consideration of which, in the opinion of the Chief Officer, the meeting is likely not to be open to the public.

10.4 The business to be transacted will be:-

i) Attendance
ii) Substitutions
iii) Declarations of Interest
iv) Minutes
v) Matters arising
vi) Continued Business
vii) New Business
viii) Motions

11. Access to Meetings

11.1 All meetings of the Board will be open to the public except in the following circumstances:-

1. where it is likely in view of the nature of the business to be transacted that there will be disclosure of exempt information, the public may be excluded from the meeting while that particular item of business is considered; or
2. Standing Order 11.3 applies

11.2 Exempt information means information which falls within any of the categories set out in Appendix 1 to these Standing Orders.

11.3 The chairperson has power to exclude any member of the public from a meeting in order to supress or prevent disorder disorderly conduct or other misbehaviour which is impeding or likely to impede the work or proceedings of the Board.

11.4 No member of the public will be permitted to speak or take in part in the proceedings of a meeting of the Board, other than in accordance with standing order 15.

12. Quorum

12.1 No business is to be transacted at a meeting of the board unless at least one half of the voting members (including substitutes appointed by virtue of Standing Order 7) is present.

13. Conduct of Meetings

13.1 At each meeting of the board, the chairperson, if attending the meeting, is to preside.

13.2 If the chairperson is absent from a meeting of the board, the vice chairperson is to preside.

13.3 If the chairperson and vice chairperson are both absent from a meeting of the Board, a voting member chosen at the meeting by the other voting members attending the meeting is to preside.

13.4 If it is necessary or expedient to do so, a meeting of the board may be adjourned to another date, time or place.

14. Minutes

14.1 A record must be kept of the names of the members attending every meeting of the board.

14.2 Minutes of the proceedings of each meeting of the board including any decision made at that meeting or to be drawn up and submitted to the next ensuing meeting of the board for agreement after which they are to be signed by the person presiding at that meeting.

15. Deputations

15.1 Any person (including an organisation) with an interest in any of the integration functions may not less than 10 clear days before and ordinary meeting of the board request an opportunity to address the board. Any such request will be made to the chief officer and will set out the matter on which the person wishes to address the board.

15.2 Where the chief officer is satisfied that the request is made in accordance with this standing order, the request will be noted on the agenda for the nest meeting. The board will determine whether to hear from the person making the request. If the request is agreed, the person making the request may address the board for up to 10 minutes and receive questions from board members. .

16. Alteration of Standing Orders

The Board shall have the power to alter these Standing Orders at any of its meetings provided due intimation of such proposed alteration shall appear on the face of the Notice of Meeting. Any such alteration may be approved by a majority of voting members present and voting.

17. Remote Attendance at Meetings

17.1 Where video conferencing (or other similar technology which allows communication between the place where a meeting of the board is to take place and another place) is available, a member of the board may participate in a meeting by way of such technology although not present at the place where the meeting is to take place.

18. Decision Making

18.1 Where the Board is to take a decision, the chairperson will determine whether there is consensus among the voting members on the proposed decision. In the absence of consensus, the question will be determined by a majority of the votes of the voting members attending.

18.2 Where the proposed decision consists of a recommendation in a report submitted to the Board, the recommendation may be moved and seconded by voting members as a motion to the Board. Where no amendment is moved and seconded, the chairperson following discussion will put the matter to a vote for or against the motion. Where an amendment is moved and seconded the chairperson following discussion will put the matter to a vote for the amendment or the motion.

18.3 Any motion relevant to the item of business may be moved by a voting member. If seconded, the motion will be dealt with in accordance with 18(2) above.

18.4 In the event of an equality of votes no decision may be made on that item of business at the meeting.

18.5 Where 18.4 applies, the Chief Officer after consulting with the chairperson, the vice chairperson and the constituent authorities, shall reconsider the proposal giving rise to the equality of votes and may:

ix) present the proposal to a future meeting of the Board in an amended form;

x) provide the Board with further and better information on the proposal; and

xi) provide the Board with advice on any legal, financial or other risk arising from the failure to take a decision.

18.6 Where 18.4 applies, standing order 19 will not have effect.

19. Revocation of Previous Decisions

19.1 A decision by the Board cannot be considered or changed within six months or being made unless:-

i) it is required by statute;

ii) or two thirds of the voting members present and voting agree otherwise.

20. Motions

20.1 Without prejudice to standing order 18, a voting member of the board may submit a motion to the board on any matter within its decision making remit. Any such motion will be submitted at least 10 clear days before any ordinary meeting of the board to the chief officer.

20.2 Unless the chief officer determines that the motion is outwith the board decision making remit, or contains defamatory or otherwise improper content, the motion will appear on the agenda for the next meeting.

21. Committees

21.1 The board may establish committees of its members for the purpose of carrying out such of its functions as it may determine.

21.2 Where the board establishes a committee, it must determine who will act as chairperson of the committee.

21.3 A committee established must include voting members and must include an equal number of the voting members appointed by the health board and the council.

21.4 Any decision relating to carrying out of functions under the Act or to integration functions taken by a committee established by virtue of this standing order must be agreed by a majority of the votes of the voting members who are members of the committee.

21.5 Meetings of committees will be conducted in accordance with standing orders 3, 4, 7, 9 to 11, 13, 14 and 17 to 20 subject to all references to the board being read as references to the committee.

Appendix 1

Exempt Information

The following categories of information are defined as being “exempt”:-

(i) Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office holder, former office holder or applicant to become an office holder under, the Council;

(ii) Information relating to any particular occupier or former occupier of, or applicant for, accommodation provided by or at the expense of the authority;

(iii) Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Council;

(iv) Information relating to any particular applicant for, or recipient or former recipient of, any financial assistance provided by the Council;

(v) Information relating to the adoption, care, fostering or education of any particular child or relating to the supervision or residence of any particular child in accordance with a supervision requirement of that child made under the Children (Scotland) Act 1995;

(vi) Information relating to the financial or business affairs of any particular person (other than the Council);

(vii) Information relating to anything done or to be done in respect of any particular person for the purposes of any matter referred to in section 27(1) of the Social Work (Scotland) Act 1968 (providing reports on and supervision of certain persons);

(viii) The amount of any expenditure proposed to be incurred by the Council under any particular contract for the acquisition of property or the supply of goods or services;

(ix) Any terms proposed, or to be proposed by or to the Council, in the course of negotiations for a contract for the acquisition or disposal of any property or the supply of goods or services;

(x) The identity of the Council (as well as any other person, by virtue of item (vi) above) as the person offering any particular tender for a contract for the supply of goods or services;

(xi) Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under, the Council;

(xii) Any instructions to Counsel and any opinion of Counsel (whether or not in connection with any proceedings) and any advice received, information obtained or action to be taken in connection with:-

(a) any legal proceedings by or against the Council, or

(b) the determination of any matter affecting the Council, (whether, in either case, proceedings have been commenced or are in contemplation);

(xiii) Information which, if disclosed to the public, would reveal that the Council proposes:-

(a) to give under any enactment a notice under, or by virtue of, which requirements are imposed on a person, or

(b) to make an order or direction under any enactment;

(xiv) Any action taken, or to be taken in connection, with the prevention, investigation or prosecution of crime;

(xv) The identity of a protected informant.

For the purposes of these standing orders, references to the Council in this appendix shall be read as including a reference to the Health Board or the Integration Joint Board as the context requires.

This paper relates to Agenda Item 7

Title/Subject:	**Programme of Meetings 2016**
Meeting:	**Integration Joint Board**
Date:	**6 November 2015**
Submitted By:	**Chief Governance Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1 The purpose of this report is to provide a timetable of meetings of the Falkirk Integration Joint Board (IJB) for 2016.

2. RECOMMENDATION

2.1 **The Falkirk Integration Joint Board is asked to agree the timetable of meetings for 2016.**

3. PROPOSED DATES

3.1 The meeting dates proposed below have been identified consistent with the decision by the transitional board that meetings should take place on a monthly basis, incorporating a recess in July.

3.2 It is worth nothing that the transitional board has discussed the possibility of moving to a bi-monthly schedule once the workload of the board could accommodate it. Such a revision the programme of meetings could be made at a later date if necessary. Meetings have been scheduled for the first Friday of the month, as was the case for the transitional board.

3.3 Due to the proximity of the first meeting to the return from the winter break, and considering the timescales for issuing reports five clear days ahead of the meeting, there are a number of practical difficulties in providing the board with a complete agenda for the January meeting. The IJB may wish to consider whether it wishes to hold the first meeting of 2016 in January or February, the latter allowing for the information presented to the board to be more fully prepared.

3.4 In line with arrangements for the transitional board it is proposed that meetings are hosted on a rotational basis by the Health Board and Council.

Meeting Date	Venue
4 December	Forth Valley Royal Hospital
8 January	Municipal Buildings, Falkirk
5 February	Forth Valley Royal Hospital
4 March	Municipal Buildings, Falkirk
1 April	Forth Valley Royal Hospital
6 May	Municipal Buildings, Falkirk
3 June	Forth Valley Royal Hospital
5 August	Municipal Buildings, Falkirk
2 September	Forth Valley Royal Hospital
7 October	Municipal Buildings, Falkirk
4 November	Forth Valley Royal Hospital
2 December	Municipal Buildings, Falkirk

All meetings will start at 9.30 am.

4. CONCLUSION

4.1 The arrangements set out in this report are in line with those previously agreed by the transitional board. The board are asked to consider whether a meeting of the IJB in January is needed.

……..
Approved for submission by: Depute Chief Governance Officer, Falkirk Council
Author: Jack Frawley, Committee Services Officer, Tel: 01324 506116
Date: 16 October 2015-10-16

List of Background Papers:
No background papers were relied upon in the preparation of this report.

This paper relates to

Agenda Item 8

Report to: **Integration Joint Board**

Title/Subject: **Strategic Plan**

Date: **6 November 2015**

Submitted By: **Interim Chief Officer**

Action: **For Decision**

1. PURPOSE OF THE REPORT

1.1. The purpose of the report is to provide an update to the Integration Joint Board on the Strategic Planning arrangements.

2. RECOMMENDATION

The Transitional Board is asked to:

2.1. note the content of the report

2.2. consider the recommendation from the Strategic Planning Group for GP representation on the group as noted at section 4.2

2.3. consider draft Strategic Plan for consultation as noted at section 5.3

3. BACKGROUND

3.1. The Board members are aware that the Integration Joint Board (IJB) is responsible for the preparation of a Strategic Plan in relation to the functions delegated to it by the Council and NHS Board. The Board is required to establish a Strategic Planning Group as part of the process to prepare the Strategic Plan for their area.

3.2. The IJB will oversee the development and delivery of the Strategic Plan for the integrated functions and budgets that they will be responsible for. The plan is to be prepared before the integration start day as defined in the Act, which will be no later than 1 April 2016.

4. STRATEGIC PLANNING GROUP

4.1. The membership of the Strategic Planning Group (SPG) is prescribed in the Public Bodies (Joint Working) (Membership of the Strategic Planning Group) (Scotland) Regulations 2014 and the Board has previously agreed to extend the minimum prescribed membership to include Board and staff representation.

4.2. The SPG has met on two occasions, 28 September and 27 October 2015. At the first meeting it was suggested that membership should be extended to include GP representation and this is being explored. The Board are asked to consider this recommendation.

4.3. Feedback will be provided to the Board on the outcome from the most recent meeting. The purpose of this workshop style meeting was to ensure the SPG have been fully engaged in the preparation of the Strategic Plan.

4.4. The Strategic Planning Co-ordinating Group has continued to meet in a fortnightly basis to ensure the production of the draft Strategic Plan in line with the engagement work completed to date with the Board, SPG and stakeholder event, with those participants in line with the SPG prescribed membership.

4.5. This approach has supported the development of the draft plan in a co-produced and inclusive way, and in line with the legislative requirements.

5. STRATEGIC PLAN

5.1. The preparation of the Strategic Plan is clearly defined in the Act and includes:

- the board prepare proposals for what the strategic plan should contain, and seek the views of its Strategic Planning Group on the proposals
- take account of any views expressed to prepare a first draft of the strategic plan, and seek the views of its Strategic Planning Group on the draft
- take account of any views expressed to prepare a second draft of the strategic plan for wider consultation in line with all prescribed consultees.

5.2. The draft Strategic Plan is attached for comment.

5.3. The Board are asked to consider the draft plan (Appendix 1) and approve this for consultation.

6. STRATEGIC NEEDS ASSESSMENT

6.1. The Public Bodies (Joint Working) (Scotland) Act 2014 requires partnerships to undertake a Joint Strategic Needs Assessment (JSNA) in order to understand and demonstrate the needs which exist in the partnership and to inform the Strategic Plan.

6.2. The partnership has been supported to complete the JSNA by additional analytical input from the Local Intelligence Support Team (LIST) with two analysts supplementing local capacity.

6.3. The draft JSNA is attached for information –The second draft will be available at the end of October and circulated to Board members when available

6.4. The next stages for JSNA development will include locality profiles to support locality planning and will be developed in line with the 3 areas previously agreed as follows:
- Falkirk
- Grangemouth / Bo'ness /Meadowbank
- Denny / Bonnybridge / Larbert / Stenhousemuir.

7. CONSULTATION AND ENGAGEMENT ARRANGEMENTS

7.1 The intention is to undertake a range of approaches to engage with key stakeholders and obtain feedback. This will include:
- Public events – Dates being agreed
- Targeted sessions with key groups
- Distribution of the draft plan through global email distributions to employee groups, partner organisations and through meeting networks
- Web-based information including a web-based survey, which was also made available in paper format. This will be hosted on the NHS Forth Valley website with links to this from Falkirk Council website.

8. CONCLUSIONS

8.1. An Equalities Impact Assessment will be required for the Strategic Plan. The partnership will use a range of information to inform the EqIA, including the equalities data being collated as part of the Strategic Needs Assessment.

_____

Approved for Submission by: Tracey Mckigen, Interim Chief Officer

Author: Suzanne Thomson, Programme Manager – Integration (Falkirk)
Date: 15 October 2015

Appendix 1 Draft Strategic Plan

Appendix 2 Joint Strategic Needs Assessment

List of Background Papers:
Transitional Board report: 6 February 2015 – Planning Requirements
Transitional Board report: 1 May 2015 – Strategic Planning
Transitional Board report: 5 June 2015 – Strategic Planning
Transitional Board report: 7 August 2015 – Strategic Planning
Transitional Board report: 4 September 2015 – Strategic Planning
Transitional Board report: 2 October 2015 – Strategic Planning

Falkirk Council

NHS Forth Valley

Falkirk Integrated Strategic Plan 2016-2019

Version Control		
Date	Change	Doc Name
23/10/15	Added – Housing & Deprivation info section 2	Falkirk_Integrated_Strategic_Plan_231015.doc
27/10/15	Added – 5.3 'Developing an Enabling Structure' and amended - priorities in appendix and 4.4.	Falkirk_Integrated_Strategic_Plan_271015.doc
28/10/15	Amended – 1.1 and local initiatives	Falkirk_Integrated_Strategic_Plan_281015.doc
29/10/2015	Amended – 2.7 Delayed Discharges; 2.10 summary; proofread for typos Foreword, priorities	Falkirk_Integrated_Strategic_Plan_291015.doc

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FOREWORD

Insert Photo

On behalf of the Falkirk Health and Social Care Partnership, we are pleased to introduce our draft Strategic Plan for your views. This will be the first Strategic Plan for health and social care integration for the Falkirk area. This is required with the introduction of new legislation that is intended to ensure that people who use health and social care services get the right care and support whatever their needs, at any point in their care journey.

To achieve our plan, we understand there is a need to build on our existing relationships and develop new relationships with residents and communities, our services and staff, and many other organisations. This will ensure a joint contribution to encouraging, supporting and maintaining the health and wellbeing of people who live in our community.

The integration of Health and Social Care will see the establishment of a Partnership with it's own Integration Joint Board, developed by Falkirk Council and NHS Forth Valley, giving the opportunity to work in a truly integrated way. The main purpose of the Partnership is to ensure that people get the joined up and seamless support and care they require to meet their individual needs. **This will enable people to live full, independent and positive lives within supportive communities**; forming Falkirk's vision.

We should celebrate that people are living longer, are active and contributing citizens, and in the main are healthier or are able to live at home with long-term and multiple conditions.

We do recognise that there are challenges for the new partnership, including the current and forecast financial climate and increased demand that will exceed the resources available if we do not work together in a more integrated way. There is an opportunity to look at how as a Partnership, we can use our combined resources in a more effective, efficient and person-centred way.

There are inequalities within our communities, which we aim to address by working with our partners to prevent and reduce poverty, promote equality of access, and tackle patterns of ill health in communities at a local level. We will ensure that people have the opportunity to achieve the outcomes that matter to them in an equal and fair way.

The partnership will have a focus on prevention and early involvement to encourage and support self-management and people being in control of their own health and care, as it has proven to add to a better quality of life and can lead to better long term outcomes. We will do this in a way that supports people to be independent.

This three year strategic plan is informed by a variety of events and local and national information available to us. However, in order to make this Partnership the best possible for our residents, your view is essential. We would therefore like to

invite you to provide us with your perspectives and views on what good care would look like for you and those around you, in order to shape our plans for the future.

On behalf of Falkirk Health & Social Care Partnership:

Allyson Black	**Tracey McKigen**
Chair, Falkirk Integration Joint Board	**Interim Chief Officer**

1 INTRODUCTION

1.1 Setting the Scene

The Scottish Government's *2020 Vision* is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. Such a vision will only become a reality, locally, by statutory agencies working together. In order to make this new way of working truly successful, it is key that the views of people within local communities, including service users, their carers and families are taken into account in shaping future services.

The *Public Bodies (Joint Working) (Scotland) Act 2014* formalises the requirement to work towards the *2020 Vision* and legally requires NHS Boards and Local Authorities to establish Health and Social Care Partnerships. These Partnerships are required to work in an integrated way and are responsible for the delivery of national agreed outcome targets, termed *National Health and Wellbeing Outcomes*.

Whatever the setting, the person should be at the centre of all decisions and their care and support must be provided to the highest quality and safety standards. When admission to hospital is required, there will be a focus on ensuring that people are supported to return back into their home or community environment as soon as appropriate. In doing so, there is a need to ensure there is minimal risk of re-admission to hospital**,** whilst focusing on prevention, anticipation and supported self-management.

At a local level, NHS Forth Valley and Falkirk Council are building on existing common working practices to put in place robust single working arrangements with the aim of providing better, more integrated adult health and social care services. Integration of these services is driven in part by the following:

- People in Falkirk would like to have access to more joined up care and support near home;
- More people in Falkirk are living longer with a range of conditions and illness;
- Local demand for existing health and social care services is changing and there are resource constraints in terms of human and financial resources;
- NHS Forth Valley and Falkirk Council must continuously improve services and contribute to achieving better personal outcomes;
- Locally there is an opportunity to make better use of public resources while creating increased public value in avoiding duplication of effort.

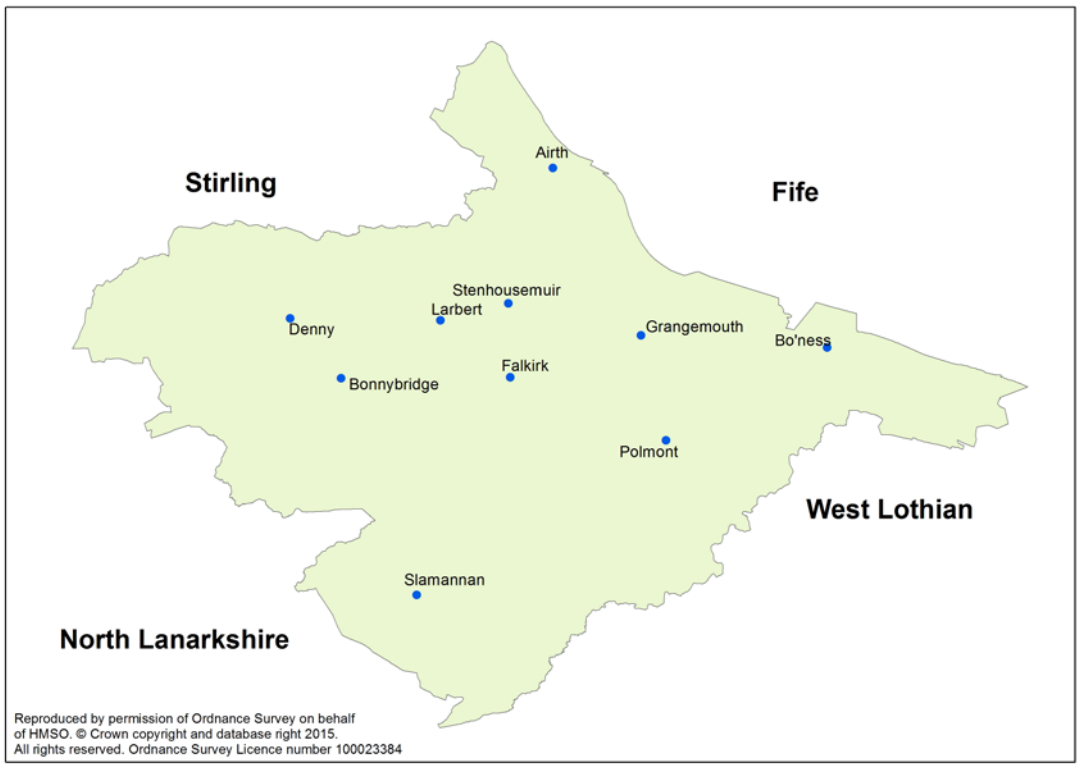
NHS Forth Valley and Falkirk Council have agreed to deliver integrated health and social care services through delegation to an Integration Joint Board. The Board is established as a *body corporate*, with the appointment of a Chief Officer as the jointly accountable officer. With effect from 1st April 2016, the Integration Joint Board will be operational and will have responsibility for the

planning and delivery of health and social care for adults within the boundaries of the Falkirk Council area. In order to facilitate this transition, the Integration Joint Board was established on 3rd October 2015.

Consistent with legislation, the partnership has to identify locality areas for service planning purposes. It has been agreed to establish three localities within the Falkirk Council area, namely:

- Falkirk Town;
- Bo'ness, Grangemouth and Braes;
- Denny, Bonnybridge, Larbert and Stenhousemuir.

Falkirk Council Area



The establishment of these three localities will provide further opportunity for local communities and professionals (including GPs, acute clinicians, community care workers, nurses, Allied Health Professionals, pharmacists, Care at Home Staff, Residential Care Staff and others) to play an active role in the development of future local services.

This strategic plan describes why, what and how health and social care services will be configured. This plan presents a framework to deliver the agreed vision over the following three years. Furthermore, a number of key priorities have been identified, which will help people living in Falkirk to live full and positive lives.

2 WHY CHANGE?

2.1 The Key Challenges

Change is constant. At the moment, people within the Falkirk Council area are living longer and healthier lives. Many people over 60 contribute greatly to society through volunteering within their community and caring for relatives. Simultaneously, this brings new challenges. The way that health and social care is being provided must change to meet current and future demands, as well as rising public expectations. The current delivery of health and social care is unsustainable, due to an ageing population; growing numbers of older people living with multiple conditions and complex needs; and the continuing shift in the pattern of disease towards long term conditions.

It is becoming increasingly difficult to afford and sustain health care and social care systems which have traditionally focussed on a crisis reactive approach. Consequently, providing institutional care for people rather than supporting them to live more independent lives in their communities. This reactive approach often leads to unnecessary, potentially damaging, expensive and prolonged hospital admissions and to a dependency on social care, which is unsustainable in the longer term.

Moreover, high levels of public resources are devoted annually to alleviating health and social problems, related to individuals and families who are trapped in cycles of ill health *(Christie, 2011)*. Consideration should also be given to other important factors, such as unemployment and poverty. This suggests the need to adopt a whole-systems approach to maximise health and social care outcomes. The Partnership will work alongside Community Planners in order to address these wider issues.

In summary, the traditional ways in which health and social care and support services are structured and delivered in Falkirk are becoming increasingly untenable and therefore fundamental change is required.

The information presented within this section has been drawn from the draft Joint Strategic Needs Analysis (JSNA), outlining some of the key challenges driving change. The JSNA is still under development and therefore, as information becomes available, further consideration will be given to emerging priorities, which will then be reflected in the final Strategic Plan.

2.2 Local Population

The Falkirk Council area has a population of approximately 157,640 (2014) and is increasing. The population has been increasing for over 20 years after some years of little change. The area has grown by almost 12,500 since the Census in 2001 (8.5%) compared to an increase in Scotland of 5.6%, and had the ninth fastest growth rate of all Scotland's councils.

Based on the previous 2012 mid-year estimate of population from *National Records of Scotland (NRS)*, the population is projected to increase further to 162,800 by 2020 and 173,100 by 2037 (see Figure 1 and 2). The growing population presents a key challenge to the Falkirk Partnership by placing increasing demands on services.

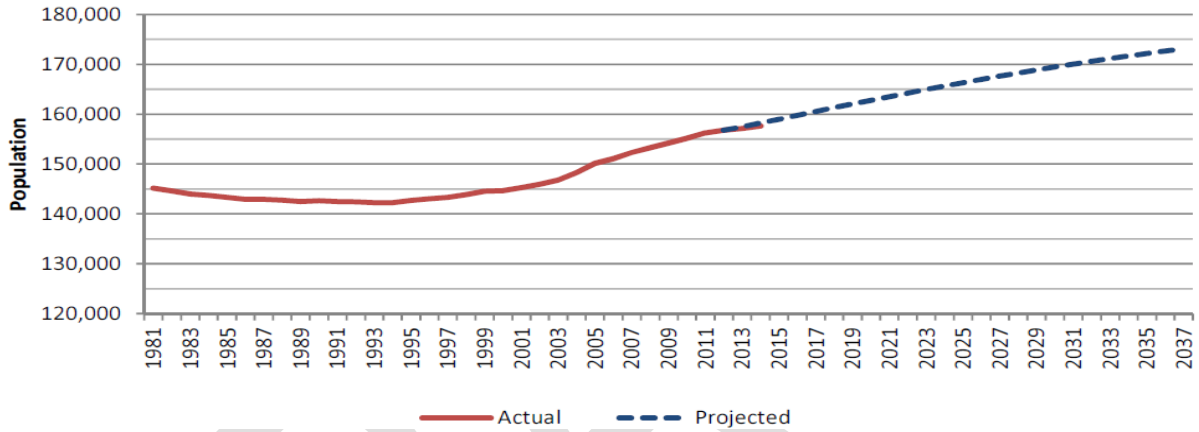


Figure 1. Population 1981-2037 *Source: National Records of Scotland midyear estimates of population 1981-2014 (Crown Copyright) 2012 based population projections 2012-2037 (Crown Copyright).*

Figure 2 illustrates an increasing forecasted population, with the biggest increase represented by the 65+ age group. A decline is forecasted for the 16-49 age group.

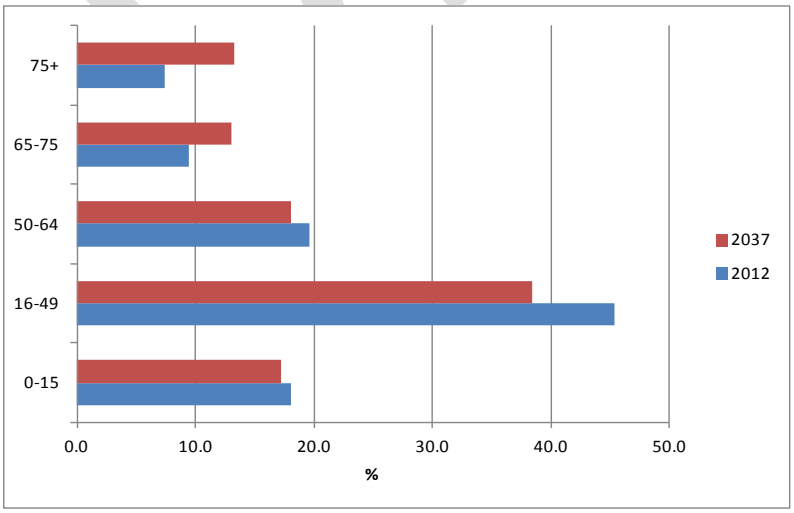


Figure 2. Projected Population Age distribution in Falkirk. *Source: NRS population projections.*

In reviewing various localities, Table 1 illustrates work carried out for the *Falkirk Housing Strategy* and the *Local Development Plan*. On a 2008 base, it is demonstrated that up to 2018, all areas except Grangemouth would have an increase in population. By 2033, both Falkirk and Grangemouth are expected to begin to show a decrease in population.

Sub area	2008	2018	2033	Change 2008-2018 No	Change 2008-2018 %	Change 2008-2033 No	Change 2008-2033 %
Bo'ness	15,297	15,658	17,313	+ 361	+ 2.4%	+ 2,016	+ 13.2%
Denny and Bonnybridge	26,394	30,094	33,291	+ 3,700	+ 14.0%	+ 6,897	+ 26.1%
Falkirk	37,872	38,139	35,716	+ 267	+ 0.7%	- 2,156	- 5.7%
Grangemouth	16,827	16,157	14,290	- 670	- 4.0%	- 2,537	- 15.1%
Larbert, Stenhousemuir and Rural North	26,230	27,470	31,435	+ 1,240	+ 4.7%	+ 5,205	+ 19.8%
Polmont and Rural South	28,954	32,721	39,166	+ 3,767	+ 13.0%	+ 10,212	+ 35.3%
Falkirk Council total	151,570	160,239	171,211	+ 8,669	+ 5.7%	+ 19,641	+ 13.0%

Table 1. Sub area projections of total population 2018 and 2033 (on a 2008 base) *Source: Falkirk Council, Local Housing Strategy 2011-2016, Demographic Report Table 27*

In order to ensure that people have access to services, irrespective of where they live, consideration must be given to the challenges faced by people living in rural areas. The majority (90%) of Falkirk's Partnership area population, lives in urban areas, and a small percentage live in Accessible Small Towns (2%) and Accessible Rural Areas (8%) (Figure 3).

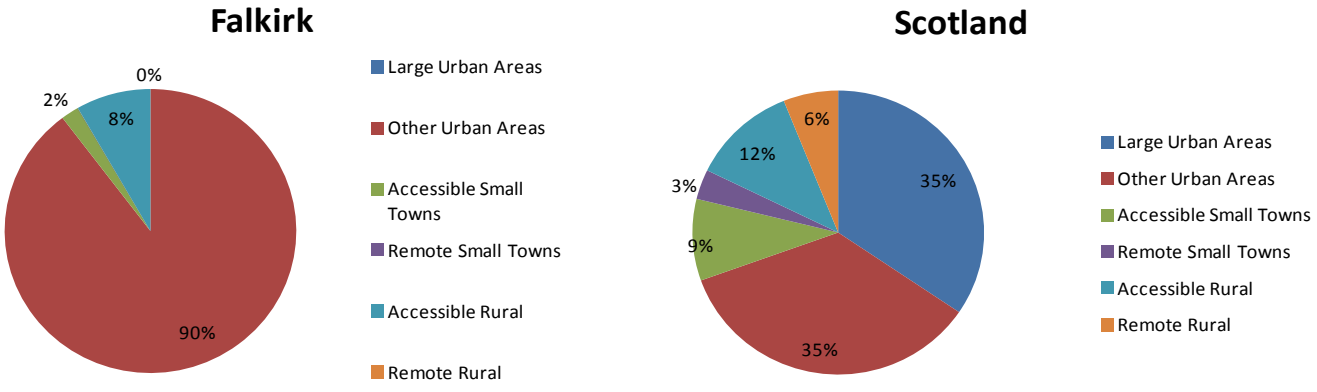


Figure 3. Population Density (persons per square kilometre) 2011. *Source: Census 2011*

2.3 Employment

Personal financial issues and concerns can cause health and social problems. Job insecurity, redundancy, debt and financial problems can all cause emotional distress, affect a person's mental health and contribute to other health issues.

Table 2 below shows the percentage of the population aged 16-74 by their economic activity in Falkirk, and Scotland as a whole. The percentage of people who are economically active is 65% of the population in Falkirk, a couple of percentage points higher than the national average. As a result the proportion of those economically inactive is lower than the Scottish figure, although the percentage of people who are disabled or long-term sick is the same.

Area	Economically active	Unemployed (actively seeking work)	Economically inactive (includes retirees & students)	Long-term sick or disabled
Falkirk	65.0%	5.2%	35.0%	4.8%
Scotland	62.8%	5.1%	37.2%	4.8%

Table 2. Percentage of total population by economic activity. *Source: 2011 Census*

Figures from the Department for Work and Pensions show that there were 13,104 claims for housing benefit in Falkirk in May 2015.

2.4 Housing

Housing may be considered a determinant of health. Inadequate housing can cause or contribute to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer (King's Fund, 2014).

The National Records of Scotland household projections predict that household numbers will increase between 2012 and 2037. Falkirk's increase will be lower (16%) than Scotland's (17%).

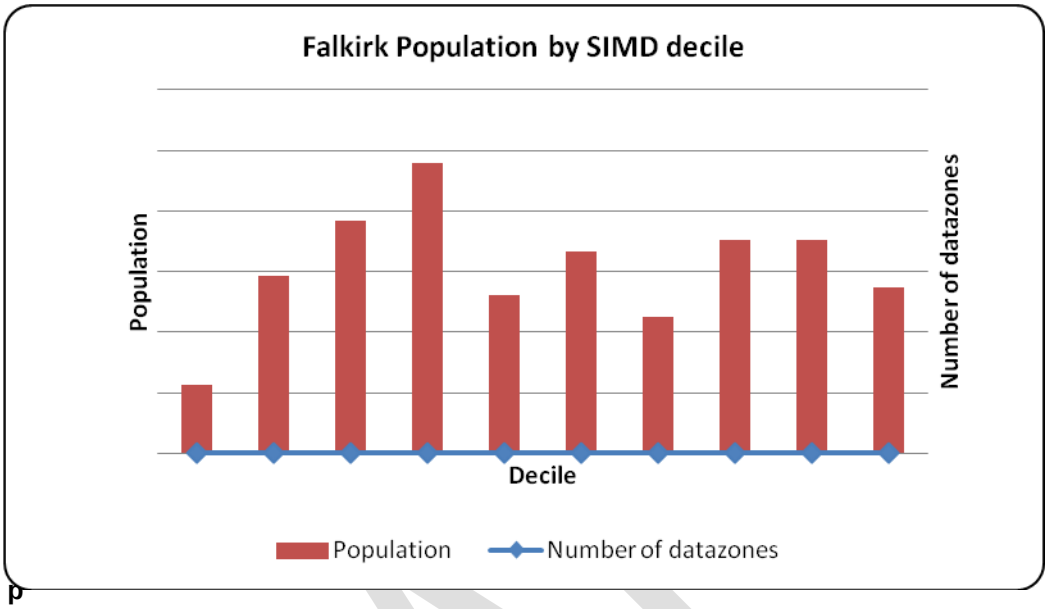
The percentage of those households headed by someone aged 75 and over is estimated to increase from 2012-2037 by 89% in Falkirk, greater than that in Scotland which is estimated to increase by 83%.

In 2013 home ownership accounted for 65% of households in Falkirk, comparable to 61% in Scotland. (Scottish Household Survey 2013). Social renting was the second largest group accounting for 27%, and private renting 8%.

2.5 Deprivation

Deprivation is a risk factor for the vast majority of conditions. Health and social care services must continue to reduce health inequalities through positive health and social outcomes for those experiencing deprivation.

Within the deciles, 1 is the most deprived and 10 the least deprived Figure 4 illustrates the number of people and data zones in each decile in Falkirk. The population in Falkirk can almost be split right down the middle, half of the population live in the lowest five deciles, and the other half in the highest five deciles.



p
opulation by SIMD decile. *Source: SIMD 2012*

2.6 Emergency Hospital Admissions

The delivery of emergency and urgent care is becoming increasingly challenging due to a range of factors such as the ageing population, increasing numbers of people with complex conditions and changes in the availability of the workforce to deliver care (CSR, 2015). Figure 5 shows the number of emergency hospital admissions for patients aged 65+ from 2004/5 to 2013/14 which has increased. Figure 5 demonstrates that the rate and number of admissions remains below the Scottish average.

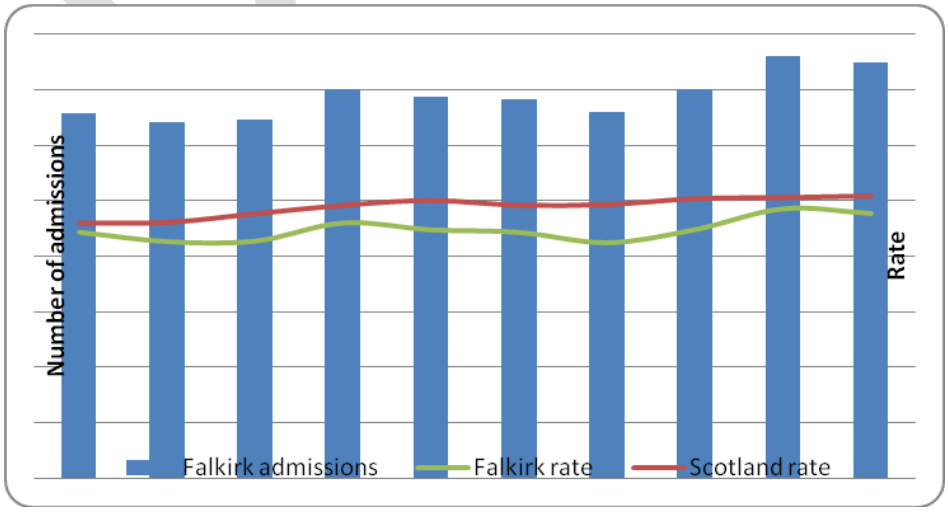


Figure 5. Falkirk emergency admissions to hospital - 2004/05 to 2013/14. *Source: ISD Scotland*

As the numbers of older people increase, the number of hospital admissions is likely to increase. For example, Figure 6 demonstrates that 65+ year olds represent over a third of emergency admissions. Therefore, there is a need to reduce the rate of avoidable admissions.

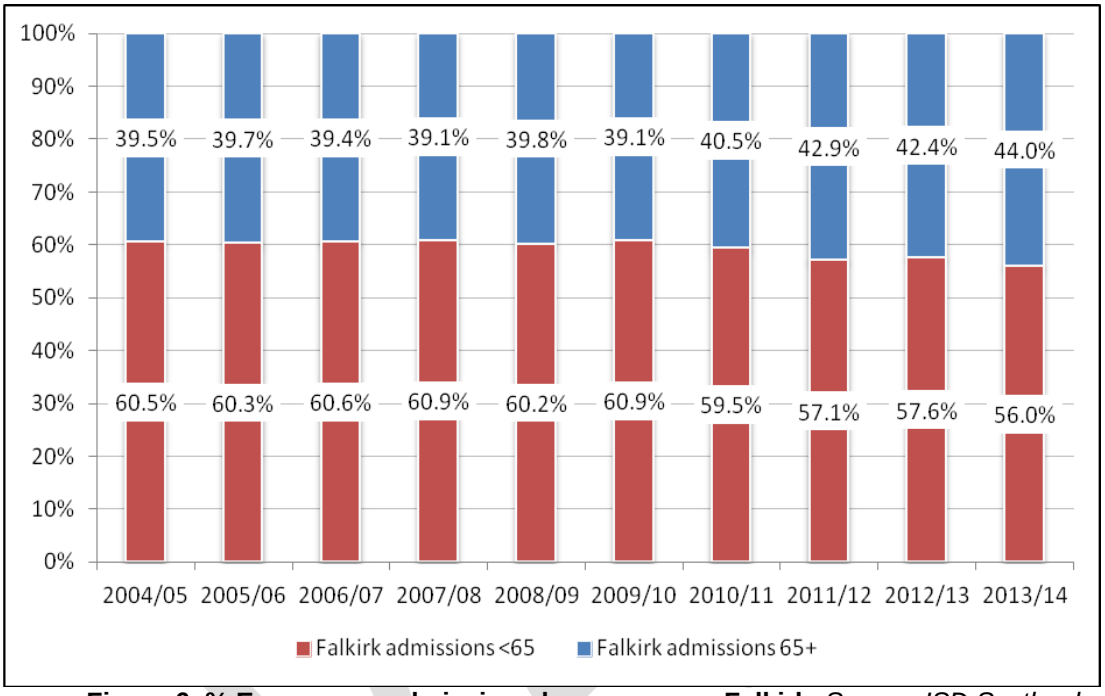


Figure 6. % Emergency admissions by age group, Falkirk. *Source: ISD Scotland*

2.7 Delayed Discharges

People do not want to stay in hospital longer than needed. The Scottish Government target is that no one should wait longer than 2 weeks to be discharged. Unnecessary delays can lead to deterioration in an individual's health and consequently a potential loss in their ability to remain independent. Delays in a person's discharge can occur for a variety of reasons.

Figure 7 represents the number of people within Falkirk with Delayed Discharges over the time period April 2015 until September 2015. The figure represents all delayed discharges, from and beyond one day delay.

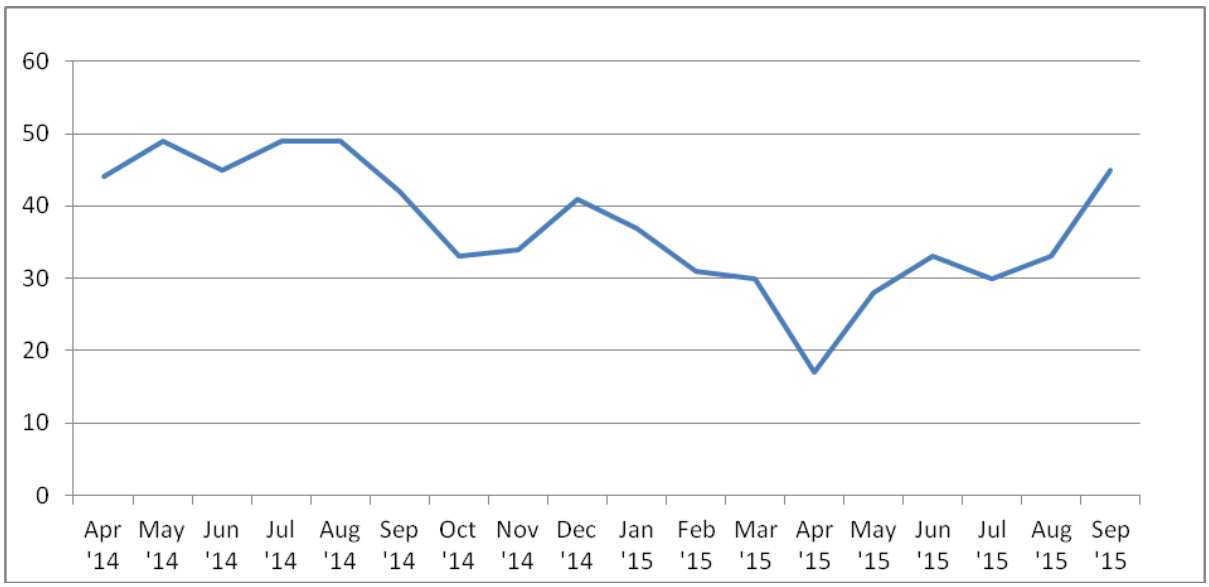


Figure 7. Delayed Discharges in Falkirk LA, April 2014 – September 2015. Source: ISD Scotland

The Falkirk partnership is working towards the target of ensuring that no one stays in hospital for more than two weeks beyond their agreed discharge date and will work through a number of actions identified which will support timely and appropriate discharge and support people returning home with appropriate care wherever possible.

2.8 Multiple and Long-term Conditions

Consistent with many partnerships across Scotland, Falkirk has to manage an increase in demand, whilst facing pressures on scarce resources. For example, Falkirk has an ageing population with many more people living with multiple and long-term conditions. This has contributed to escalating the number of people in middle and older age groups presenting with co-morbidities. Furthermore, from national research it emerged that people generally have less family and informal social support resulting in increasing reliance on health and social care services.

Figure 8 demonstrates the estimates of the proportion of the population in Falkirk, with various numbers of long term conditions, which is forecasted to increase between 2015 and 2037 (Figure 8 and 9).

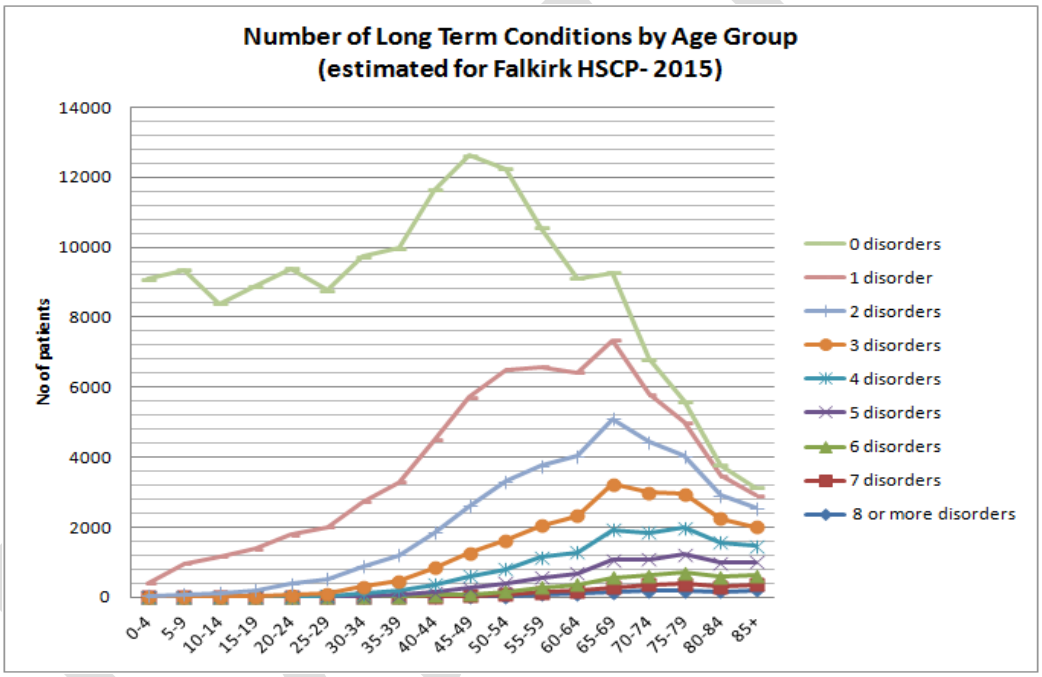


Figure 8. Estimated number of people within Falkirk with various numbers of long-term conditions – 2015. Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk

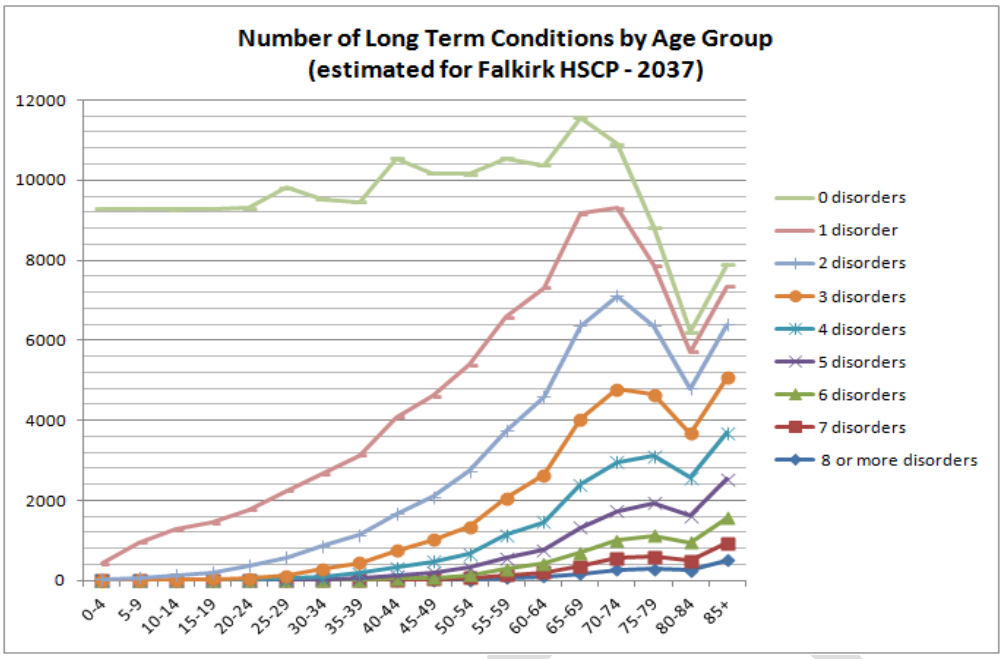


Figure 9. Estimated number of people within Falkrik with various numbers of long-term conditions – 2037. Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk.

2.9 Carers

It is estimated that in the UK nearly two million carers provide care for over 20 hours a week. Individuals and families experiencing the impact of disability, illness and ageing are dependent on a care and support system that responds to their real needs *(Glasby et al., 2010)*.

Research also indicates that although an average of 12% of the population provides a high proportion of unpaid care, as carers get older, they take on more caring responsibility. This was acknowledged in the *Scottish Government Caring Together: The Carers Strategy for Scotland 2010 – 2015* which predicts that the wider society will become even more dependent on older carers' contribution to health and social care delivery.

There are an estimated 492,231 carers in Scotland (Census, 2011). The Census estimated 28,014 of these carers are within the Forth Valley area. This comprised of approximately 15,056 in Falkirk, 9.7% of the local population. The Falkirk Partnership will:

- Recognise and value carers as equal partners in care.
- Support and empower carers to manage their caring responsibilities with confidence, in good health and enabled to have a life of their own outside of caring.
- Fully engage carers as participants in the planning and shaping of services required for the service user and the support for themselves.
- Ensure that carers are not disadvantaged, or discriminated against, by virtue of being a carer.
- Will recognise the needs of young carers as carers of adults are supported.

2.10 Summary

The previous section outlines some of the key challenges faced within the Falkirk Council area. These include an ageing population with an increase in multiple and long-term conditions, which have an impact on emergency hospital admissions as well as delays in discharge. Another challenge is the increase of dependency of the wider society on carers. Simultaneously, housing, employment and deprivation pose challenges for the health and wellbeing of Falkirk's population.

It is important that the Integration Joint Board is able to monitor progress being made towards local outcomes, through focussing on the priority areas identified. As further needs analysis information is produced and analysed, priorities and agreed outcomes will also be reviewed and further developed, where appropriate.

3 WHAT IS THE...?

3.1 Falkirk Strategic Plan

The Falkirk strategic plan is a high level strategic framework setting the context for how Falkirk Health and Social Care Partnership will begin to make the transformational changes and improvements to develop health and social services for adults over the next three years.

This plan takes account of the neighbouring partnership priorities of Clackmannanshire and Stirling. There are a number of NHS and Local Authority services which will continue to be planned and delivered across Forth Valley where this makes sense to do so and will meet local needs. Further consideration has also been given that Falkirk residents may access specialist services outwith Forth Valley.

There are a number of existing plans that relate to health and social care, which have been developed and implemented by partners over the last five years. In the development of the Strategic Plan it is important to recognise existing plans. Whilst this is not an exhaustive list these include:

- Falkirk Single Outcome Agreement 2013 - 23
- Falkirk Area Strategic Community Plan 2010 - 15
- NHS Forth Valley Strategic Plan 2015 - 2020
- Adult Services Plan 2015 - 2016
- NHS Forth Valley Clinical Services Review 2015
- NHS Forth Valley Local Delivery Plan 2015 - 16
- NHS Forth Valley Winter Plan 2014 - 15
- NHS Forth Valley Workforce Plan 2013 - 14
- Falkirk Council Corporate Plan 2012 - 17
- Poverty Strategy: Towards a Fairer Falkirk 2011- 21
- NHS Forth Valley Integrated Healthcare Strategy 2011 – 14
- Joint Commissioning Plan for Older People 2014 – 17
- Forth Valley Integrated Carers Strategy 2012 - 15
- Drug and Alcohol Strategy (*2015*)
- FV Falls Fracture Prevention & Bone Health Strategy 2008 -13
- National Mental Health Strategy 2012 - 15
- National Keys to Life Strategy (Learning Disabilities) 2013
- National Dementia Strategy 2012
- Integrated Children Services Plan 2010 - 15
- Physical Activity Strategy 2007 - 17

3.2 Policy Context

Integration of Health and Social Care is one of the Scottish Government's major legislative programmes of reform of public bodies' roles and responsibilities. At its centre, Health and Social Care Integration seeks to ensure that those who use services get the right care and support whatever their needs, at any point in their care journey.

The mutual dependency and overlap of responsibilities that exists between adult health and social care services is well documented. However, there often still remains a lack of clarity for people using services and their carers around the co-ordination of services resulting in a disjointed and fragmented approach**.** Figure 7 provides a simple illustration of this common disjointed and fragmented approach.

Figure 7. Disjointed and Fragmented Care provision (Thistlewaite, 2011).

However, by bringing together health and social care services across Falkirk and having staff working under the umbrella of a single organisation, there is an opportunity to improve the outcomes for people receiving services. Indeed, such an approach would improve outcomes for people and their carers, enhance communication, improve efficiency and reduce duplication. Figure 8 provides an illustration of how the Falkirk Partnership seeks to deliver joint up and coordinated care.

Figure 8. Joint up and Coordinated Care provision (Thistlewaite, 2011).

3.3 Scope of Services

Locally within the Falkirk Council area there is an existing range of excellent social care, primary and secondary healthcare and public health improvement services that will provide the fundamental infrastructure required. By further enhancing how staff across these services can work together in a much more integrated way and avoiding unnecessary duplication, the outcomes of those using health and social care services will be improved.

The *Public Bodies (Joint Working) (Scotland) Act 2014* has required that NHS Forth Valley and Falkirk Council integrate the planning and delivery of adult health and social care services under the agreed scope of a number of key services.

It has therefore been agreed within the *Health and Social Care Integration Scheme for Falkirk (2015)* that the following services currently provided by the NHS Forth and Falkirk Council are to be integrated, namely:

<table>
<tr><th>Community Health Based Services</th><th>Local Authority Based Services</th></tr>
<tr><td>• District Nursing;
• Services related to substance addiction;
• Services provided by AHPs in outpatient clinics or out of hospital;
• Public dental service/Primary medical services/General dental, Ophthalmic and Pharmaceutical services;
• Community Mental Health and Learning Disability services.</td><td rowspan="3">• Social work services for adults and older people;
• Services and support for adults with physical disabilities and learning disabilities;
• Mental health services;
• Drug and alcohol services;
• Adult protection and domestic abuse;
• Carers support services;
• Community care assessment teams;
• Support services;
• Care home services;
• Adult placement services;
• Health improvement services;
• Aspects of housing support, including aids and adaptations;
• Day services;
• Local area co-ordination;
• Respite provision;
• Occupational therapy services;
• Re-ablement services, equipment and Technology Enabled Care.</td></tr>
<tr><th>Hospital Based Services*</th></tr>
<tr><td>• Emergency Department;
• Inpatient hospital services (General Medicine/Geriatric Medicine/Rehab Medicine/Respiratory);
• Hospital based Mental Health services;
• Psychiatry of Learning Disability.</td></tr>
</table>

* for Strategic Planning purposes

3.4 Participation and Engagement

The Falkirk Partnership will ensure that people continue to be at the centre of developing current and future services and fully contribute to discussions around new ways of working. The Partnership would like to promote an open and honest dialogue with people and acknowledge the valuable contribution that communities make.

As previously indicated, redesigning services must be informed by the views of people within local communities. *The Falkirk Participation and Engagement Plan* describes in detail how it is intended to involve all stakeholders in the redesign of local health and social care services. It draws on a variety of national and local plans and reviews, which have taken into account the views of a variety of stakeholders.

Various public and staff engagement activities have taken place to help identify Falkirk's strategic priorities. The following provides a list of the type of key ongoing engagement activity undertaken locally:

Engagement Activities
• Cross sector Staff Engagement Sessions; • Transitional Board Strategic Planning Workshop; • Falkirk Stakeholder Strategic Planning Event; • Staff Newsletter; • Discussion with Falkirk's Community Care and Health Forum; • Discussion with Falkirk Community Planning Partnership; • Discussion with Falkirk Council and NHS Forth Valley Health Board

4 A PLAN FOR FALKIRK

4.1 Vision

The agreed vision for Falkirk's Health and Social Care Partnership is described as:

To enable people in Falkirk to live full and positive lives within supportive communities

4.2 Falkirk's Outcomes

Consistent with the nine national *Health and Well-being Outcomes,* the following five high level local outcomes have been agreed to describe what changes the Falkirk Partnership wishes to see over the next three years:

Theme	Desired Local Outcome
Self-Management	Individuals, their carers and families are enabled to manage their own health, care and wellbeing.
Autonomy and Decision Making	Where formal supports are required, people are enabled to exercise as much control and choice as possible over what is provided.
Safe	Health and social care support systems are in place, to help keep people safe and live well for longer.
Experience	People have a fair and positive experience of health and social care.
Community Based Supports	Informal supports are in place, which are accessible and enable people, where possible, to live well for longer at home or in homely settings within their community.

4.3 People's Views

Stakeholder engagement events have allowed participants to consider the five local outcomes with a view to identify what future services should look like, **to *enable people in Falkirk to live full and positive lives within supportive communities*.** People said future services should be:

- **Person-centred** – Good services are outcomes focused, centred round the needs of individuals. Individuals are able to make informed decision regarding their own care pathway and supported to self-manage, where possible. Single care plans should be 'owned' by the service user, their carers and family. Information about services is co-ordinated and communicated in an accessible way.

- **Enhancing Information sharing** – Information sharing is critical to good integrated care – and is extend across all sectors. Information sharing includes single shared assessments and care plans, which are co-produced by services users and professionals, and can be used and updated across professional specialism. This allows the co-ordination of care, so that the right care is provided at the right time by the most appropriate service. Infrastructure, particularly IT systems are in place to support this, and staff are able to access and use the system.

- **Focusing on Early Intervention** – Individuals are supported by responsive, proactive services, before reaching crisis. Education and information is accessible and readily available to individuals, their carers and families, which allows them to make informed choices and manage their own health and wellbeing.

- **Improving Access** – Individuals are able to access services quickly via a single point of contact. Transition between services is supported with a back office infrastructure that facilitates smooth transition via effective communication and information sharing. In addition, services are responsive and available consistently throughout the year, on a 24/7 basis, if appropriate.

- **Developing the Workforce** – A shared vision is held across all partners. The workforce across all sectors is highly skilled. Collaborative working across agencies and sectors is the norm and frontline staff are empowered to take decisions, which allows them to tailor response and care to suit the needs of the service user.

4.4 Falkirk's Priorities

Taking into consideration both the first draft Joint Strategic Needs Assessment and the output from the Stakeholder Engagement Events, the following priorities were identified:

Falkirk Partnership Outcomes				
Self Management	**Autonomy and Decision Making**	**Safe**	**Experience**	**Community based support**
Individuals, their carers and families are enabled to manage their own health, care and wellbeing.	Where formal supports are required, people are enabled to exercise as much control and choice as possible over what is provided.	Health and social care support systems help to keep people safe and live well for longer.	People have fair and positive experience of health and social care.	Informal supports are in place, accessible and enable people, where possible, to live well for longer at home or in homely settings within their community.
Universal Priorities				
Cultural change across agencies and the public Information sharing Workforce, including unpaid carers Maximise better use of existing resources Early intervention & Prevention Availability of Services and Resources Effective Risk Management at all levels Information is accessible and presented in a consistent manner				
Falkirk's Priorities				
Education is accessible and delivered consistency with messages being reinforced Support is available for un-paid Carers	Person-Centred care is reinforced, acknowledging family/carer views Care and support is underpinned by informed choices and decision making throughout life	Technology is used in an effective and appropriate way to support care Risk is acknowledged and managed effectively	Greater focus is given to an individual case management approach, enhanced by the provision of advocacy support Feedback drives continuous improvement Service users are engaged and involved across the Partnership Co-location, where appropriate	Information about community based support is accessible and presented in a consistent manner Build sustainable capacity within all sectors Adopt a consistent framework when commissioning services Build on existing assets within local communities Support is available for un-paid Carers

In summary, the Falkirk Health and Social Partnership seeks to establish an integrated health and social care approach with an emphasis on self-management, early intervention and prevention, balanced with the ability to react responsively to acute health and social care needs.

5 HOW WILL THIS PLAN BE DELIVERED?

5.1 Building on Existing Policies and Plans

There are a number of priorities and actions that have been identified from existing national and local policies and plans (see section 4.1) that partners have individually and/or collectively agreed to work towards. It is acknowledged that these plans are at different stages of completion. Nevertheless within the context of this Strategic Plan, those plans are critical as helpful starting points in which to identify future partnership activity to be implemented.

In addition, within Falkirk there are several examples of integrated working arrangements already in place, such as Community Mental Health and Learning Disability Teams. These provide valuable insight into integrated practice.

Public views and evidence based approaches have informed the development of these local plans, which were subject to wide consultation and research. Partners have started to take into account the new and emerging legislative strategic planning requirements and how future local plans must align with the integration agenda and a whole system approach.

5.2 Falkirk's Commitments

It is important that the Falkirk Partnership continually focuses on the identified priorities in order to achieve its outcomes. Collectively these priorities will support the transformational change leading to robust integrated services.

A number of commitments have also been identified within the Integration Scheme, which underpins how these priorities will be approached, these are;

- Putting individuals, their carers and families at the centre of their own care by prioritising the provision of support which meets the personal outcomes they have identified as most important to them.
- Recognising the importance of encouraging independence by focusing on reablement, rehabilitation and recovery.
- Providing timely access to services, based on assessed need and best use of available resources.
- Providing joined up services to improve quality of lives.
- Reducing avoidable admissions to hospital by ensuring that priority is given to strengthening community based supports.
- Sharing information appropriately to ensure a safe transition between all services.
- Encouraging continuous improvement by supporting and developing our workforce.
- Identifying and addressing inequalities.
- Building on the strengths of our communities.
- Planning and delivering Health and Social Care in partnership with

Community Planning Partners.

- Working in partnership with organisations across all sectors e.g. Third Sector and Independent Sector.
- Communicating in a way which is clear, accessible and understandable and ensures a two way conversation.

5.3 Developing an Enabling Structure

In realising the strategic vision and delivering the agreed outcomes, Falkirk Partnership is committed to ensuring that there is effective leadership, systematic risk management arrangements, robust accountability and an agreed performance management system. This will allow evidence based decisions to be taken.

Effective leadership – is crucial in providing direction and delegation, enabling staff at all levels across the Partnership to fully adopt a person-centred approach to care. In addition, a systematic review and evaluation of current services will provide the basis for the necessary transformational change.

Systematic risk management – will provide staff with the necessary structure, to empower them to manage and tolerate certain levels of risk. Such an approach will be adopted at all levels of the partnership to include management decisions and front line services with consideration of service users' and carers' views.

Robust accountability – is necessary to ensure that there is clarity around roles and responsibilities regarding reporting structures that ensure actions are delivered. This links backs to effective leadership and the ability to make informed decisions.

Performance management – is vital to ensure that efficiency, effectiveness and quality of services are evaluated and monitored regularly. The Integration Joint Board will be held accountable for all services within the scope of the Integrated Service provision. This will include evaluating collaborative working within and across all sectors.

6 SUMMARY STATEMENT

The Scottish Government has set out its future vision for Health and Social care namely the *2020 Vision.* This vision is supported by the National Health and Well-being Outcomes. These outcomes are set within the legal framework of the *Public Bodies (Joint Working) (Scotland) Act.*

Falkirk's Partnership has identified its local vision and five specific outcomes. In order to achieve these outcomes a number of priorities have been identified which align to each outcome. It is acknowledged that a number of these priorities are relevant to all the outcomes.

Many of initiatives are currently running within the Falkirk area, which are already contributing to local outcomes. Actions have been and will continue to be developed consistent with the priority areas.

The following overview demonstrates the alignment between the national and local outcomes and priorities. Additionally, existing local initiatives and programmes have been included.

Scottish Government's 2020 Vision for Health and Social care

By 2020 everyone is able to live longer healthier lives at home, or in a homely setting

National Health and Well-being Outcomes

People are able to look after and improve their own health and wellbeing and live in good health for longer.	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	People who use health and social care services have positive experiences of those services, and have their dignity respected.	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Health and social care services contribute to reducing health inequalities.	People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being.	People using health and social care services are safe from harm.	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Resources are used effectively and efficiently in the provision of health and social care services.

Integrated Vision for Falkirk

To enable people in Falkirk to live full and positive lives within supportive communities

Local Outcomes

Self-Management – Individuals, their carers and families are enabled to manage their own health, care and wellbeing.	*Autonomy and Decision Making* – Where formal supports are required, people are enabled to exercise as much control and choice as possible over what is provided.	*Safe* – Health and social care support systems help to keep people safe and live well for longer.	*Experience* – People have fair and positive experience of health and social care.	*Community based Supports* – Informal supports are in place, accessible and enable people, where possible, to live well for longer at home or in homely settings within their community.

Falkirk Partnership Priorities

Universal Priorities

Cultural change across agencies and the public
Information sharing
Workforce, including unpaid carers
Maximise better use of existing resources
Early intervention & Prevention
Availability of Services and Resources
Risk Management
Information is accessible and presented in a consistent manner

Self-Management	Autonomy and Decision Making	Safe	Experience	Community based Supports
Education is accessible and delivered consistency with messages being reinforced	Person-Centred care is reinforced, acknowledging family/carer views Care and support is underpinned by	Technology is used in an effective and appropriate way to support care Risk is acknowledged and managed	Greater focus is given to an individual case management approach, enhanced by the	Information about community based support is accessible and presented in a consistent manner

Support is available for un-paid Carers

informed choices and decision making throughout life

effectively

provision of advocacy support

Feedback drives continuous improvement

Service users are engaged and involved across the Partnership

Co-location is pursued where appropriate

Build sustainable capacity within all sectors

Adopt a consistent framework when commissioning services

Build on existing assets within local communities

Support is available for unpaid Carers

Local Initiatives aligned with Local Outcomes & Priorities				
Self-Management	**Autonomy and Decision Making**	**Safe**	**Experience**	**Community based Supports**
Health and Wellbeing activities programme (carers) Support break for carers Community rehab at home Intermediate rehabilitation service Enhanced support for FCH developing the rehab support worker Developing personalised assessment and support planning for carers	FDAMH social prescribing service Intermediate care capacity Short term assessment out of hospital	Telecare innovations – MECs (**Mobile Emergency Care Service)** night services and Fall management Augmented capacity in the Falkirk Community Hospital Social Work Team OT, equipment and adaptation redesign Support for carers at hospital discharge Rapid Access Frailty Clinic at FVRH Home Essential Leaving Pack (HELP) Medication management project	Forth Valley case management service for people with Alcohol Related Brain Damage Expansion of the Delayed Discharge Hub and associated staffing	Top Toes Living it up (DALLAS) Braveheart Optimise Health and Wellbeing Service Marie Curie patient visit services Alzheimer's Scotland PDS link workers Training for carers in their own community Active minds: a physical activity and wellbeing programme for Falkirk Closer to home project

7 Appendix 1 - Core Indicators

Core Indicators That Will Guide Us

Outcome indicators based on survey feedback, to emphasise the importance of a personal outcomes approach and the key role of user feedback in improving quality. While national user feedback will only be available every 2 years, it is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often.

1. Percentage of adults able to look after their health very well or quite well.
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5. Percentage of adults receiving any care or support who rate it as excellent or good
6. Percentage of people with positive experience of care at their GP practice.
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
8. Percentage of carers who feel supported to continue in their caring role.
9. Percentage of adults supported at home who agree they felt safe.
10. Percentage of staff who say they would recommend their workplace as a good place to work.*

Indicators derived from organisational/system data primarily collected for other reasons. These indicators will be available annually or more often.

11. Premature mortality rate.
12. Rate of emergency admissions for adults.*
13. Rate of emergency bed days for adults.*
14. Readmissions to hospital within 28 days of discharge.*
15. Proportion of last 6 months of life spent at home or in community setting.
16. Falls rate per 1,000 population in over 65s.*
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
18. Percentage of adults with intensive needs receiving care at home.
19. Number of days people spend in hospital when they are ready to be discharged.
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
22. Percentage of people who are discharged from hospital within 72 hours of being ready.*
23. Expenditure on end of life care.*

***** Indicator under development

http://www.gov.scot/Resource/0047/00473516.pdf

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Falkirk Council

NHS Forth Valley

Falkirk Health & Social Care Partnership

Draft

Joint Strategic Needs Assessment

September 2015

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1.

Executive Summary

The traditional public service model – is to identify and 'assess' need and aim to meet it (on both and individual and population basis)

The public sector as we know it was established in the immediate post-war period where the population experienced poverty, overcrowding and slum housing. At this time the UK Welfare State was being established to ensure at least a minimum standard of living, through the National Assistance Act and a range of other legislation.

Since that time there has been great change:

- Demographic change (in part a result of the success of the welfare state)
- People living longer and healthier
- (This despite an increase in the prevalence of Long Term Conditions (LTCs) - due to a combination of new conditions and better/ earlier-diagnosis)
- So, the population of Falkirk is growing in size, ageing and increasing in complexity and multiplicity of health and social problems such that demand is exceeding supply in the present model
- There are rising costs and debt (national and personal)

However it may be argued that the traditional model for public services has often required individuals to abdicate responsibility, leading to 'learned helplessness' on the part of individuals, and risk aversion on the part of services / staff/ clinicians.

So there are positive consequences and negative consequences of current service provision. The changes experienced since 1945 are so great that the traditional model is no longer fit for purpose

The new paradigm needs to:

- put the individual person at the centre
- encourage individual responsibility and motivation for change to maximise wellbeing
- encourage ambition on the part of individuals, staff and all stakeholders
- encourage critical realism - the empathetic approach - based on intention, attention, mutual understanding, exploring options etc.

This is not to say that the individual is to be abandoned by public services, or that help will be with-held. Rather it is to recognise that intervention can be unintentionally disabling longer

term, and that to maximise wellbeing longer term, we should provide support that is the minimum required to be effective, empathetic and enabling.

'Engagement' is key

- to recognise value as a key concept 'values-based value management'
- to consider how to maximise value generated by limited resources

The service implications, therefore are:

- real engagement ++
- workforce development in person-centeredness
- wholesale, continuous redesign of public / third sector
- realistic access - e.g. consider signposting rather than referral (the onus is then on the individual to make the arrangements), but also a realistic increase in opportunities for access / addressing barriers (by working with carers and other stakeholders)
- realistic risk management - e.g. falls prevention (some risk of a fall needs to be accepted for the re-enablement process to occur)

The recommendations for the future therefore come under the following headings:

Engagement:

- Of the workforce in these issues, to generate understanding and a positive attitude to the future. And to build on workforce development in person-centred care (see appendix for examples)
- Of individuals – in their own health and wellbeing, facilitated by staff and other contributors and based on understanding, empathy, to improve connectedness, beliefs and values, knowledge and skills etc. (coming under the general heading of 'resilience'). And thence to health improving behaviours – physical activity, diet and nutrition, no substance use; and also recognising adherence to medication and advice, for example, as a health behaviour.

Redesign

- Wholesale public sector/ third sector redesign, outcomes-focussed yes, but recognising that process is key.
- Linking with engagement work – MCDM (Multi-criteria Decision Making), PSP (Public Social Partnerships) to reach a common understanding of goals and how these may be met
- Person-centred redesign – based on the above and work on person-centred care developed locally

- Working with CPPs (Community Planning Partnerships) on the 'determinants of health' with the aim of improving structural approaches and reducing the tendency for 'lifestyle drift'. And emphasising work as key to health (not just paid employment, but caring and volunteering) which is often the basis for meaning and purpose in people's lives.
- 'Integrated anticipatory care' – whereby the value of each of: prevention, early identification, treatment, management etc. is recognised in a spectrum of help/ intervention from a range of contributors – not least the client (self-care).

If we make these changes....then we can expect

- better motivation in individuals - decreased risk factors, increased adherence to (minimal) intervention
- longer term, reduced disease (could be up to 40% or so)
- more efficient processes / less waste
- increased wellbeing, increased employability, increased work/ productivity of the population

Framework and Methods

A general philosophical framework considers ontology (what exists), epistemology (how knowledge is created) and logic (reasoning, causality and if...then relationships). The methods used attempts to work to the principles of applying these disciplines.

The following is a discussion of current and potential methods, in two groups – use of data items (usually singularly), and creation and development of models (using multiple data sources).

Data

- In using data it is important to consider their validity, which depends on the source, what the original intention was when they were generated, general reliability and validity etc.
- Population projections are based on modelling, using data from the census, modified to take into account various factors.
- Population projections tend to be inappropriately precise – down to single figures for single year of age – and are forecasts rather than predictions.
- Prevalence data often comes from a sample (e.g. through a survey) with the assumption that it is sufficiently representative, e.g. Scottish Health Survey
- Activity data relate to activity and any extrapolation to disease needs to be carried out with caution, e.g. data from ISD.

- Benchmarking is comparison with different areas' healthcare arrangements and again requires caution that the areas being compared are sufficiently alike.
- 'Synthesis' is applying data from one source to another to give an estimate – e.g. applying prevalence data to population projections (also known as spreadsheet modelling). It is important to be aware of the assumptions and caveats etc. with this kind of forecasting.

Models

- As discussed above models may be of different types – static or dynamic
- The findings section includes a large number of models, some of which are class models, others the beginnings of dynamic models (produced in a qualitative way but may be developed to using data)
- There is potential to use more sophisticated modelling techniques:
- Data envelopment analysis is used for assessing efficiency. Rather than simply benchmarking, it allows various data items to be combined as 'inputs', and others as 'outputs'. Plotting inputs against outputs for a range of 'decision making units' gives an 'efficiency frontier'. The advantage of this is that it gives a better idea of the scope for improvement for individual units, should inputs be increased.
- The origins and development of benchmarking have recognised the need to consider values, and processes in addition to a simple comparison of outcomes or outputs
- Discrete event simulation is used to forecast the results of changes in process or capacity at an operational level (see paper on modelling stroke beds)
- Systems dynamic modelling is higher level, considering 'stocks and flows' and might be used for modelling at the population level.

Needs assessment methods

What is need? One definition is the gap between 'what is' and 'what should be' – which is inherently a value judgement. Hence we need to be clear on the value base of this work.

NHS Forth Valley has specified 6 core values. These are:

- Respect
- Ambition
- Team work
- Supportiveness
- Integrity
- Person-centeredness

It seems likely that in the process of integration these can be adopted by the whole of the public sector for Falkirk. A further value of 'fairness' could also be added, as our objectives include addressing inequalities.

The process of needs assessment could include expanding the agreed objectives, based on our values, to consider in more detail 'what is' and 'what should be'. For example, to be ambitious (a core value) about what 'should be' in regards to living longer and healthier lives we could say everyone should live a perfectly healthy life and die on or after their 100th birthday.

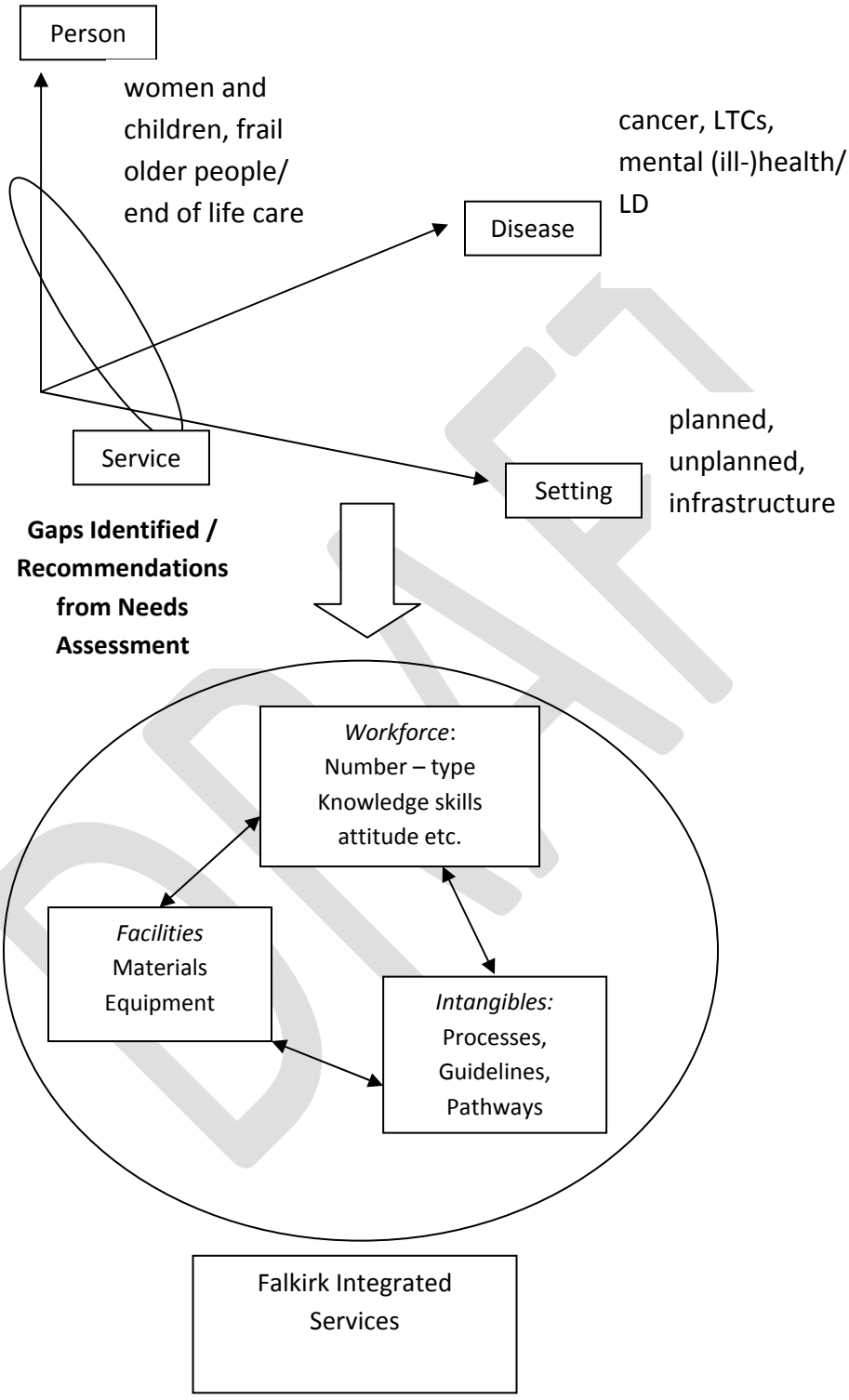
Types of need

The ontological basis of our needs assessment helps in defining types of need. Within this report we have described

- The people in our communities – demographics, but also their attributes in terms of life circumstances, risk factors, disease and long term conditions.
- The services and their attributes – including capacity

So need can be described at each level – population health and social care needs, which can be met by service activity; and service needs which require to be met in order to optimise service activity.

These elements come together as illustrated in the diagram below:

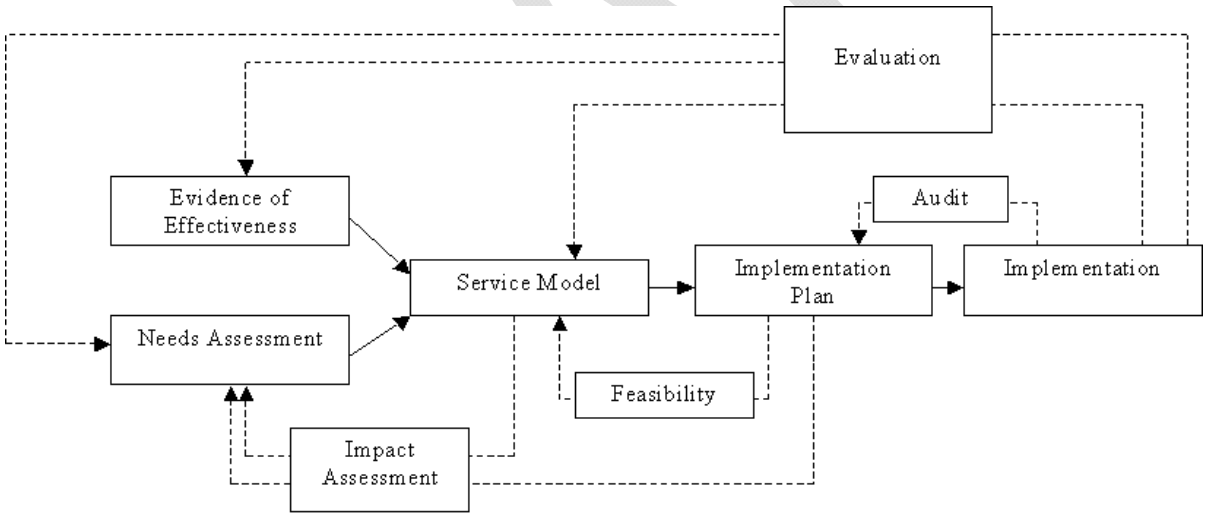

Person
women and children, frail older people/ end of life care
cancer, LTCs, mental (ill-)health/ LD
Disease
Service
Setting
planned, unplanned, infrastructure
Gaps Identified / Recommendations from Needs Assessment
Workforce: Number – type Knowledge skills attitude etc.
Facilities Materials Equipment
Intangibles: Processes, Guidelines, Pathways
Falkirk Integrated Services

Beyond these needs, other types of need can be described, e.g. the 'engagement' needs of individuals – i.e. improvement in attitude and motivation in regard to the individual's own health, and for services organisational needs and redesign needs. In many ways a needs assessment is not required for us to know that there is significant room for improvement in each.

Further Description of needs assessment

Population based needs assessment tends to be one-size-fits-all whereas working from a person-centred holistic approach we want everyone to be treated as individuals – implies 150,000 or so needs assessments/ personal health plans

The process of needs assessment is iterative (encompassing impact assessment, evaluation etc.) – not just a one-off exercise



Interpretation of data can depend on perspective – is the glass half full or half empty? And identified need in terms of a gap does not imply that resources should be allocated to it necessarily – effectiveness, feasibility, fairness etc. must also be considered.

1 Introduction

1.1 Background

The integration of health & social care is a key Scottish Government Programme of reform designed to improve care and support for those who use health and social care services. The legislation relating to the integration of health and social care is set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

A list of 9 high-level statements of what health and social care partners are attempting to achieve through integration have been produced. These are known as the National Health and Wellbeing Outcomes.

By working with individuals and local communities, health and social care partnerships will support people to achieve the following outcomes:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Outcome 5: Health and social care services contribute to reducing health inequalities

Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

Outcome 7: People using health and social care services are safe from harm

Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services

Linking the Information presented to the Intended Outcomes

	Information Section					
Outcome:	**Population**	**Life Circumstances**	**Risk Factors**	**Population Health**	**Provision of Health and Social Care**	**Carers**
Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer	●[1]	●[2]	●[3]	●[4]	●[5]	●[6]
Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	●[7]	●[8]	●[9]	●[10]	●[11]	●[12]
Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected		●[13]			●[14]	
Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services		●[15]	●[16]		●[17]	
Outcome 5. Health and social care services contribute to reducing health inequalities		●[18]			●[19]	
Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being						●[20]
Outcome 7. People using health and social care services are safe from harm					●[21]	
Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide					●[22]	
Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services					●[23]	

Comments on connections and gaps:

1 The total population and demographic profile impacts on the number of people whose self-care and longevity are under consideration
2 Life circumstances impact on ability to look after oneself and improve health. This may be through mental wellbeing or less tangible concepts such as resilience
3 Health improvement often requires the addressing of risk factors
4 Longevity is strongly affected by the development of individual diseases and multiple conditions
5 Provision of health and social care should be enabling and health improving, and increase longevity
6 Carers can enable individuals to improve their health, reduce risk factors and live longer
7 The total population and demography impact on the number of people living at home or in homely settings
8 Life circumstances include a consideration of the home setting and extent to which housing needs can be and are met
9 People, including those with long term conditions have opportunities for health improvement through addressing risk factors
10 Population health includes a consideration of the epidemiology of long term conditions and frailty etc,
11 Provision of health and social care should be enabling and encourage rehabilitation
12 The role of carers is important and may be crucial in helping people continue to live at home
13 Life circumstances are an important factor in individuals' attitudes to and therefore use of health and social care services
14 Good information on health and social care service activity is available. Information on the quality of provision in terms of experience is collected through more qualitative means such as surveys (not presented here)
15 Health and social care services can have a positive impact on life circumstances
16 Health and social care services can be health improving through addressing risk factors
17 The provision of health and social care is based on evidence of effectiveness (which may be variable). Direct impact in terms of health and social outcomes may need to be inferred.
18 Experience of deprivation and other equality / inequality factors come under life circumstances
19 Health and social care services should reduce health inequalities through positive health and social outcomes for those experiencing deprivation. However the 'inverse care law' applies – those with less need are better able to access services (see items 2 and 13)
20 Carers have health and social care needs, which when met also have a positive impact on the person being cared for.

21 The information presented may not quite capture the 'safe from harm' aspect. More qualitative data from inspectorate reports or patient safety initiatives could provide further evidence

22 The information on workforce is fairly basic and quantitative. Further information from staff surveys etc. would be useful. Workforce development is key to achieving the nine outcomes.

23 The information presented does not quite capture effectiveness and efficiency – this may need to be implied or extrapolated. More complex methods such as benchmarking, data envelopment analysis or economic evaluation such as (social) return on investment may be required.

This needs assessment will feed in to a strategic planning process, for which there are a number of important factors to consider prior to implementation, summarised as the CURVE model for strategic improvement

CURVE is

- **C**ulture
- **U**nderstanding
- **R**esponsibility
- **V**alues, value, valuing
- **E**nterprise

Culture

Culture is defined as "what is learned, shared, and transmitted in a group – reflected in that group's beliefs, norms, behaviours, communication and social roles" (Kreuter and Haughton, 2006)

Further it can be defined using the 'model for a person' and extending this to collective attributes of a group or community etc. – i.e.

Collective:

- Physical and social environment
- Behaviour and sensation / perception within this environment
- Memory, imagination, and emotion
- Knowledge, skills and creativity
- Beliefs, values and attitudes
- Identity
- Spirituality / sense of connectedness

Culture change

Culture changes over time. The extent to which this can be guided or facilitated is debatable. It has been suggested that certain factors can facilitate culture change at the 'edge of chaos'. These are:

- Diversity
- Information flow
- Connectivity
- Reducing barriers or inhibitors
- Enhancing or increasing catalysts
- Watchful waiting
- Positive intent

Understanding

Knowledge is a personal attribute and collective knowledge is a community or cultural attribute. But to be really useful it needs to go deeper to form understanding. There are several senses to the term understanding:

- Awareness of a situation in context, its meaning – based on evidence. Being able to see how things relate to each other, often in complex ways.
- Having and demonstrating common understanding between individuals, which relates to empathy and positive intent.

Responsibility

Within the context of family support, for example, improvement ultimately relies on individuals taking responsibility. Such individuals may be children, parents, other family members, peers, public sector or third sector staff. A process of engagement and involvement may be required to facilitate this, as may the meeting of some basic client needs. Within the public sector there is increasing recognition that client rights need to be balanced with responsibilities (as described in the recent Patient Charter for the NHS in Scotland, which is derived from legislation)

Interaction between the themes:

	Culture	**Understanding**	**Responsibility**
Culture	-	Cultural understanding	Cultural responsibility
Understanding	Understanding culture	-	
Responsibility	Responsibility for culture	Responsibility for understanding	-

Values, value, valuing

Fundamental to improvement work is the underlying set of core values to which we are working. NHS Forth Valley has defined its core values as:

- Respect
- Integrity
- Person-centredness
- Supportiveness
- Ambition
- Teamwork

Value is also an important concept, as improvement work / redesign is often aimed at increasing the value gained from the use of resources. Value can be subjective however and this needs to be considered.

Valuing can also be important in terms of appreciating resources or actions. For example if the services offered are not valued by clients, uptake will decline as will value.

Enterprise

Organisations and partnerships are engaged in some form of enterprise – establishing a vision and working towards it. Entrepreneurship encompasses core skills that are relevant for improvement work in general:

- Establishing and developing networks, teamwork and collaboration
- Understanding value and value chains
- Identifying and developing personal skills
- Identifying and developing innovative practice
- Understanding motivation

The emergence of the concept of a 'Social Enterprise' is particularly important for the public and third sectors. In the field of social enterprise a "triple bottom line" is described consisting of the 3 'P's

- Profit (monetary value) – or value for money in public spending
- People (social value) – quality and effectiveness in making a real difference to people's lives
- Planet (ecological value) – long-term sustainability of public services

Implementation

Each element needs to be considered in some depth. The CURVE model sets out 'what?' but for implementation there needs to be a consideration of 'how?'

1.2 Joint Strategic Needs Assessment

Each health and social care partnership is required by the legislation to produce a detailed strategic plan. Falkirk's strategic plan will explain how the partnership will make changes and improvements to develop health and social services for adults over the coming years.

In order for the partnership to produce a detailed strategic plan that best meets the needs of its local population we first require a clear understanding of the health and care needs of the population, from both the perspective of the NHS and Local Authority, and other key stakeholders.

Need is the discrepancy between "what is" and "what should be". This document aims to bring together the available data in order to describe the current pattern and level of supply of these services and where possible identify the extent of the gap between need and supply.

Understanding the differing levels of need and service provision across the partnership will be key to future success. Therefore the ability to assess need at locality level is extremely important. This document will focus on information and analysis at partnership/local authority level and will sit alongside a locality profile document. The proposed localities for strategic planning purposes are:

Add locality details once agreed

2.

2 Population

2.1 Current Population

A key aspect for determining the need of many health and social cares services is the size and age distribution of the local population. Table 2.1a, below, illustrates the population profile in Falkirk. Falkirk has an estimated population of 157,640 made up of 77,022 (49%) males and 80,618 (51%) females.

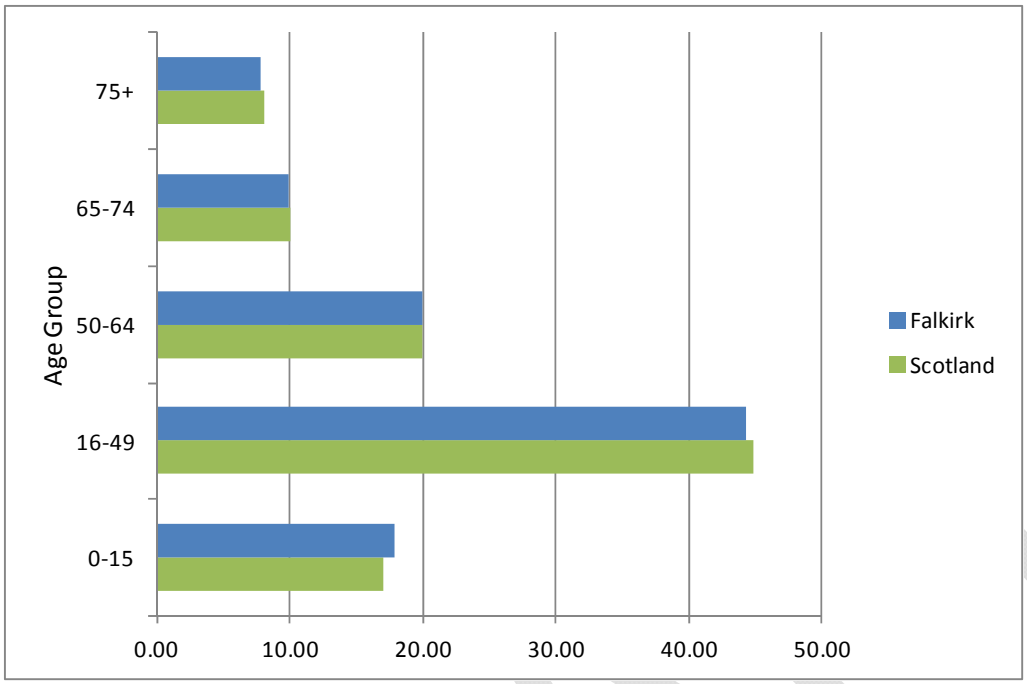
Table 2.1a Falkirk Population Profile

	Falkirk		
Age Group	**Total**	**Males**	**Females**
0-15	28,278	14,382	13,896
16-49	69,850	34,639	35,211
50-64	31,551	15,490	16,061
65-74	15,729	7,521	8,208
75+	12,232	4,990	7,242
Total	157,640	77,022	80,618

Source: NRS Population Estimates

Figure 2.1a, below, illustrates the age distribution in Falkirk compared to Scotland. The age profile is very similar to that of Scotland as a whole. Roughly 64% of the population are aged between 16 and 64, 17% under 16, 10% aged 65-74 and roughly 8% aged over 75.

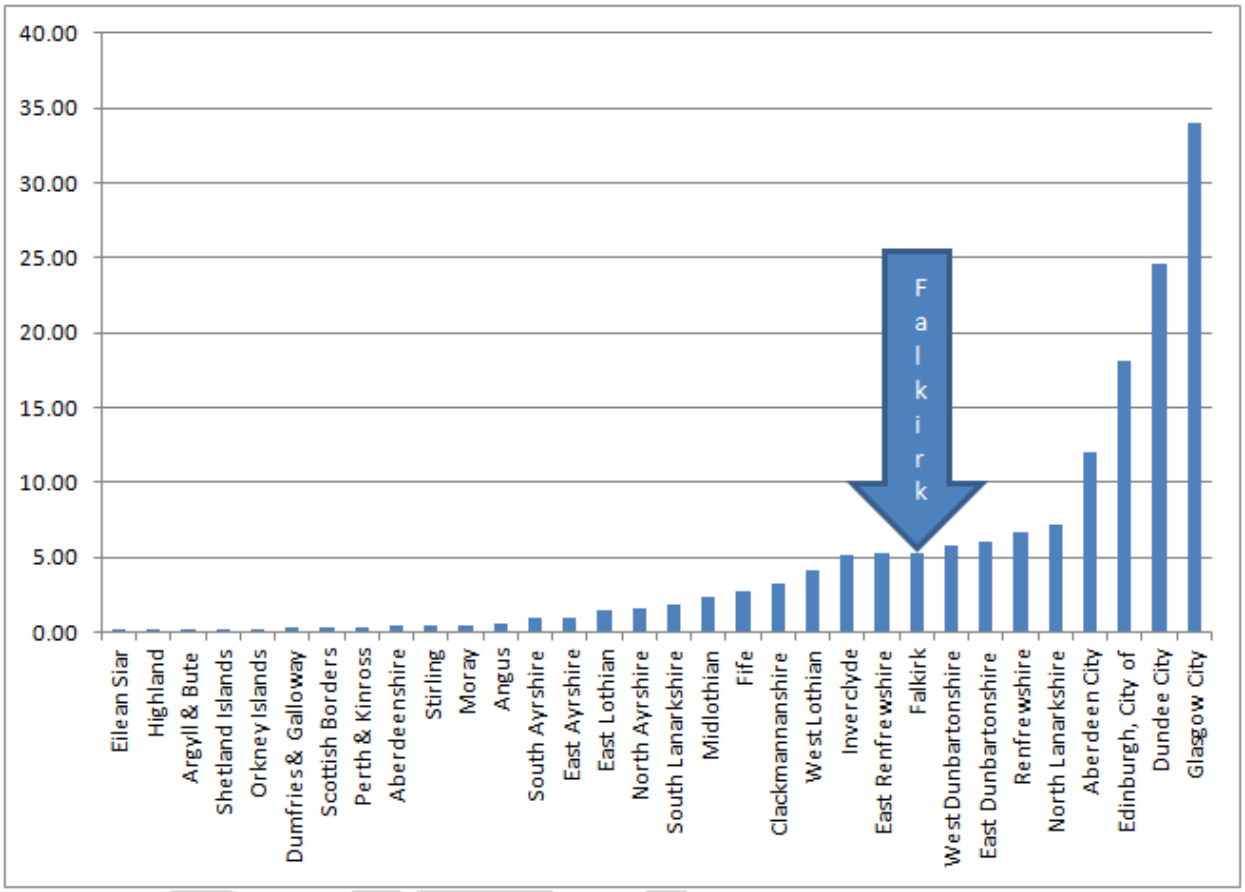
Figure 2.1a Falkirk age distribution compared to Scotland



Source: NRS Population Estimates 2014

Figure 2.1b, below, illustrates the population density of Local Authorities across Scotland. Falkirk is the 9th most densely populated area in Scotland with 5.25 persons per hectare.

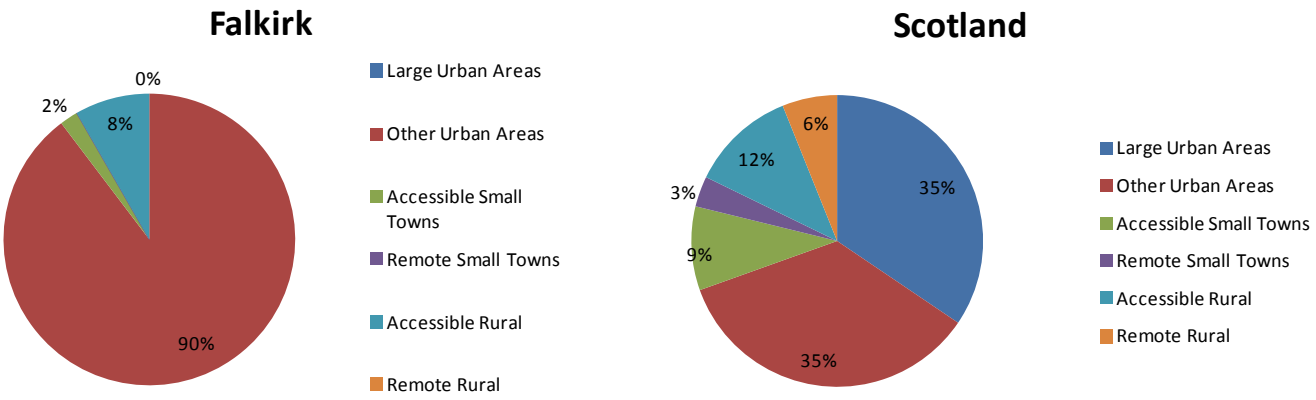
Figure 2.1b Population Density (persons per hectare) 2011



Source: Census 2011

The vast majority (90%) of Falkirk's population live in Urban Areas of between 10,000 and 124,999 people (figure 2.1c). There are no Large Urban Areas in Falkirk. 2% of the population live in Accessible Small Towns and 8% live in Accessible Rural area.

Figure 2.1c Population Density (persons per square kilometre) 2011



Source: Census 2011

Table 2.1b - Urban/Rural Classifications

Category	Description
1 – Large Urban Areas	Settlements of 125,000 or more people.
2 – Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 – Accessible Small Towns	Settlements of 3,000 to 9,999 people and within 30 minutes' drive of a settlement of 10,000 or more.
4 – Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 – Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 – Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland.

Ethnic Origin

Table 2.1c shows that in the 2011 Census Falkirk had a less diverse population than Scotland on the whole, with a greater 'White – Scottish' population and a smaller proportion of BME (Black and Minority Ethnic) groups (1.9%) compared to 4.0% at national level.

Table 2.1c – Ethnicity in Falkirk and Scotland 2011

Ethnicity	Falkirk (%)	Scotland (%)
White - Scottish	91.3	84.0
White - Other British	4.5	7.9
White - Irish	0.6	1.0
White - Polish	0.7	1.2
White - Other	1.0	2.0
Asian, Asian Scottish or Asian British	1.3	2.7
Other ethnic groups	0.6	1.3

Source: 2011 Census

Religion

Of the Falkirk population, the largest group would consider themselves to be non-religious (39.0%) while the most common Religion in Falkirk is the Church of Scotland (36.5%). In both cases Falkirk has a larger percentage than Scotland on the whole; coincidently the percentage of people from other religious backgrounds is less than the Scottish average.

Table 2.1d – Religion in Falkirk and Scotland 2011

Religion	Falkirk (%)	Scotland (%)
Church of Scotland	36.5	32.4
Roman Catholic	12.3	15.9
Other Christian	4.1	5.5
Muslim	0.9	1.4
Other religions	0.6	1.1
No religion	39.0	36.7
Not stated	6.6	7.0

Source: 2011 Census

Sexual Orientation

It is not possible to accurately report sexual orientation either at national or local level and it is likely that the numbers of LGB (Lesbian, Gay and Bisexual) are under-represented. The health needs of the LGB population are not well understood since they are not routinely identified in health surveys or population-based surveys. The Scottish Household Survey 2013 included a question on Sexual Orientation and the results are shown in **Table 2.1e** below. The results should be interpreted with caution as the survey only covers a small sample of the population; however the Falkirk population is primarily heterosexual with around 1% of the male population reporting themselves as Gay or Bisexual.

Table 2.1e – Sexual Orientation by Gender for Falkirk and Scotland 2013

	Falkirk (%)*		Scotland (%)*	
Sexual Orientation	**Male**	**Female**	**Male**	**Female**
Heterosexual / Straight	99	100	98	99
Gay / Lesbian	1	-	1	0
Bisexual	1	-	0	0
Other	-	-	0	0
Refused / Prefer not to say	-	-	1	1
Base (Population Examined)	*240*		*9920*	

Source: 2013 Scottish Household Survey

*In general, percentages in tables have been rounded to the nearest whole number. Zero values are shown as a dash (-), values greater than 0% but less than 0.5% are shown as 0%, and values of 0.5% but less than 1% are rounded up to 1%. In line with the Code of Practice for Official Statistics base numbers have been rounded to the nearest 10.

2.2 Projections of future population

The size and make-up of the population going forward will be a key consideration when planning and delivering health & social care services. The NRS population projections (Table 2.2a) show the estimated change in the population to 2037.

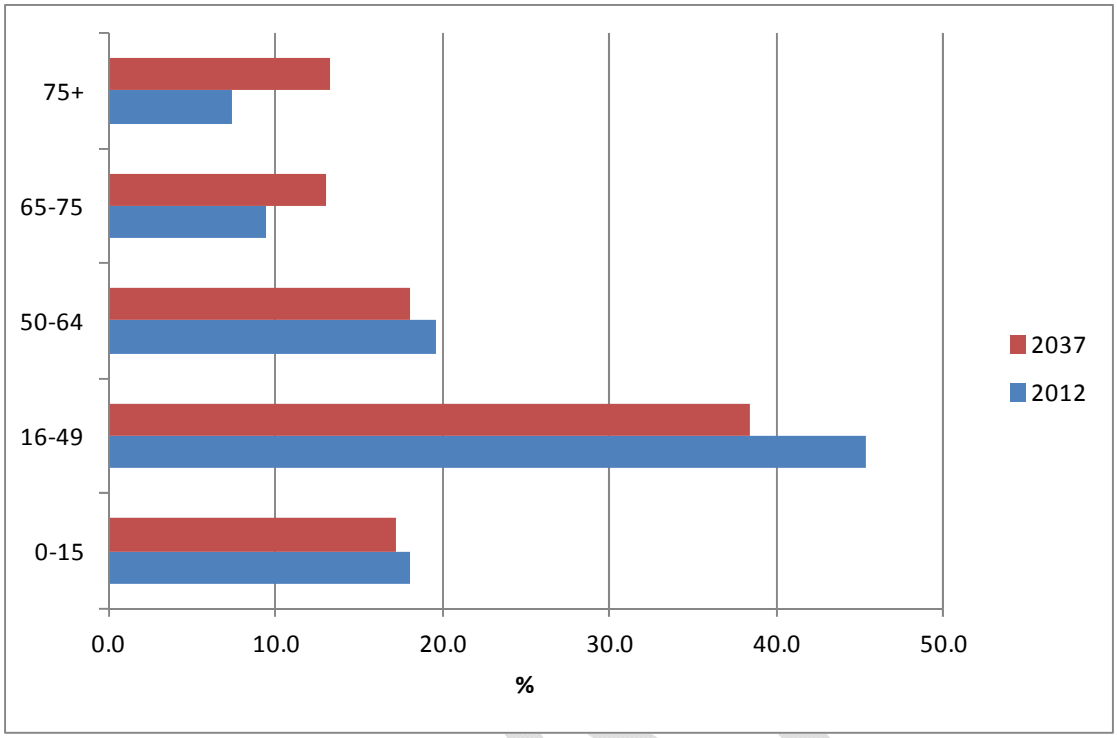
Table 2.2a Population projections to 2037

	2012		2032		2037	
Age Group	#	%	#	%	#	%
0-15	28,423	18.1	29,525	17.3	29,771	17.2
16-49	71,097	45.3	66,086	38.7	66,623	38.5
50-64	30,820	19.7	33,433	19.6	31,253	18.1
65-75	14,871	9.5	21,457	12.6	22,560	13.0
75+	11,589	7.4	20,117	11.8	22,923	13.2
Total	156,800	100	170,618	100	173,130	100

Source: NRS Population Estimates

The size and shape of the Falkirk population is projected to experience significant change between now and 2037. The overall population is projected to increase by over 16,000 to 173,130. The age distribution is also projected to experience significant changes. The number of individuals aged 75+ is expected to double to 22,923 and the number of individuals aged 65-75 is also expected to rise from 14,871 to 22,560.

Figure 2.2a – Projected Population Age distribution in Falkirk



Source: NRS Population Projections

Figure 2.2a, above, illustrates the projected change in the distribution in the population as opposed to the change in the actual size as just discussed. The chart shows that the working age groups (16-49 and 50-64) make up a smaller proportion of the population in 2037 than they do in 2012.

2.3 Dependency Ratio

The dependency ratio is a measure of the proportion of the population seen as economically 'dependant' upon the working age population. The definition generally used in Scotland is: 'those aged under 16 or of state pensionable age, per 100 working age population'. Table 2.3a illustrates the projected change in dependency ratio for Falkirk and Scotland to 2037.

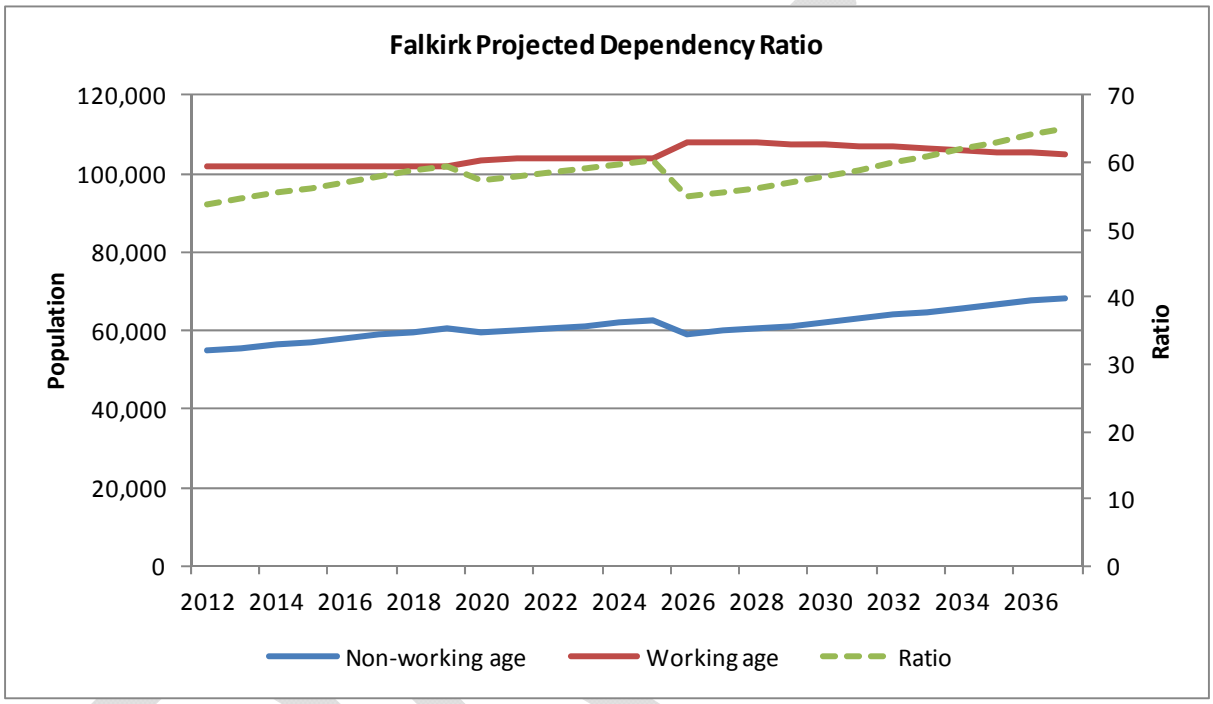
Table 2.3a – Projected Dependency Ratios to 2037

Year	2014	2015	2020	2025	2030	2035
Falkirk	55.5	56.2	57.4	60.3	58.0	63.1
Scotland	54.2	54.8	55.8	59.8	57.8	61.7

Source: NRS Population Projections

Falkirk is projected to follow a similar trend to Scotland but will have a slightly higher projected dependency ratio in 2037. Figure 2.3a examines this trend more closely. The projected increases in dependency ratio could potentially have a significant impact on the area. Falkirk is projected to have more individuals of a non-working age as a proportion of those of a working age and this will impact upon the services required locally as well as on the economy.

Figure 2.3a – Falkirk Projected Dependency Ratios to 2037



Source: NRS Population Projections

2.4 Population Considerations/Implications

- Older people are generally high users of services. The number, and percentage, of older people across Falkirk is projected to double and this could impact significantly on demand for services.
- There is a projected increase in the ratio of non working aged people to people of working age. This may impact on the local economy.

3 Life Circumstances

3.1 Scottish Index of Multiple Deprivation

The Scottish Index of Multiple Deprivation (SIMD) identifies small area concentrations of multiple deprivation across all of Scotland. It ranks small areas called datazones from the most deprived (ranked 1) to the least deprived (ranked 6,505). One way ISD uses these is to divide all of the datazones in Scotland into 10 equal deprivation deciles, by calculating each individual zone's rank from the distribution of all ranks. For example if a zone in Falkirk is ranked 517, it is in the bottom 7.9% of all zones so would be in the first decile which encompasses values between 0 and 10. If a zone is ranked 1985, it would be in the bottom 30.5%, and in the fourth decile for values between 30 and 40.

Within the deciles, 1 is the most deprived and 10 the least deprived (this categorisation is applicable for SIMD 2009v2, SIMD2012 and future releases). Figure 3.1a below illustrates the number of people and data zones in each decile in Falkirk.

The population in Falkirk can almost be split right down the middle, half of the population live in the lowest five deciles, and the other half in the highest five deciles. The population in the lowest five deciles are spread across a greater area, with 76,540 people in 107 different datazones. In contrast, the 76,740 people in the highest five deciles are in 90 different datazones.

Four percent of the population in Falkirk are in the lowest decile group, this is approximately 5,600 people. The lowest scoring datazone is in Dunipace, the other zones in this decile include areas in Camelon, and Bainsford and Langlees.

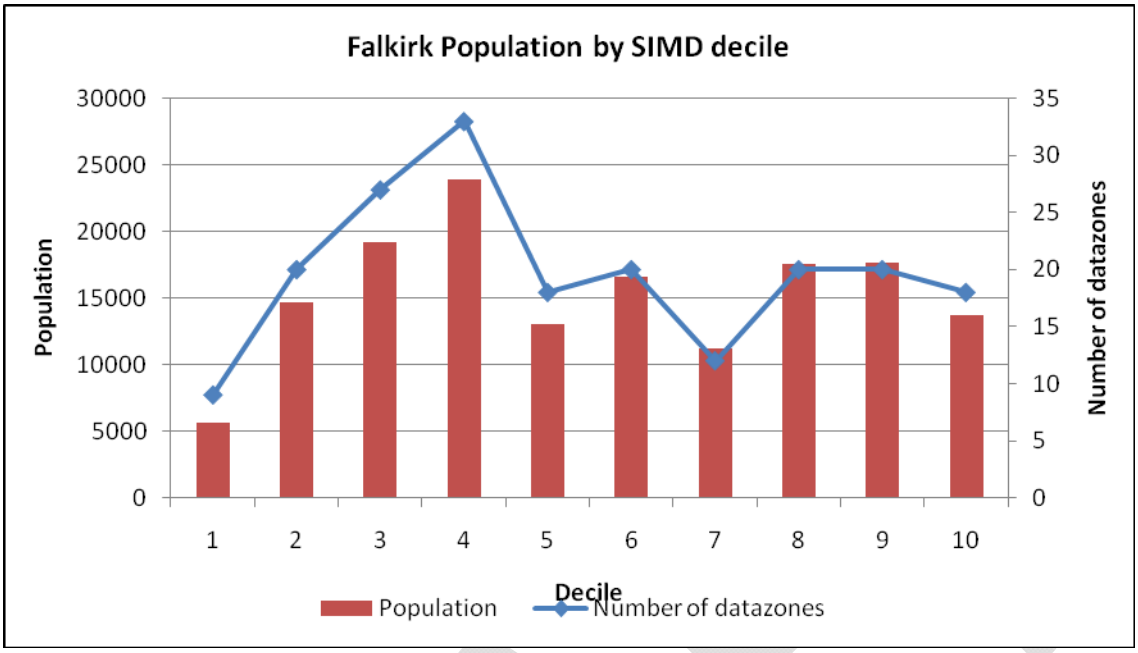


Figure 3.1a Falkirk population by SIMD decile

Source: SIMD 2012

The distribution of the population in Falkirk across the different decile groups is relatively even, excepting those in the lowest decile. The percentage of the population in the decile groups from 2 to 10 ranges from 7% in the seventh, to 16% in the fourth.

3.2 Housing

This section will provide an overview of the housing issues in Falkirk.

- The National Records of Scotland household projections predict that household numbers will increase between 2012 and 2037 Falkirk's increase will be lower (16%) than Scotland's (17%).
- The percentage of those households headed by someone aged 75 and over is estimated to increase from 2012-2037 by 89% in Falkirk, greater than that in Scotland which is estimated to increase by 83%.

- In 2013 home ownership accounted for 65% of households in Falkirk, comparable to 61% in Scotland. (Scottish Household Survey 2013).
  Social renting was the second largest group accounting for 27%, and private renting 8%.
- Since 1999 there has been an 8% increase in private renting and a 14% decrease in social renting in Falkirk (Scottish Household Survey 2013).
  In Scotland, private renting has increased by the same figure, 8% but social renting has only decreased by 9%.
- There are a greater proportion of houses than flats in Falkirk (73% compared to 27%) than in Scotland (63% compared to 37%).
  The same proportion of dwellings were built before 1945 in Falkirk as in Scotland, which is 20% (Scottish House Conditions Survey 2013).
- https://www.falkirk.gov.uk/services/homes-property/policies-strategies/local-housing-strategy.aspx
- The Falkirk Local Housing Strategy 2011-2016 set out a number of key target outcomes for housing in the area. As well as establishing that best use was to be made of existing housing stock to address local needs, the strategy outlined that new affordable housing stock was required. By 2016, there were to be 725 new residencies, and of that 100 were to be new-build affordable housing and 133 that were to make best use of existing housing stock.

3.3 Fuel Poverty

Fuel poverty is a measure based on a calculated spend on energy and fuel compared to the annual household income. If the energy spend is greater than 10% of the household income then the household is considered to be fuel poor. This includes spending for heating, lighting and appliances, and cooking. The implication for being fuel poor is that the household would be unable to use appliances or heat and light their property to a suitable standard. This affects households greatly especially during the winter months, as the colder outside temperature and lack of suitable heating inside increases the risk of developing health problems such as cardiovascular and respiratory conditions. Fuel poverty also means that the dwelling is more susceptible to issues such as damp and mould, which in turn affects the quality of life and health of the people living in it.
Extreme fuel poverty is where the cost to fuel the household to the required standard would be greater than 20% of the annual household income.

Table 3.3a below shows the percentage of households in Falkirk that can be considered fuel poor and extremely fuel poor compared to the Scottish average. All households in Falkirk are below the Scottish average for both measures.

Table 3.3a – Fuel Poverty in Falkirk and Scotland 2011-2013 (All Households)

All households	Fuel Poverty	Extreme Fuel Poverty
Falkirk	32%	5%
Scotland	36%	10%

Source: Scottish House Condition Survey Local Authority Tables 2011-2013

Table 3.3b shows the percentage of pensioner households in Falkirk that are fuel poor and extremely fuel poor. Whilst half of pensioner households are fuel poor, only 8% are extremely fuel poor. These are lower than the figures for Scotland as a whole.

Table 3.3b – Fuel Poverty in Falkirk and Scotland 2011-2013 (Pensioner Households)

Pensioner households	Fuel Poverty	Extreme Fuel Poverty
Falkirk	50%	8%
Scotland	54%	15%

Source: Scottish House Condition Survey Local Authority Tables 2011-2013

There are a number of factors that contribute to fuel poverty.

- In Falkirk, 21% of the dwellings were built before 1945, and older properties are more likely to have no insulation or be poorly insulated. This increases heating and fuel costs as well as affecting the quality of life for inhabitants. Between 2011/13 an average of 70% of the dwellings in Falkirk were wall insulated (cavity and solid/other).
  In comparison, across Scotland 32% of properties were built before 1945, and only 52% of all dwellings had wall insulation in 2011/13.

- The Falkirk area also includes a higher proportion of urban households (89.6%) compared to Scotland as whole (69.6%). This helps to reduce fuel poverty as urban properties tend to be newer properties, and their location makes them less exposed to the elements than those in rural areas. Exposure to wind, rain, and snow, which is more likely in rural locations, makes the household more expensive to heat.
  Additionally, rural locations are unlikely to be connected to the mains gas lines, with energy being provided by other methods including heating oil and gas bottles. These types of energy supply are less efficient than mains gas, thus increasing fuel costs. In Falkirk in 2011/13, 15% of properties were off the gas grid.

- The energy efficiency of the dwelling also affects the fuel costs. The lower the efficiency of the dwelling, the higher the fuel costs. In Falkirk 2% of properties are in the lowest groupings for energy efficiency, this is lower than the Scotland average which in 2011/13 was 4%.

3.4 Employment, Benefits and Financial Issues

The 2011 Census return details the economic activity of respondents. This is categorised into those who are economically active (in or seeking employment) and those who are economically inactive (not in or seeking employment).

Table 3.4a below shows the percentage of the population aged 16-74 by their economic activity in Falkirk, and Scotland as a whole. The percentage of people who are economically active is 65% of the population in Falkirk, a couple of percentage points higher than the national average. As a result the proportion of those economically inactive is lower than the Scottish figure, although the percentage of people who are disabled or long-term sick is the same.

Table 3.4a Percentage of total population by economic activity

Area	Economically active	Unemployed (actively seeking work)	Economically inactive (includes retirees & students)	Long-term sick or disabled
Falkirk	65.0%	5.2%	35.0%	4.8%
Scotland	62.8%	5.1%	37.2%	4.8%

Source: 2011 Census

Figures from the Department for Work and Pensions show that there were 13,104 claims for housing benefit in Falkirk in May 2015.

Table 3.4b Housing benefit claims by local authority May 2015

Housing benefit claims	May 2015
Falkirk	13,104

Source: Department for Work and Pensions Stat-Xplore

Financial issues and concerns can cause health and social problems. Job insecurity, redundancy, debt and financial problems can all cause emotional distress, affect a person's mental health and contribute to other health issues. Information from the 2013 Scottish Household Survey shows statistics for how well households manage finances. The charts below show how well households managed their finances by amount of income, and also by the main source of income. 18% of households in Falkirk where the income is less than £15,000 do not manage their households well. Similarly, 20% of households whose main income is through benefits do not manage well either. *Are these the same people?*

Table 3.4c Household management by annual household income – Falkirk 2013

Source: Scottish Household Survey

Table 3.4d - Household management by income type – Falkirk 2013

Source: Scottish Household Survey

3.5 Life Circumstances Considerations/Implications

- Deprivation can be a key contributing factor in the health of a population.
- The percentage of those households headed by someone aged 75 and over is estimated to increase from 2012-2037 by 89% in Falkirk, greater than that in Scotland which is estimated to increase by 83%.
- The Falkirk Local Housing Strategy 2011-2016 set out a number of key target outcomes for housing in the area. As well as establishing that best use was to be made of existing housing stock to address local needs, the strategy outlined that new affordable housing stock was required. By 2016, there were to be 725 new residencies, and of that 100 were to be new-build affordable housing and 133 that were to make best use of existing housing stock.

4 Lifestyle/Risk Factors

Lifestyle and risk factors have a hugely important effect on a person's health and well-being. Behaviours such as smoking, alcohol consumption, drug use, and poor diet can have an adverse effect on health. People from less well-off and more deprived areas and communities are more likely to indulge in these behaviours which have a negative impact on health.

4.1 Smoking

Smoking related illnesses not only affect an individual's health but also put a strain on health services. It is estimated that in NHS Forth Valley in 2009 there were 2,187 hospital admissions are a result of smoking and that over £15 million was spent treating smoking related illness.[1] Reducing the number of people who smoke will therefore help an individual but also reduce the pressure on health services.

Table 4.1a shows the percentage of the adult population who smoke in Falkirk compared with the Scotland average from 1999 to 2013. Data for individual local authorities for 2011 is not available.

Table 4.1a - Percentage adult smokers 2013

Area	1999-2000	2001-2002	2003-2004	2005-2006	2007-2008	2009-2010	2011	2012	2013
Falkirk	31.3	30.7	28	27.1	30.3	28.1		18.6	21.2
Scotland	30.0	28.6	27.5	26.0	25.4	24.2	23.3	22.9	23.1

Source: Scottish Household Survey - Annual Report 2013 - LA Tables

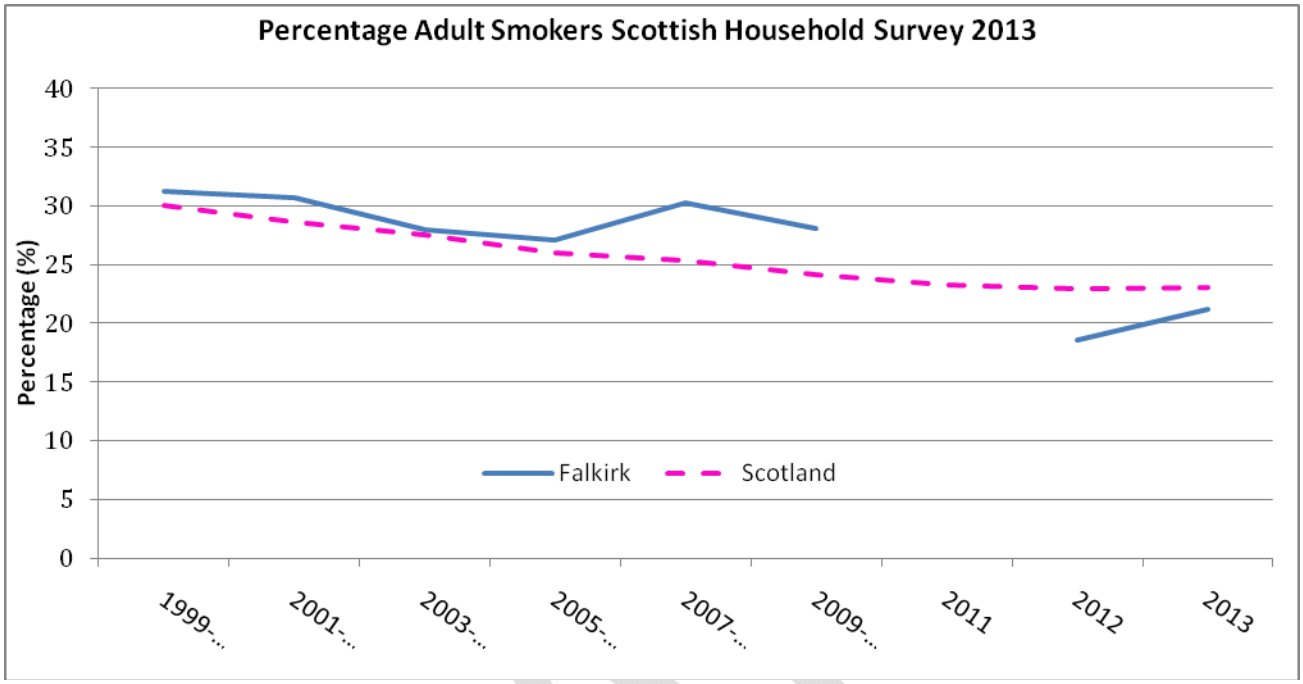
The percentage of the adult population who smoke has decreased between 1999/2000 and 2013, but there was a slight increase between 2012 and 2013 in Falkirk and Scotland as a whole.

In 1999/2000, 31.3% of adults in Falkirk smoked; by 2013 this had fallen to 21.1%. This is comparable to the trend for the total Scotland figures in the years between 1999/2000 and 2013.

In 2012, the percentage of adults who smoked in Falkirk fell below the Scottish average. The percentage of adult smokers increased the next year but it still was less than the Scottish average.

[1] ScotPHO Smoking Ready Reckoner – 2011 Edition

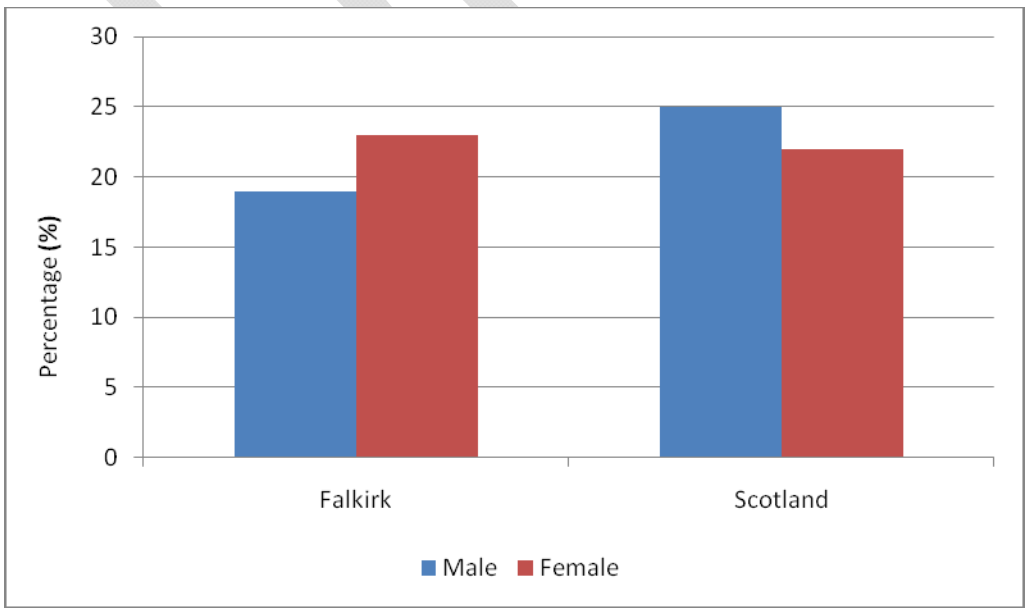
Figure 4.1a - Trend in the percentage of adults who smoke from 1999/2000 to 2013



Source: Scottish Household Survey - Annual Report 2013 - LA Tables

Figure 4.1b shows a breakdown of those who smoked in 2013 by sex. In 2013, a higher percentage of women in Falkirk smoked than men. In Scotland as a whole, the reverse is true, more men smoke than women.

Figure 4.1b - Smoking by sex



Source: Scottish Household Survey - Annual Report 2013 - LA Tables

Table 4.1c shows the rates of smoking related illnesses in Falkirk compared to the Scotland rate. In Falkirk in 2012 the rates for smoking related deaths, lung cancer deaths and COPD deaths were higher than the Scotland rate.

Table 4.1c - Age standardised rate of smoking related illnesses

Measure	Year	Falkirk	Scotland
Smoking attributable admissions	2012	2,208.7	3149.4
Smoking attributable deaths	2012	340.6	325.9
Lung cancer registrations	2011	132.0	133.3
Lung cancer deaths	2012	114.8	107.1
COPD incidence	2012	400.3	391.1
COPD deaths	2012	97.0	77.9

Source: ScotPHO Tobacco Control Profile

4.2 Alcohol

Alcohol related health issues are a major concern for public health in Scotland. Excessive consumption of alcohol can cause both short-term and long-term health and social problems. This includes liver and brain damage, as well as mental health issues, and it is also a contributing factor in cancer, stroke and heart disease.

The rate of alcohol related hospital admissions in Falkirk has increased slightly in the five years between 2009/10 and 2013/14 from 503.5 to 513.7. The number of hospital stays fell in 2010/11 but have gradually been increasing since. In 2013 there were 791 stays related to alcohol.

Table 4.2a shows the figures for the different measures from 2009/10 to 2013/14.

Table 4.2a - Alcohol Related Hospital Statistics 2013/14

Falkirk	EASR Standardised rate	Number of hospital stays
2009/10	503.5	759
2010/11	374.0	570
2011/12	423.7	649
2012/13	441.9	682
2013/14	513.7	791

Source: ISD Scotland

Table 4.2b displays the age standardised mortality rates for Falkirk compared to the national average between 2009 and 2013. The figures are also presented in the form of a chart in chart

4.2c.

The alcohol related mortality rate in Falkirk in 2013 at 18.16, was not significantly different from than the average rate of 21.43 for Scotland. Alcohol related mortality is the rate per 100,000 people where alcohol is the underlying cause of death.

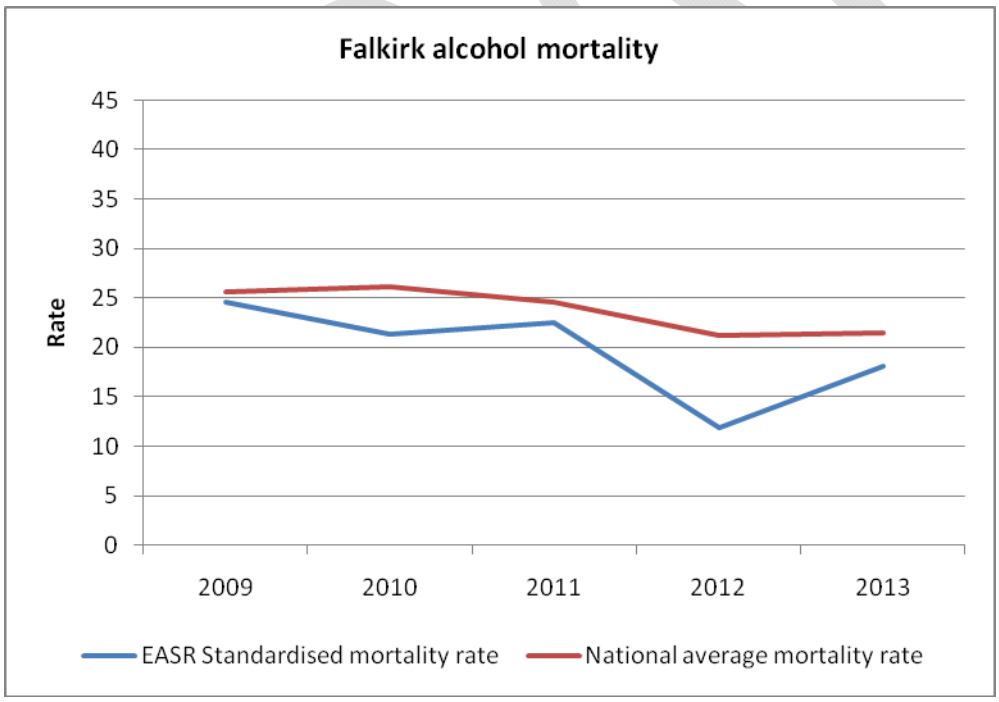
The alcohol related mortality rate has been below the Scottish average in each year from 2009 to 2013.

Table 4.2b - Alcohol related mortality

Falkirk	EASR Standardised mortality rate	National average mortality rate
2009	24.58	25.65
2010	21.34	26.14
2011	22.49	24.56
2012	11.86	21.19
2013	18.16	21.43

Source: ISD Scotland/National Records of Scotland

Figure 4.2a - Alcohol related mortality



Source: ISD Scotland/National Records of Scotland

4.3 Drugs

In 2012/2013 across Falkirk there were an estimated 1,700 people aged 15-64 with a problem drug use. Problem drug use can lead to a number of health and social problems.

The estimated prevalence of those with a problem drug use has increased in Falkirk when comparing the data from 2009/10 and 2012/13. This is in contrast to Scotland as a whole, where the estimated percentage of the population with a problem drug use fell slightly.

Table 4.3a - Estimated prevalence of problem drug use by Council area (ages 15-64)

Council Area	Estimated Prevalence 2009/10	Estimated Prevalence 2012/13
	%	%
Falkirk	1.00	1.63
Scotland	1.71	1.68

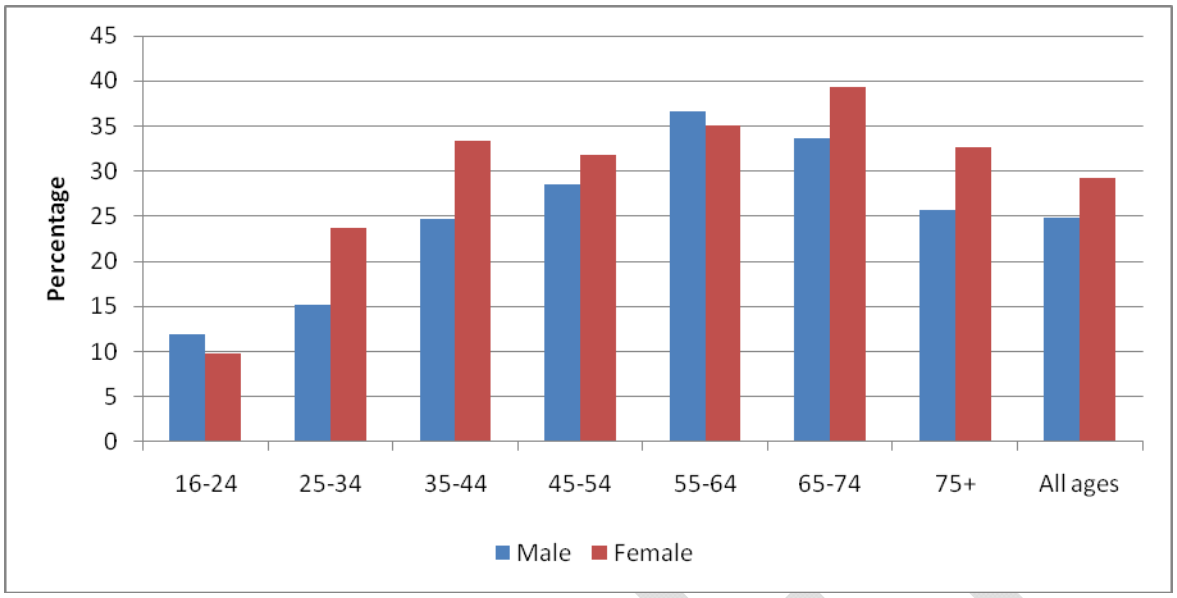
Source: ISD Scotland

4.4 Diet and Obesity

Obesity is when a person's weight increases to an extent that it could potentially cause health problems. Obesity is linked to a number of health problems and diseases, common complaints include cardiovascular disease and diabetes. One of the major factors that causes an individual to become obese is poor diet.

For Scotland in 2013 it was estimated that 27% of the adult population aged 16+ were classified as being obese (a Body Mass Index of 30 or more). When this is broken down into different age groups and by sex, it shows that obesity is highest for men between the ages of 55-64, and for women between the ages of 65-74.

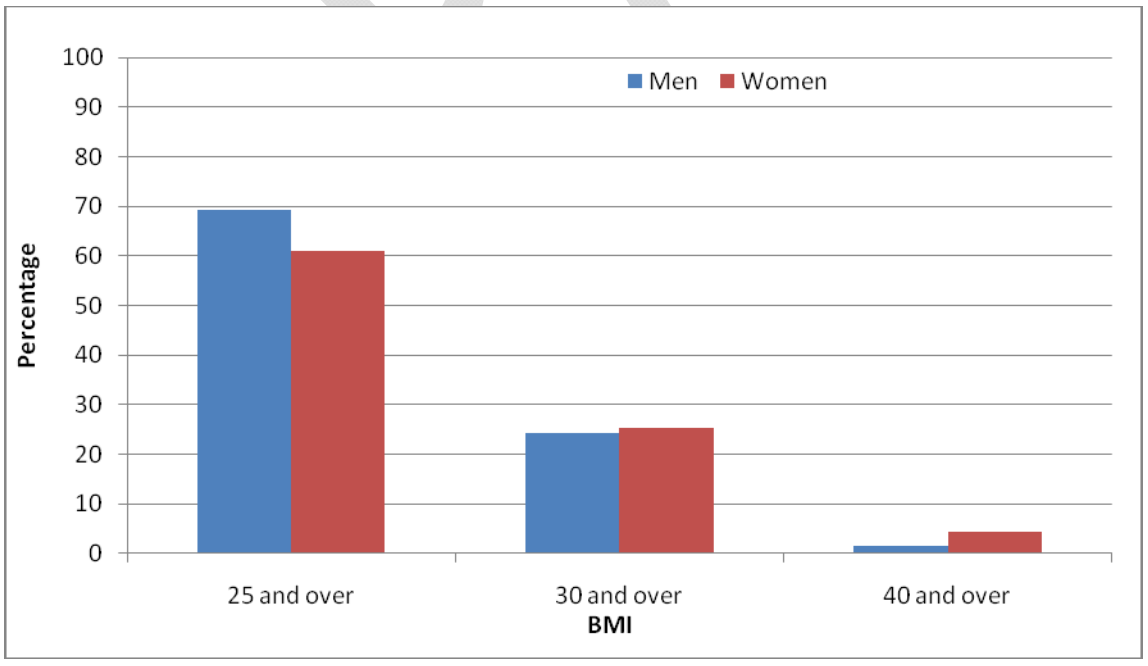
Table 4.4a - Percentage of population with a BMI of 30 plus – 2013



Source: The Scottish Health Survey 2013

Data and information concerning diet and obesity is not regularly published at the local authority or health board levels. Information from the Scottish Health Survey in 2011 showed a four year average of obesity rates in NHS Forth Valley. This information is shown in table 4.4b.

Table 4.4b - Percentage of the adult population in Forth Valley with a BMI of 25 plus, 30 plus and 40 plus - 2008-2011.



4.5 Lifestyle/Risk Factor Considerations/Implications

There is evidence to suggest that people living in more deprived areas are more likely to adopt unhealthy behaviours such as smoking and alcohol and drug use and this can impact on the level of services required in local areas.

5. Population Health

5.1 General Health

According to the 2011 Scotland Census the general health of people in Falkirk closely aligns with that of Scotland. The majority of people in Falkirk consider their health to be good or very good (Table 5.1) with only a nominal percentage bad or very bad.

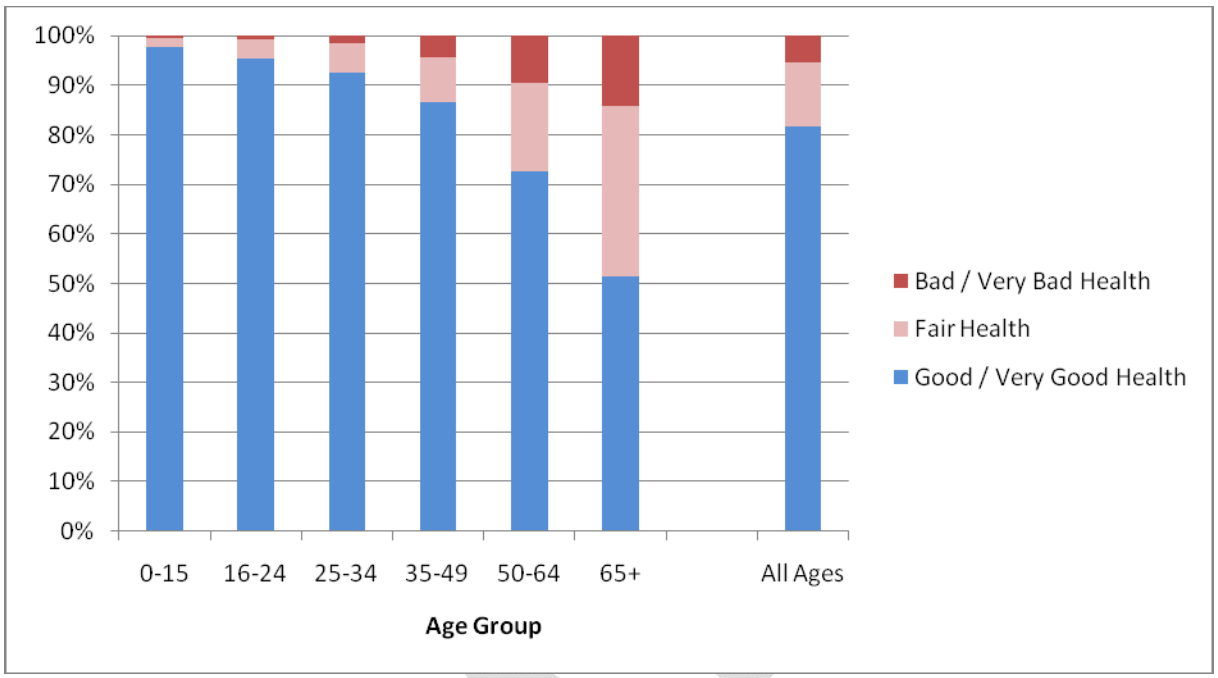
Table 5.1 – General Health by population and age

	Good/Very Good Health (%)	Fair Health (%)	Bad/Very Bad Health (%)
Falkirk	81.8	12.7	5.5
Scotland	82.2	12.2	5.6

Source: Scotland's Census 2011 - National Records of Scotland

Figure 5.1 shows that with increasing age, there is a considerable increase in the percentage of people who consider themselves to be in bad or very bad health. With the projected increase in Elderly population, the proportion of people who consider themselves to be in bad or very bad health is expected to increase accordingly.

Figure 5.1 – Health Status of population in 2011 by age group



Source: Scotland's Census 2011 - National Records of Scotland

5.2 Life Expectancy and Healthy Life Expectancy

Life expectancy is an estimate of how many years a person might be expected to live. Figure 5.2a shows Female life expectancy at birth is higher than for Males both at Falkirk and Scotland level. Life expectancy is slightly lower in Falkirk than Scotland for both males and females. The estimate of female life expectancy has increased directly in line with Scotland between 2001-2003 and 2011-2013. The estimate life expectancy has increased by a greater percentage over the same period though it has not increased at the same rate as Scotland on the whole.

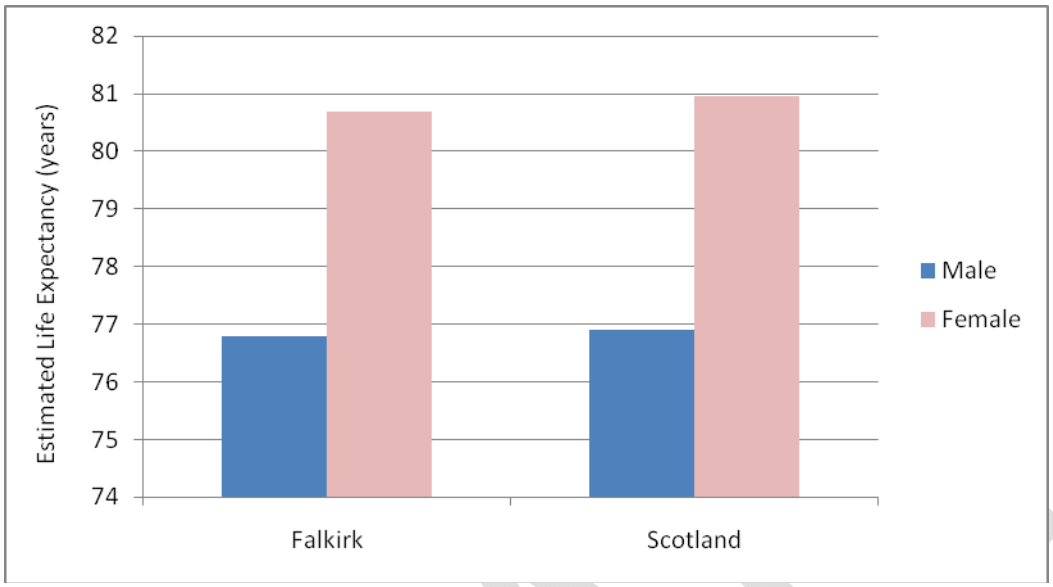
Table 5.2a - Life Expectancy at Birth, Falkirk and Scotland 2001-03 and 2011-13

	Falkirk		Scotland	
	Male	Female	Male	Female
2011-2013	76.8	80.7	76.9	81.0
2001-2003	73.8	78.6	73.5	78.8
% Change over 10 years	4.1	2.7	4.6	2.7

Source: National Records for Scotland

Figure 5.2a shows that estimated life expectancy at birth is just slightly under that of Scotland for both males and females in Falkirk.

Figure 5.2a - Life Expectancy at Birth, Falkirk and Scotland 2011-13



Source: National Records for Scotland

Healthy life expectancy is an estimate of how many years a person might live in a 'healthy' state. The difference between life expectancy and healthy life expectancy for Falkirk and Scotland is presented in Table 5.2b and Figure 5.2b below. Healthy life expectancy for males is very similar at Falkirk and Scotland level while Female life expectancy is less than the Scotland level. The difference between Life expectancy and Healthy life expectancy gives an estimate of years in "poor health". At both Falkirk and Scotland level there is a considerable difference in years not healthy between Males and Females, Females are expected to live almost 2 years longer in poor health than Males (Table 5.2b).

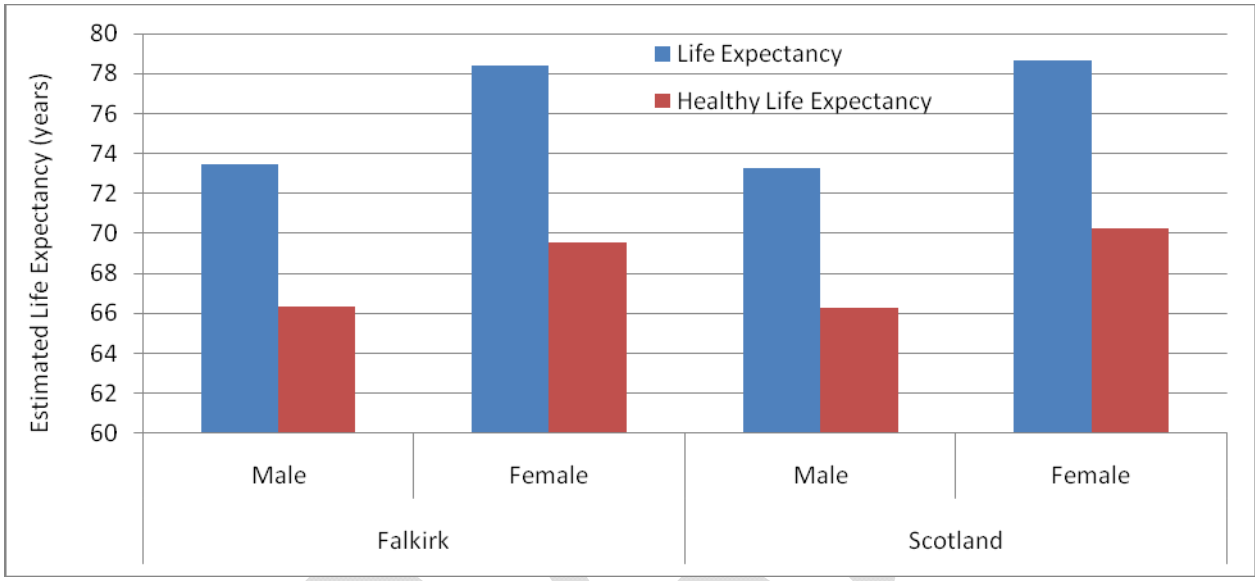
Table 5.2b - Life Expectancy & Healthy Life Expectancy, Falkirk Community Health Partnership and Scotland for the 5-year period 1999-2003

	Falkirk		Scotland	
	Male	Female	Male	Female
Life Expectancy	73.5	78.4	73.3	78.7
Healthy Life Expectancy	66.4	69.5	66.3	70.2
Expected Years "Not healthy"	7.1	8.9	7.0	8.5

Source: Scottish Public Health Observatory

The estimated years "Not healthy" for the Falkirk population are very similar to the Scotland figures and significantly lower than in some other areas in Scotland.

Figure 5.2b - Life Expectancy & Healthy Life Expectancy, Falkirk Community Health Partnership and Scotland for the 5-year period 1999-2003



Source: Scottish Public Health Observatory

5.3 Long Term Health Conditions

Long term conditions (LTCs) are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support. LTCs can have a serious impact upon a person's personal life but can also have a serious economic impact on health and social care services. 60 per cent of all deaths are attributable to long term conditions and they account for 80 per cent of all GP consultations (http://www.gov.scot/Topics/Health/Services/Long-Term-Conditions).

As part of the Quality and Outcomes Framework (QOF), GP practices across the UK are funded to keep registers of all of their patients that they know to have certain health conditions. Table 5.3a illustrates the number of patients, in Falkirk, known to GP practices having selected conditions as at March 2014.

Table 5.3a - Numbers of patients on selected QOF registers of Falkirk GP practices

QOF register	Numbers as at March 14	% of all practice patients As at March 14	Numbers as at March 13	Numbers as at March 12
Asthma	9,949	6.29	8,743	9,596
Atrial Fibrillation	2,415	1.53	2,086	2,203
Cancer	3,381	2.14	2,808	2,953
CHD (Coronary Heart Disease)	7,362	4.65	6,616	7,478
CKD (Chronic Kidney Disease)	5,662	3.58	4,851	5,288
COPD (Chronic Obstructive Pulmonary Disease)	3,708	2.34	3,130	3,389
CVD (Primary Prevention of Cardiovascular Disease)	4,390	2.77	3,035	2,551
Dementia	1,304	0.82	1,113	1,141
Diabetes	7,984	5.05	6,794	7,279
Epilepsy	1,115	0.70	992	1,097
Heart Failure	1,163	0.73	926	996
Hypertension	23,264	14.70	20,556	22,289
Hypothyroidism	5,308	3.35	4,624	5,014
Learning Disabilities	719	0.45	642	702
LVD (Left Ventricular Dysfunction)	357	0.23	630	702
Mental Health	1,257	0.79	1,095	1,193
Obesity	14,384	9.09	12,981	13,865
Osteoporosis	290	0.18	N/A	N/A
Palliative Care	391	0.25	330	312
Peripheral Arterial Disease	1,338	0.85	N/A	N/A
Rheumatoid arthritis	838	0.53	N/A	N/A
"Smoking" (conditions assessed for smoking)	41,193	26.03	36,189	39,342
Stroke & Transient Ischaemic Attack (TIA)	3,474	2.20	3,030	3,336

Source: Quality and Outcomes Framework (QOF) www.isdscotland.org/qof

The following subsections will look at particular LTCs in more detail:

5.3.1 Dementia

Dementia presents a significant challenge to individuals, their carers and health and social care services across Scotland. As at March 2014 there were 2480 individuals known to GP practices as having dementia in Falkirk. This equates to 0.82% of all patients registered to a GP practice in Falkirk.

However, it is suspected that dementia is under diagnosed in Scotland. Alzheimer Scotland has produced estimates, by local authority, of the number of people living in Scotland in 2015 with Dementia (Table 5.3.1a).

Table 5.3.1a – Estimated number of people in Falkirk with Dementia in 2015

	under 65	65+	total
Falkirk	95	2,386	2,480

Source: Alzheimer Scotland

If similar prevalence rates for dementia continue to occur we can expect to have significantly more cases of dementia in the local areas due to the projected increase in people over the age of 65 to 2037. This is likely to have a significant impact across health and social care services due to the complex nature of care required.

5.3.2 Cancer

In 2013 there were 1,665 diagnoses of cancer in Forth Valley. This was a slight increase from the year before, and also meant that the number of registrations in 2013 was the highest it had been in ten years. The number of people diagnosed with cancer is predicted to rise in the future. The risk of developing cancer increases as a person gets older, and this, coupled with an increasing elderly population means that the number of cancer registrations is set to rise.

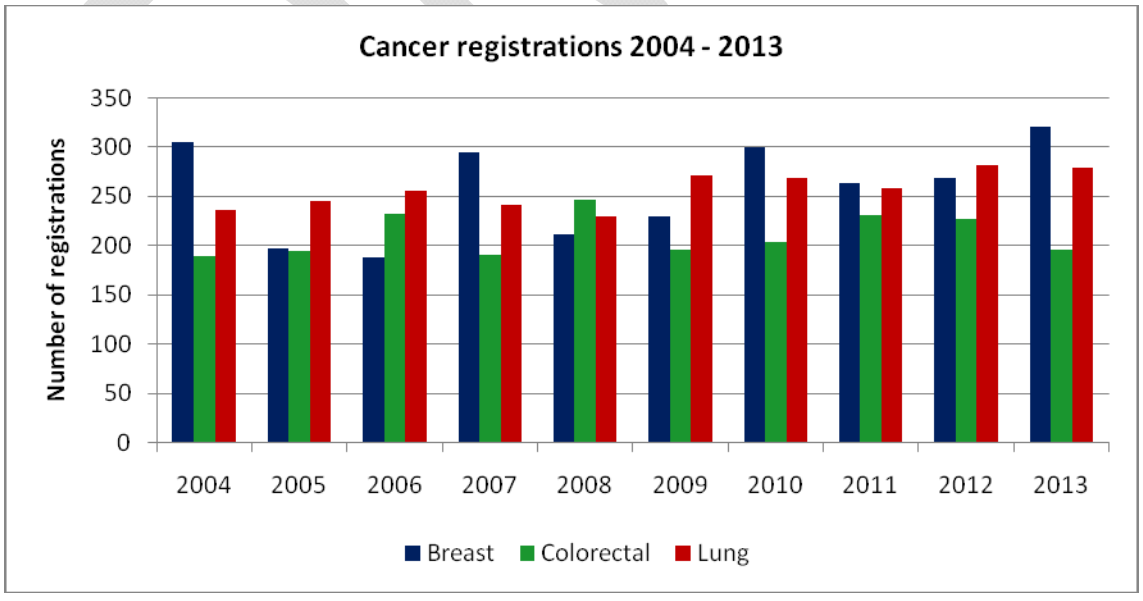
Table 5.3.2A Cancer registrations in NHS Forth Valley from 2004-2013

Cancer registrations	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
All cancers	1611	1445	1530	1512	1606	1648	1660	1605	1624	1665

Source: Scottish Cancer Registry, ISD Scotland

Figure 5.3.2 shows the number of registrations for breast, colorectal and lung cancer from 2004 to 2013. These three cancers account for approximately 45% of all cancer diagnoses in NHS Forth Valley.

Figure 5.3.2 Cancer registrations in NHS Forth Valley from 2004-2013



Source: Scottish Cancer Registry, ISD Scotland

The rate of cancer registrations in NHS Forth Valley is below the Scottish average although it is not significantly so. In 2013, the crude rate across Scotland was 630 out of 100,000 people, in NHS Forth Valley it was 556 out of 100,000 people.
The mortality rate for cancer in Forth Valley is very close to the rate for Scotland as a whole. In 2013, the figure for Scotland was 296 per 100,000 people, and in Forth Valley it was 290 per 100,000 people. The mortality rate in Forth Valley was relatively stable between 2004 and 2013; it was at its lowest in 2008 at 259, and highest in 2012 when it was 309. Despite an overall increase in the number of new registrations of people with cancer, they are able to live longer with the disease and this affects the mortality rate.

Cancer incidence in Scotland is projected to rise by a third over the next 10 years. In the five years between 2023 and 2027, it is estimated that there will be over 204,000 new cases of cancer across the whole country.
Presently, about 5% of new cancer diagnoses in Scotland are registered in NHS Forth Valley and if this was to continue to be true by 2027, it would mean that there would be over 2100 new cancer cases in the board area annually.

5.4 Projected Long Term Conditions

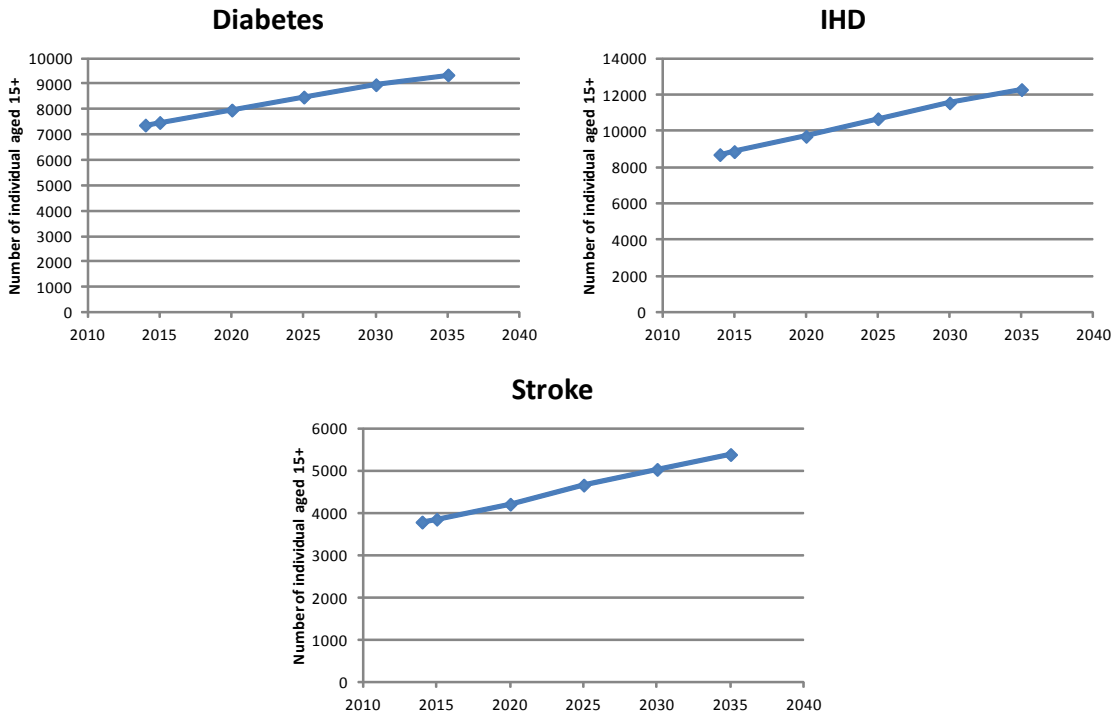
Forecasting disease prevalence can provide information regarding where resources might be needed in the future or where preventative interventions could reduce disease. There are a range of factors which influence the prevalence of disease. These are:

- Age - in general most conditions are age-related. Even if other risk factors are decreasing the effect of demographic change can be overwhelming.
- Genes – most diseases have at least some genetic component.
- Environment – physical and social.
- Deprivation – even accounting for differences in behaviour, most diseases are deprivation related. This may be mediated through stress (the socio-psycho-neuro-immuno-pathological pathway).
- Health related behaviours.
- Underlying mental wellbeing/ resilience/ self-efficacy / confidence / motivation.
- Real engagement with life in general and personal wellbeing in particular.
- Options for intervention and organisation of this.

It is easy to assume that disease trends will continue. However the trends could change to some extent. To apply a crude method consisting of application of age-specific prevalence rates to Falkirk population projections gives the forecast demonstrated in Figure 5.4a, for Diabetes, Ischaemic Heart Disease (IHD) and Stroke. The Figures show an increase in the forecasted

prevalence of disease. The assumption has been made that the age-specific prevalence remains constant.

Figure 5.4a – Estimated projections of Diabetes, IHD and Stroke in Falkirk.

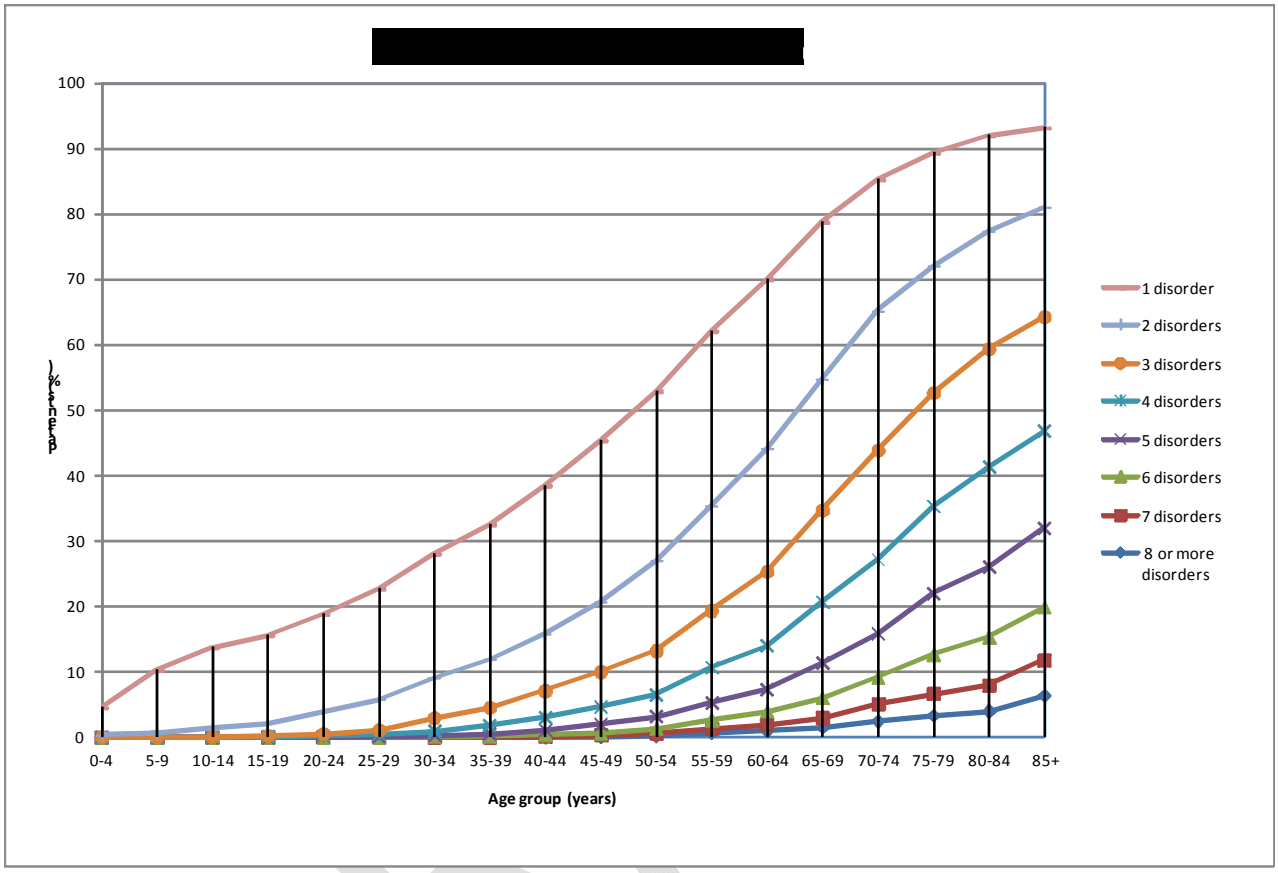


Source: Scottish Health Survey (prevalence rates) and NRS population Estimates

5.5 Multi-Morbidity

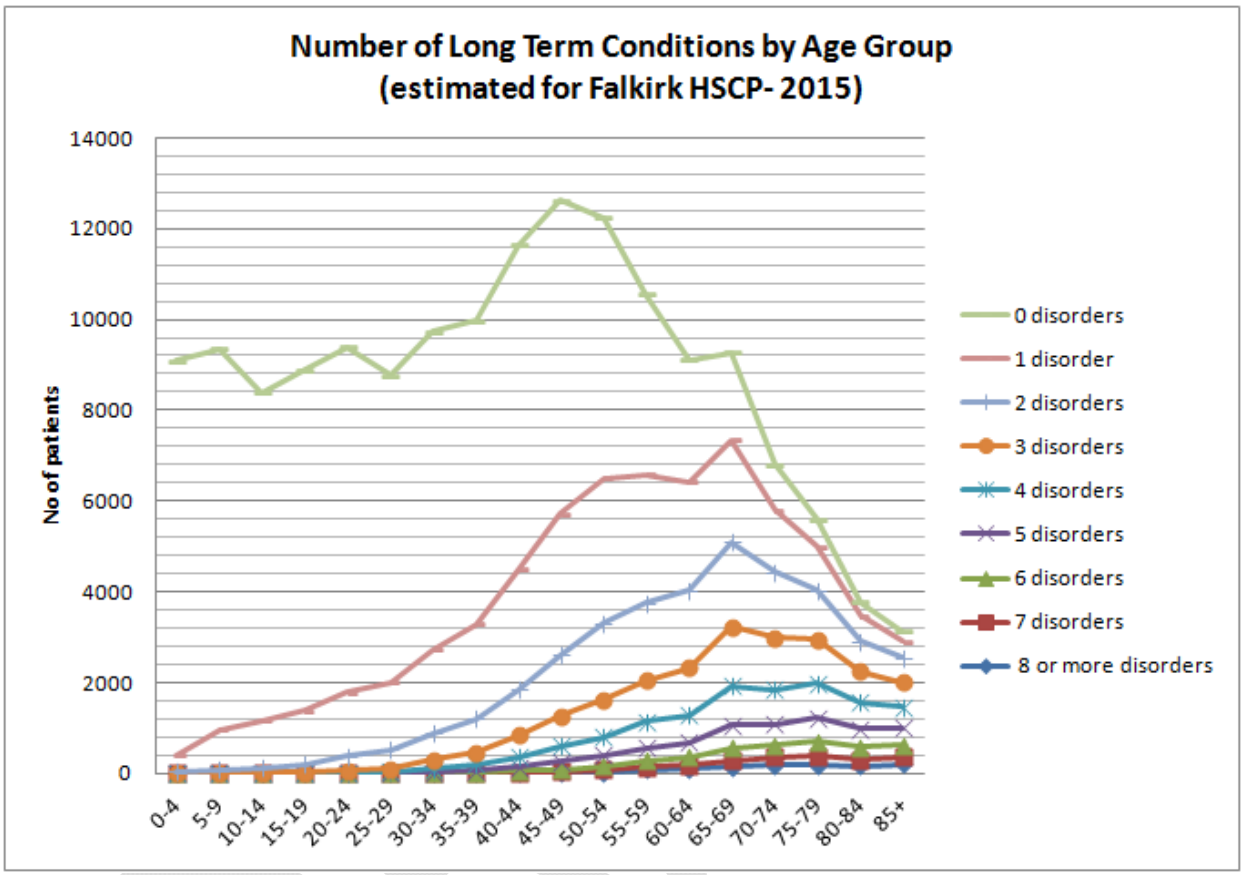
In light of ageing populations Falkirk is facing more people with multiple long term conditions (also referred to as multi-morbidities). Figure 5.5a demonstrates that patients have more conditions as they age. The estimated number of patients within Falkirk with various number of long term conditions is forecasted to increase between 2015 (figure 5.5b) and 2037 (figure 5.5c).

Figure 5.5a – Estimated number of conditions by age group.



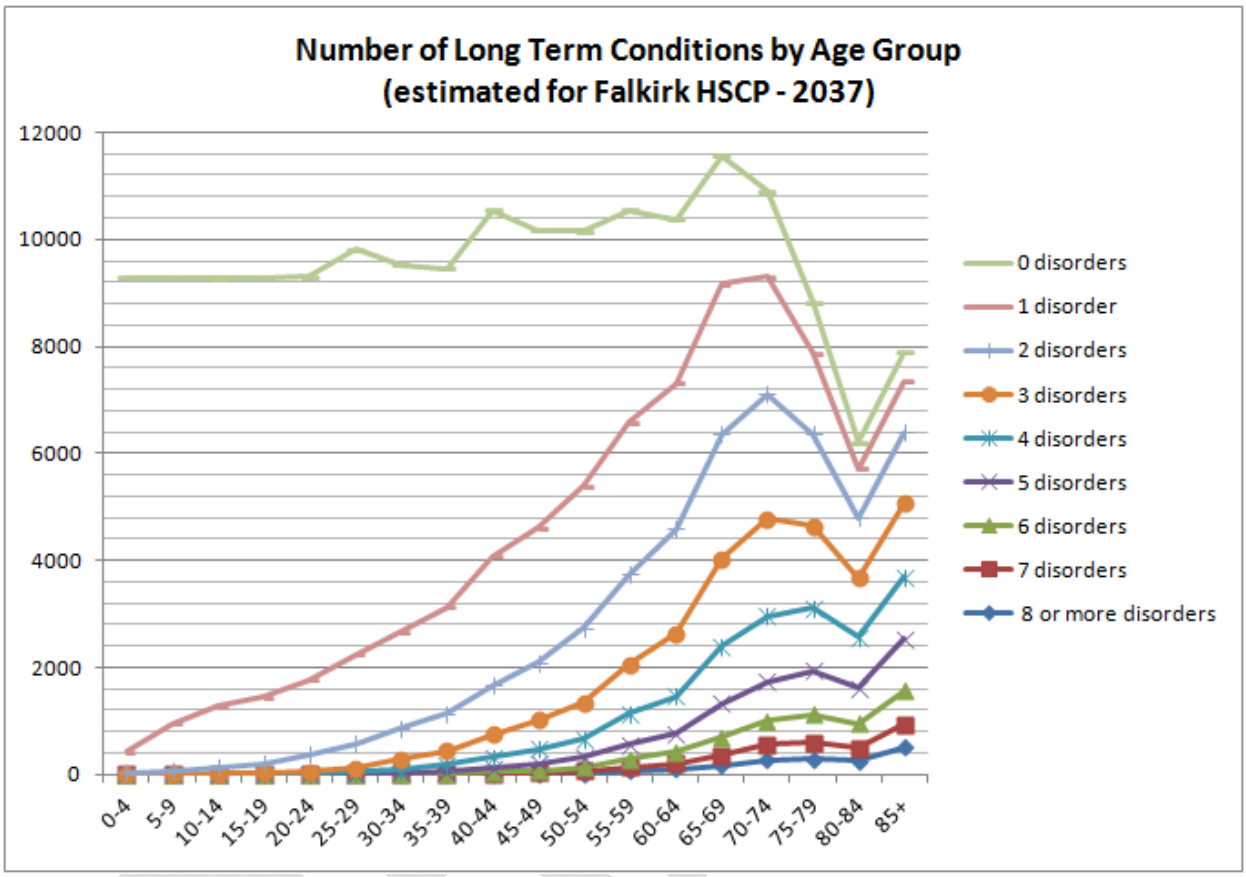
Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer

Figure 5.5b - Estimated number of people within Falkirk with various numbers of conditions (2015)



Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk

Figure 5.5c - Estimated number of people within Falkirk HSCP with various numbers of conditions (2037)



Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk.

The multiple morbidities demonstrated in Figure 5.5b and 5.5c bring both person-centred as well as financial challenges (Christie, 2011). Patients with multiple complex long term conditions are currently making multiple trips to hospital clinics to see a range of uncoordinated specialist services. A proposed way forward could be to look at developing new pathways and guidelines away from the current disease specific models to generic approaches focused on the holistic needs of patients (Lunt, 2013, p. 17). The latter ties in with the 2020 Vision and the values of designing the services around the patient. For example, we need to make sure that patients do not have to unnecessarily attend five different, disjointed, specialists for the five different conditions that they have.

5.6 High Resource Individuals

This section is currently using old data. To be updated

The term 'High Resource Individuals' (HRIs) refers to the population group who account for 50% of the total health expenditure. All service users are ranked highest to lowest in terms of their use of health resources and those at the top who collectively account for 50% of expenditure are categorised as High Resource Individuals.

ISD Scotland have undertaken cost per patient analysis on Inpatient and day case hospital admissions (including all acute specialties, maternity, geriatric long stay inpatient care, and psychiatric inpatient care), A&E attendances, consultant led outpatient clinics and community prescribing.

A High resource individual in one area might not fall into the same category at Scotland level or indeed another local area. Consequently it is vital that the data is used effectively at local level to ensure in the planning and delivery of the right services to the right people in the community.

Analysis for the financial year 2012/13 reported that **3011** individuals accounted for 50% of health expenditure in the Falkirk area. There were 129,275 patients for that same period in Falkirk meaning that **2.3%** of patients accounted for 50% of health expenditure. This matches the Scotland data where 2.3% of patients are considered to be HRIs. Table 5.6a shows the important figures relating to HRIs at Falkirk and Scotland level. While a similar percentage of the population were categorized as HRIs in Falkirk and Scotland, the number of bed days attributed to HRIs is considerably higher for Falkirk (78.5% vs. 72.9%).

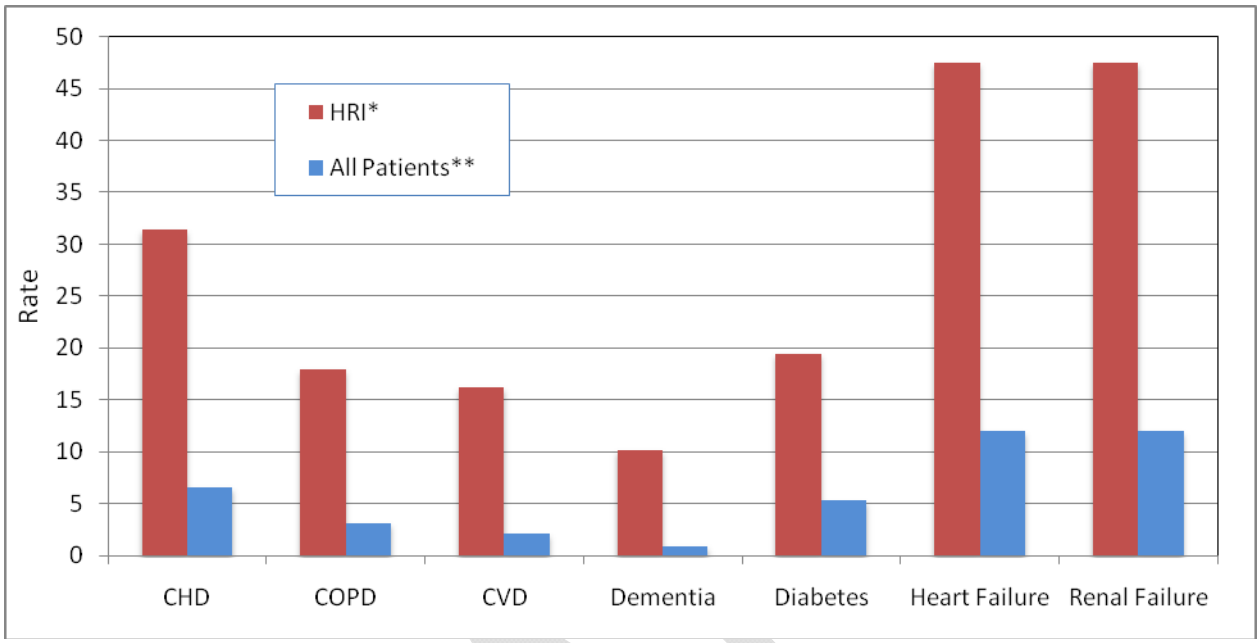
Table 5.6a – Breakdown of All Activities for HRIs and All Patients in Falkirk and Scotland for both genders, all ages

Financial Year 2012/13		Falkirk	Scotland
Number of patients	HRIs	3011	103715
	All Patients	129275	4,425,174
	% HRI	**2.3%**	**2.3%**
Number of bed days	HRIs	159,986	5,419,968
	All Patients	203,869	7,439,396
	% HRI	**78.5%**	**72.9%**
Episodes/Attendances/ Items[2]	HRIs	205,694	7,397,856
	All Patients	2,798,870	96,720,899
	% HRI	**7.3%**	**7.6%**
Cost (£)	HRIs	£71,024,900	£2,558,775,992
	All Patients	£142,060,615	£5,117,568,466
	% HRI	**50%**	**50%**
Cost per capita (£)	HRIs	£23,588	£24,671
	All Patients	**£1,099**	**£1,156**

Source: Integrated Resource Framework, ISD Scotland

There is often a close link between HRIs and Long-term Conditions (LTC) such as Chronic Heart Disease (CHD), Diabetes or Dementia. The 2012/13 data showed that 69.3% of HRIs in the Falkirk area had at least 1 LTC with the majority suffering from 2-4 different LTCs. Figure 5.6a below shows the prevalence of 7 common LTCs in HRIs compared to the rate in All patients.

Figure 5.6a – Rate (per 100 population) of individual long-term conditions for HRIs and all patients in Falkirk, in both genders and all ages



5.7 Disability

Learning disabilities

The Learning Disabilities Statistics Scotland Report 2014 looked at the numbers of adults known to have learning difficulties across Scotland (adults with learning disabilities who are known to local authorities from contact in the last 3 years). The report also looked at the Accommodation, Education and Employment situation for people with learning difficulties. In 2014 there were 990 people with learning disabilities known to the Falkirk local authority. The rate per 1000 population is shown in Table 5.7a below.

Table 5.7a Number of adults with learning disabilities known to local authorities per 1,000 population 2010 - 2014

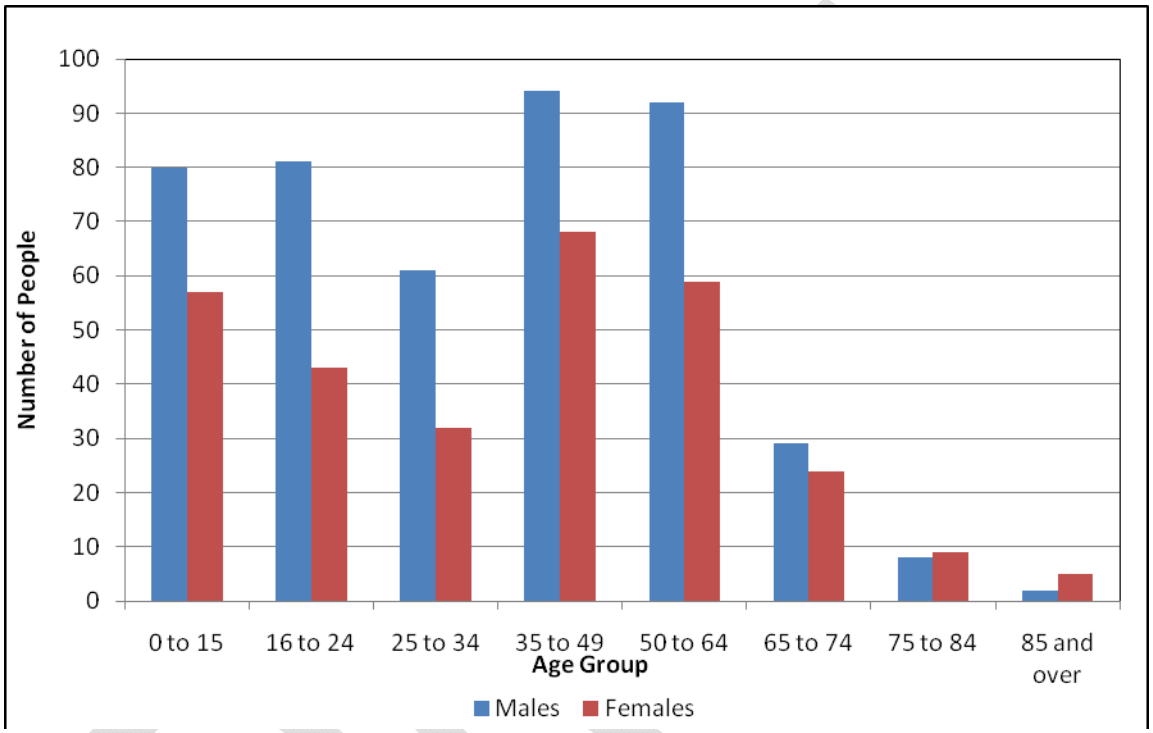
Area	2010	2011	2012	2013	2014
Falkirk	6.0	5.3	5.6	5.8	7.7
Scotland	6.4	6.0	6.0	5.9	6.0

Source: Learning Disabilities Statistics Scotland, National Records of Scotland

The chart below shows the number of people who were recorded as having a learning disability by sex and age group at the time of the census in 2011. The age group with the highest number

of people with a disability for both sexes is the 35-49 age group. The numbers fall slightly for those aged 59 to 64 but drop by 68% for males and 59% for females in the next age group, those aged 65 to 74. The number of people declines steadily for both men and women after age 65, there were only a handful of people aged 85 and over in the Falkirk area with a learning disability in 2011.

Chart 5.7b - Number of people in Falkirk with a learning disability by age and sex, 2011



Source: Scotland Census 2011

Physical disabilities

http://news.scotland.gov.uk/News/Taking-action-on-disability-1cb3.aspx

The Scottish Government has recently announced (8th September 2015) a plan to tackle inequality and advance disabled people's human rights.

In healthcare some of the key aspects of the plan are:

- More support for independent living for all disabled people who will have more say about how their support will be managed and provided

- Health, social care and other support services working together to remove the barriers faced by all disabled people

- Increased opportunities for disabled people to be involved in community development and service delivery

In the 2011 census there were over 10,800 people in Falkirk recorded as having a physical disability.

Table 5.7c Number of people with a physical disability

Area	Physical disability	Percentage of total population
Falkirk	10,868	7.0%

Source: 2011 Census

The majority of those who have a physical disability in Falkirk are over the age of 50, 80% of the total can be found in this age group. Table 5.7d below also shows that the proportion of those with a physical disability increases as people age. Only 1.2 % of the population aged 16-24 had a physical disability in 2011, compared to 32.8% for those aged 85 and over.

Table 5.7d Number of people in Falkirk with a physical disability by age and sex

Age	Male	Female	Total	Percentage of total with physical disability	Percentage of age group with physical disability
0-15	122	112	234	2.2%	0.8%
16-24	105	98	203	1.9%	1.2%
25-34	163	161	324	3.0%	1.7%
35-49	678	732	1410	13.0%	3.9%
50-64	1540	1689	3229	29.7%	10.6%
65-74	1194	1279	2473	22.8%	17.6%
75-84	846	1235	2081	19.1%	24.6%
85+	257	657	914	8.4%	32.8%

Source: 2011 Census

5.8 Mental Health and Wellbeing

http://www.gov.scot/Topics/Health/Services/Mental-Health/Strategy

Mental health and wellbeing strategies and targets were established by the Scottish Government in 2012 to cover the period 2012-2015. Among the key areas of change outlined were:

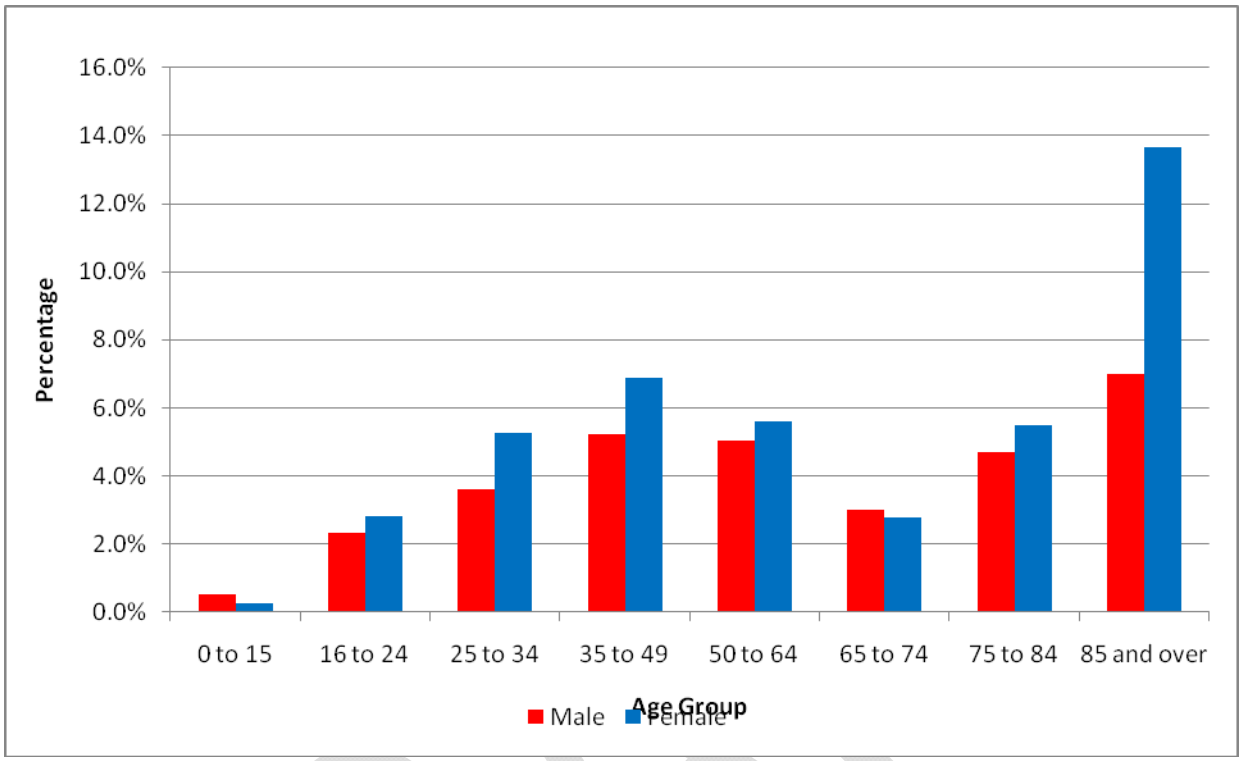
- Community, inpatient and crisis mental health services
- Work with other services and populations with specific needs.

A well functioning mental health system has a range of community, inpatient and crisis mental health services that support people with severe and enduring mental illness. Across Scotland there were variations in the pace of change, the delivery and the models of service for mental health as boards attempted to move from predominantly inpatient services to services where care and treatment can be delivered mostly in the community.
Mental health services in Falkirk are provided as part of the Forth Valley Community Health Partnership.

Health issues that are included within the area of mental health range from common problems such as dementia, stress and depression, to more severe issues like schizophrenia, bipolar affective disorder and other psychoses.

In the 2011 Census return 6375 people in Falkirk identified themselves as having a mental health condition. This is 4.1% of the total population. The distribution of this group by age group and sex is shown in Figure 5.8a.

Figure 5.8a - Percentage of population with long term mental health condition in Falkirk by age group and sex 2011



Source: 2011 Census

Further information on mental health and illnesses comes from the Quality and Outcomes Framework (QOF) for General Practices. Participation by general practices in the Quality and Outcomes Framework is voluntary but it measures achievement for general practitioners against a range of evidence-based indicators, and includes prevalence data for a range of conditions. Table 5.8b below shows information from the Quality and Outcomes Framework register.

A crude prevalence rate of the number of people in Falkirk and Scotland with a mental health condition per 100 patients is shown in the table. It shows that in Falkirk the rate of people with a new diagnosis of depression is higher than the Scottish rate but that the rate for schizophrenia, bipolar affective disorder and other psychoses is lower.

Table 5.8b - Rate of people with mental health issues in Falkirk and Scotland 2013/14

Area	Depression	Schizophrenia, Bipolar affective disorder and other psychoses
Falkirk	6.64	0.79
Scotland	5.81	0.88

Source: QOF, ISD Scotland

Wellbeing

Wellbeing is linked to mental health in that it attempts to measure how happy and content people are in their everyday lives. This data has been collected by the Office for National Statistics as part of their UK Annual Population Survey since 2011. Four questions are asked concerning wellbeing and are rated on a scale of 0 to 10.

These are:

1) Overall, how satisfied are you with your life nowadays? Where 0 is 'not at all satisfied' and 10 is 'completely satisfied'.

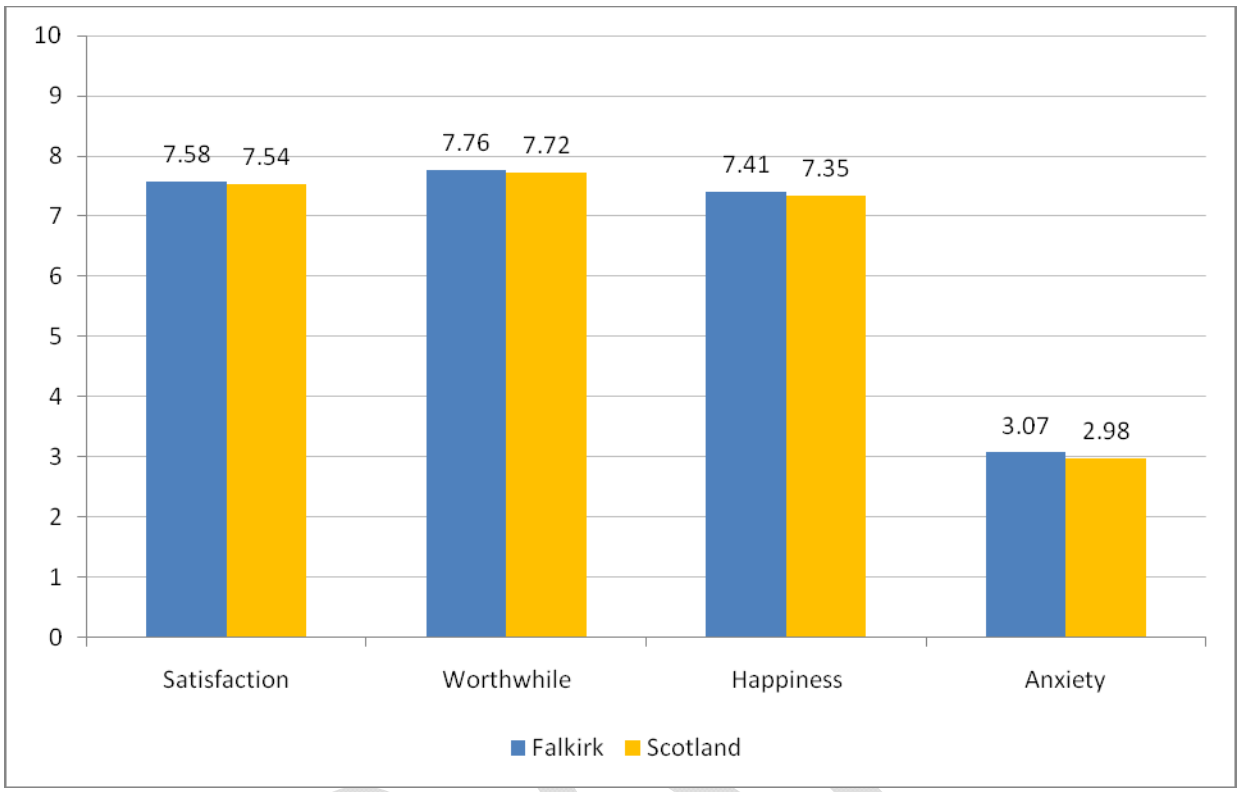
2) Overall, to what extent do you feel the things you do in your life are worthwhile? Where 0 is 'not at all worthwhile' and 10 is 'completely worthwhile'.

3) Overall, how happy did you feel yesterday? Where 0 is 'not at all happy' and 10 is 'completely happy'.

4) Overall, how anxious did you feel yesterday? Where 0 is 'not at all anxious' and 10 is 'completely anxious'.

The average scores for Falkirk and Scotland between 2011 and 2014 are shown in Table 5.8C below. Falkirk has a marginally better average score than the whole of Scotland except in the anxiety score where it is only slightly worse.

Table 5.8c Wellbeing estimates 2011-2014



Source: Office for National Statistics

5.9 Premature Mortality

Premature mortality is a measure of the number of deaths that occur under the age of 75 and can be used as an indicator of poor health of a population. The fewer deaths that occur under the age of 75, the healthier the population is judged to be. In 2014 there were 578 deaths under the age of 75 across Falkirk, 38.1% of the total deaths. This is marginally higher than the Scottish figure in 2014, which was 36.8%.

Table 5.9a Deaths under the age of 75, 2014

Area	Male	Female	Total
Falkirk	330	248	578

Source: National Records of Scotland

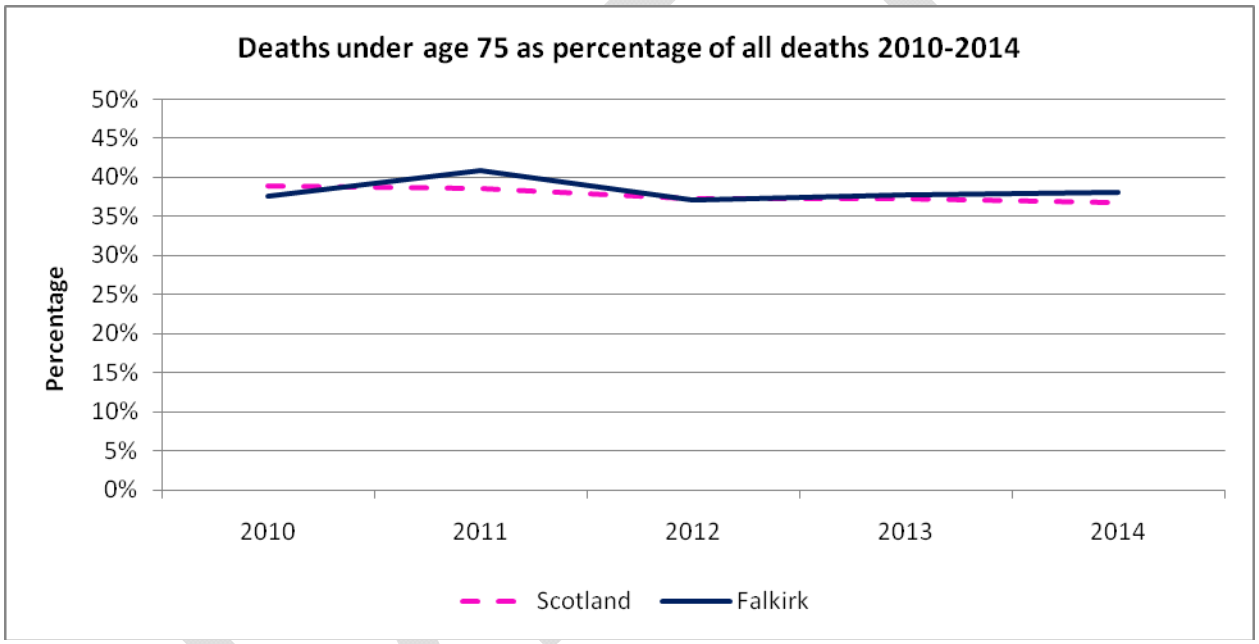
Table 5.9b Deaths under the age of 75 as percentage of all deaths, 2014

Area	Deaths under age 75	Total Deaths	% Deaths under age 75
Falkirk	578	1519	38.1%
Scotland	**19961**	**54239**	**36.8%**

Source: National Records of Scotland

The percentage of deaths occurring under the age of 75 has been gradually decreasing across Scotland between 2010 and 2014. Over the same time period the percentage of deaths under 75 in Falkirk rose initially before falling. In 2014, it was slightly higher than the 2010 figure, but not significantly different than the Scotland percentage.

Figure 5.9 - Deaths under age 75 as percentage of all deaths 2010-2014, Falkirk and Scotland



5.10 Cause of Death

In 2014 there were 1519 deaths registered in Falkirk. 57.1% of those deaths were caused by cancer and diseases of the circulatory system (including cardiovascular disease and strokes).

Table 5.10a - Number and percentage of deaths (all ages) in Falkirk by cause 2014

Cause of death	N	%	Scotland %
Cancer	462	30.4%	29.8%
Mental and behavioural disorders	132	8.7%	7.3%
Diseases of the nervous system	68	4.5%	4.8%
Diseases of the circulatory system	406	26.7%	27.7%
Diseases of the respiratory system	198	13.0%	12.4%
Diseases of the digestive system	68	4.5%	5.4%
External causes	62	4.1%	4.7%
Other	123	8.1%	7.9%
Total	**1519**	**100.0%**	**100.0%**

Source: National Records of Scotland

The percentage of all deaths caused by cancer and diseases of the circulatory system in Falkirk has not significantly changed in the years between 2010 and 2014.

Table 5.10b Number and percentage of deaths caused by cancer and diseases of the circulatory system in Falkirk between 2010 and 2015.

Falkirk	2010		2011		2012		2013		2014	
Cause of death	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Cancer	443	29.4	444	28.7	509	32.3	461	29.1	462	30.4
Diseases of the circulatory system	459	30.5	497	32.1	439	27.9	452	28.6	408	26.7

Source: National Records of Scotland

Table 5.10c Percentage of deaths caused by cancer and diseases of the circulatory system in Scotland between 2010 and 2015.

Scotland	2010	2011	2012	2013	2014
Cause of death	**%**	**%**	**%**	**%**	**%**
Cancer	28.9%	29.3%	29.4%	29.5%	29.8%
Diseases of the circulatory system	30.6%	29.7%	28.9%	28.5%	27.7%

Source: National Records of Scotland

5.11 Population Health Considerations/Implications

- Assuming age-specific prevalence remains constant for LTCs it is projected we will see greater numbers of individuals with these conditions as proportion of older adults in the population rises. This will impact on both health and care services.
- It is also projected that the number of people with multi-morbidities will increase. This means there will be more individuals attending hospital with complex needs. Currently services are un-coordinated and may mean people are making multiple visits to hospital. A re-organisation of services to ensure a more joined up approach could help to reduce the number of visits to a hospital and improve efficiency in line with Outcome 9.
- Currently around 2% of the population account for 50% of the hospital and GP prescribing spend. Gaining a better understanding about this cohort of people could allow for more effective planning and delivery of services and an improved service user experience.

6 Current Provision of Health and Social Care Services

6.1 Workforce(Waiting for data from HR Work Stream project)

Information from project led by HR Work Stream Lead to populate this section.

6.2 GP Services

General practitioner and primary care services are an integral aspect of the provision of healthcare. In 2014 in the Falkirk area there were 26 practices served by 130 General Practitioners.

Table 6.2a Number of GPs in Falkirk 2006-2014

Number of GPs (All GPs, headcount)	2006	2007	2008	2009	2010	2011	2012	2013	2014
	109	118	122	123	120	124	129	131	130

Source: ISD Scotland

In 2014, the average practice size in Falkirk was 6,108 people.
Two practices in Falkirk served areas where approximately 40% of the population were living in datazones defined as the 15% most deprived. These were Slamannan Medical Practice and Carron Medical Centre. The practice in Slamannan is the only rural practice in the Falkirk area

with 98% of the population living in a rural location, and in July 2015 it was operating under a 2C contract, which effectively meant that it was being run by the health board.

The age of the practice population is rising and in 2014 Falkirk had a similar percentage of the practice population aged 65 and above to the average figure for Scotland.

Table 6.2b - Percentage of practice populations aged 65 plus - 2010 and 2014

Area	% of practice population aged 65+	
	2010	2014
Falkirk	15.7%	17.3%
Scotland	15.9%	17.2%

Source: ISD Scotland

6.3 Unscheduled Care

Unscheduled care is the unplanned treatment and care of a patient usually as a result of an emergency or urgent event. Most of the attention on unscheduled care is on accident and emergency attendances, and emergency admissions to hospital. The Scottish Government has made unscheduled care an important area of focus for the health service in Scotland, with reducing waiting times in A&E and reducing the number of emergency admissions key targets.

6.3.1 Emergency Department Attendances

Since July 2011, Clackmannanshire, Stirling and Falkirk have been served by a single Accident and Emergency department at the Forth Valley Royal Hospital in Larbert. At this time the former A&E dept in Stirling became a minor injury unit in Stirling Community Hospital. This provides minor injury services across the health board for people in Clackmannanshire, Falkirk and Stirling between 09:00 and 21:00 hours, 7 days a week. In June 2015, around 79.1% of accident and emergency attendees in NHS Forth Valley were at the A&E department. In June 2011, the month prior to the new structure being established, 76.9% of emergency attendances were to the accident and emergency department.

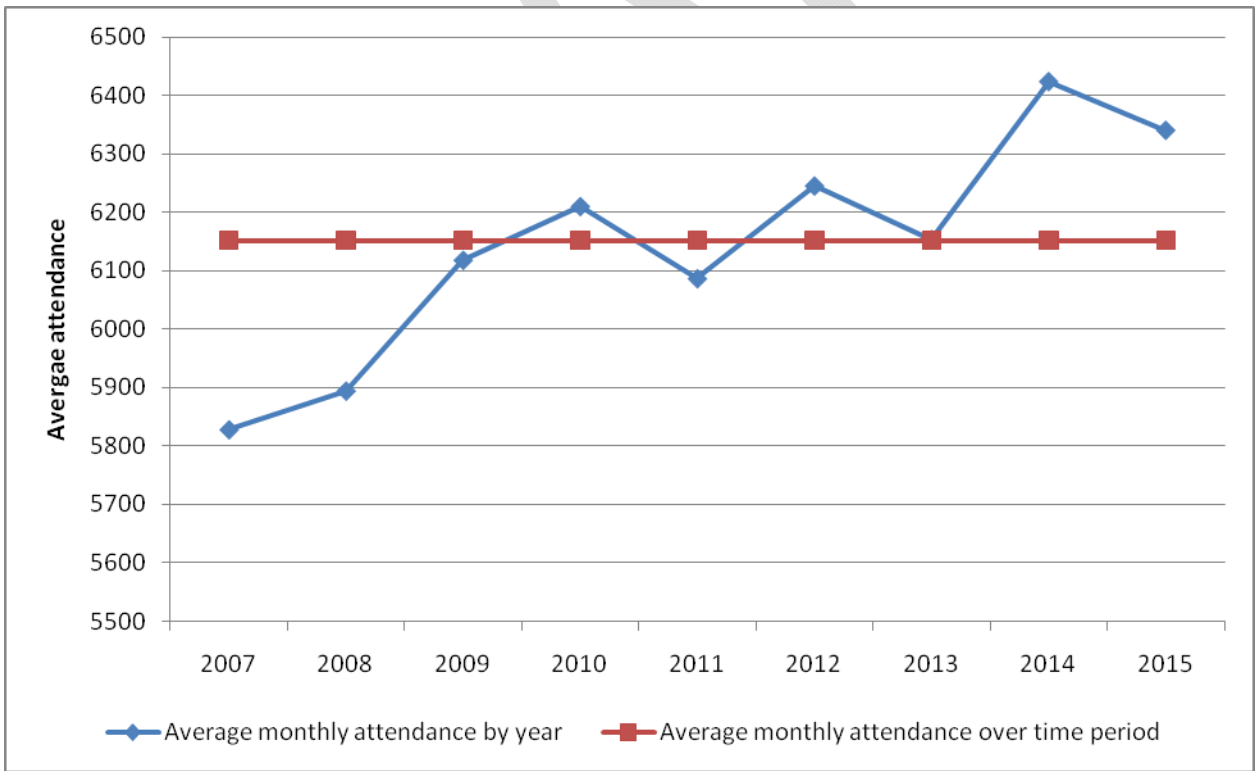
The average monthly attendance at an emergency department between 2007 and 2015 rose from 5,828.2 in 2007 to 6340.2 by June 2015. This represents an 8.8% increase in the average monthly attendance over the time period.

Table 6.3.1b - Average monthly attendance at emergency department (A&E and MIU) by year

Year	Average monthly attendance
2007 (Jul-Dec)	5,828.2
2008	5,894.3
2009	6,117.9
2010	6,209.8
2011	6,086.3
2012	6,244.9
2013	6,153.4
2014	6,423.4
2015 (Jan-Jun)	6,340.2

Source: ISD Scotland

Figure 6.3.1c - Average monthly attendance at emergency department by year



Source: ISD Scotland

The average monthly attendance at the A&E department at Forth Valley Royal Hospital had risen from 4603 in 2011 to 5023 by June 2015. This is an increase of 9.3%. During the same period the percentage of patients who met the 4 hour waiting times target each month ranged from a high of 97% in February 2014 to a low of 81.2% in December 2014.

6.3.2 Emergency Admission to Hospital

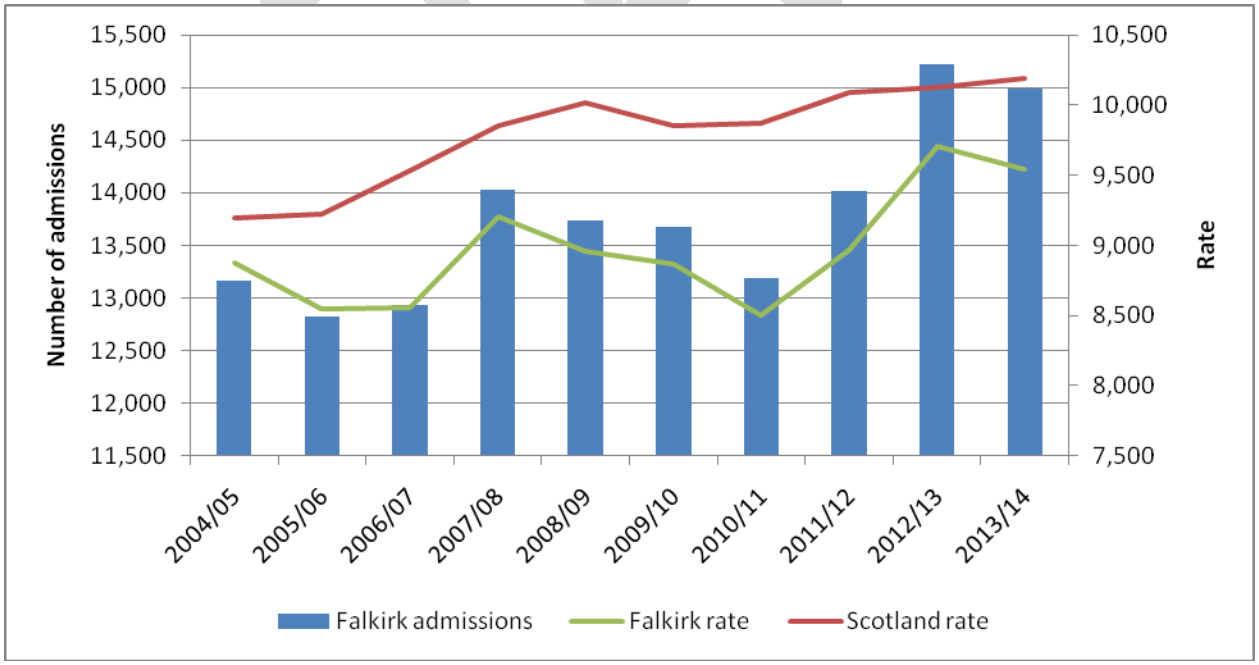
The number of emergency admissions to hospital has risen in the years between 2004/5 and 2013/14. Despite this, the rate of emergency admissions to hospital in the Falkirk area has been lower than the rate for Scotland. *Note - the figures for admissions are based on the patient's home postcode.*

Table 6.3.2a Emergency admissions to hospital - Falkirk 2004/05 to 2013/14

Local Council Area	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Falkirk admissions	13,163	12,825	12,931	14,025	13,734	13,678	13,189	14,016	15,223	14,995
Falkirk rate	8,876	8,543	8,558	9,208	8,959	8,870	8,501	8,970	9,709	9,542
Scotland rate	**9,196**	**9,222**	**9,537**	**9,849**	**10,021**	**9,849**	**9,874**	**10,090**	**10,130**	**10,188**

Source: ISD Scotland

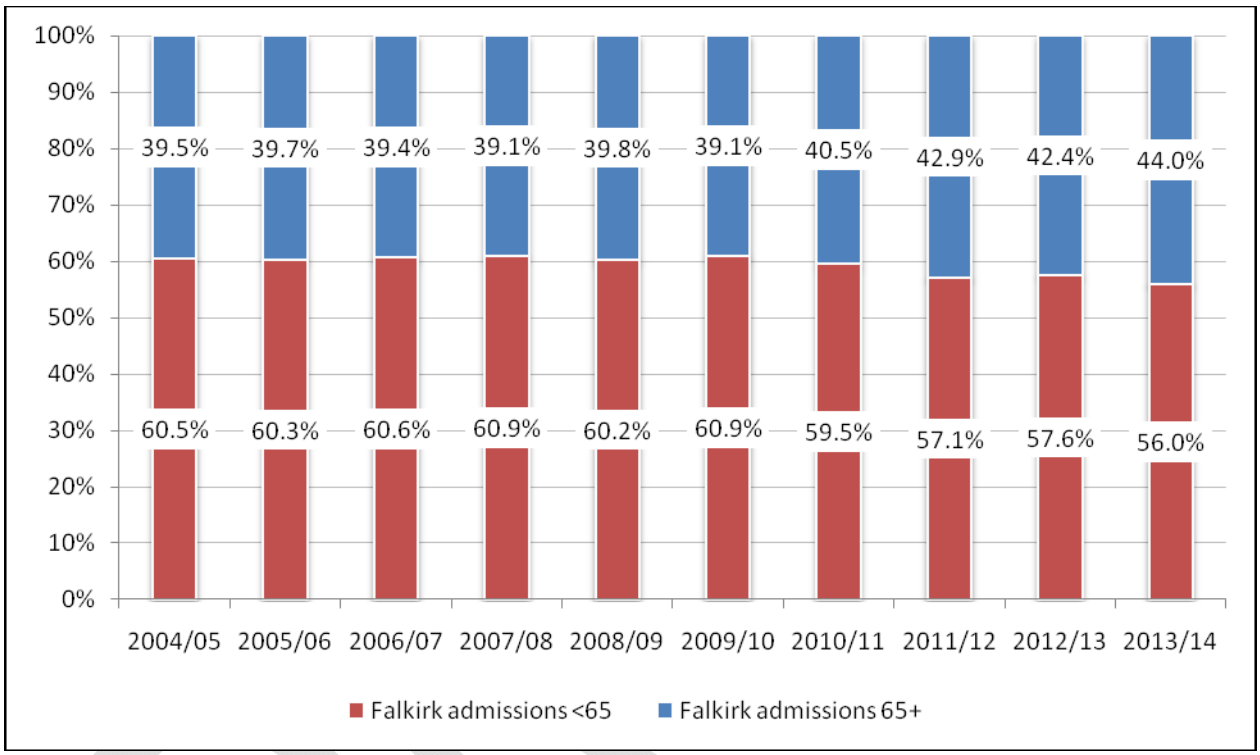
Figure 6.3.2a Emergency admissions to hospital – Falkirk 2004/05 to 2013/14



Source: ISD Scotland

Within the increase in the number of emergency admissions is an increase in the number of admissions for people aged 65 and above. A greater proportion of all admissions now come from this cohort of patients. Figure 6.3.2b below shows the increase of this group from 39.5% of all admissions in 2004/2005 to 44.0% in 2013/2014.

Figure 6.3.2b - Emergency admissions by age group Falkirk 2004/05 – 2013/14



Source: ISD Scotland

Multiple admissions

A primary focus of the work on concerning emergency admissions is to reduce the number of patients who make multiple unplanned visits to hospital and who are then admitted.
In Scotland the rate of patients who have multiple emergency admissions (2, or 3 or more) has been increasing since 2004.

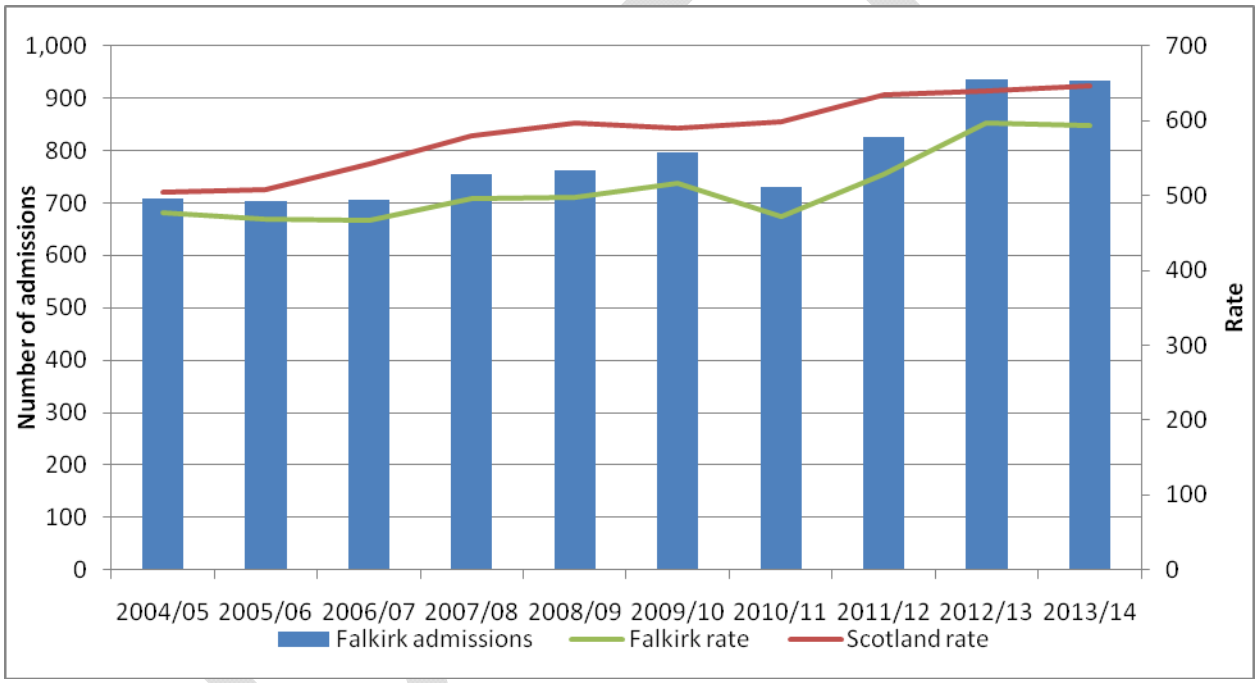
In Falkirk the rate for patients who have had 3 or more emergency admissions is higher in 2013/14 than in 2004/05. This information is shown in the table below.

Table 6.3.2b Rate and number of patients with 3 or more emergency admissions Falkirk 2004/05 – 2013/14

Local Council Area	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Falkirk admissions	708	703	705	755	763	797	731	826	937	933
Falkirk rate	477	468	467	496	498	517	471	529	598	594
Scotland rate	**504**	**508**	**542**	**579**	**596**	**591**	**598**	**635**	**640**	**646**

Source: ISD Scotland

Figure 6.3.2c - Rate and number of patients with 3 or more emergency admissions Falkirk 2004/05 – 2013/14



Source: ISD Scotland

As with the number of total emergency admissions, the number of multiple emergency admissions for people aged 65 and above is also on the rise in Falkirk. The percentage increase of admissions for patients aged 65 plus is greater than the percentage increase for all ages. The table below shows the percentage increase for all ages and those aged 65 plus between 2004/05 and 2013/2014.

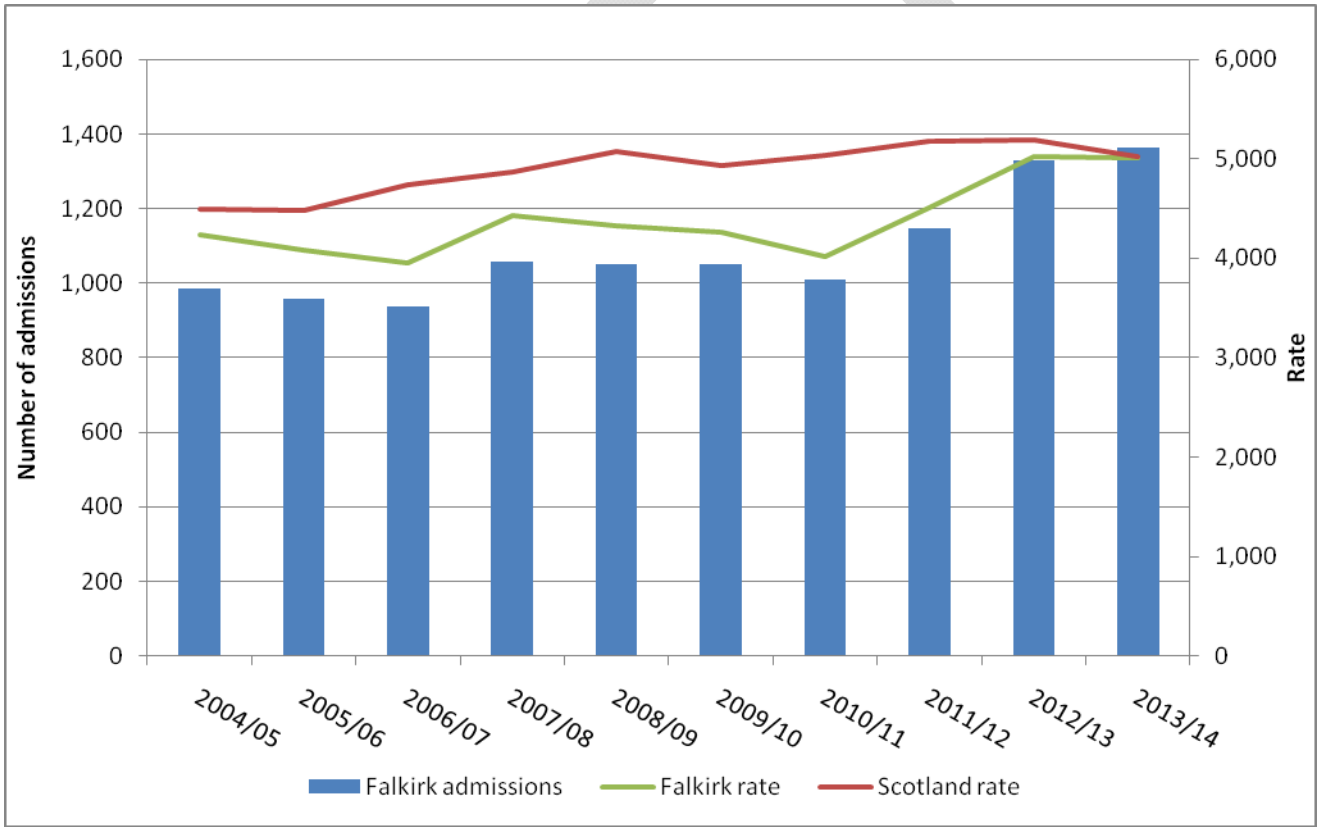
Table 6.3.2c - Increase in multiple emergency admissions 2004/05 to 2013/14

	All ages*		Age 65 +	
	N	%	N	%
Falkirk	474	22.3%	380	38.6%

*Patients with either 2, or 3 or more admissions
Source: ISD Scotland

Figure 6.3.2d below shows the trend of multiple admissions for people aged 65 and above from 2004/05 to 2013/14. It shows that in 2013/14 the number of multiple admissions in Falkirk was the highest it had been in a decade.

Figure 6.3.2d - Number and rate of multiple emergency admissions for people aged 65+ in Falkirk 2004/05 to 2013/14.



Source: ISD Scotland

6.4 Delayed Discharges from hospital

A delayed discharge occurs when a patient, clinically ready for discharge, is prevented from being discharged back into the community because the necessary support or accommodation is not ready due to a number of potential issues. Delayed discharge could be a result of social care issues, Healthcare issues or patient/carer/family-related issues.

ISD Scotland routinely collects delayed discharge information in the Delayed Discharges Census and since June 2015 it has been reporting down to local authority level on a monthly basis. Table 6.4a below shows the figures for the most recent census in August 2015 at Falkirk and Scotland level. The table below focuses on longer delays but a delayed discharge is classed as the individual's discharge date minus the RRD – "Ready for Discharge" date.

The table shows for the August 2015 census a greater number of delayed discharges in Falkirk are 'over 2 weeks' (64%) compared to the Scotland average (55%). Falkirk compares more favourably in the longer delay categories where only 8% of people in Falkirk were delayed over 6 weeks in comparison to 22% in Scotland.

Table 6.4a – Number of delayed discharges in Falkirk and Scotland, ISD Census August 2015

	Total Standard Delays	Under 2 weeks	Over 2 weeks	Over 4 weeks	Over 6 weeks
Falkirk[1]	25	9	16	8	2
% of All Delays		36%	64%	32%	8%
Scotland	879	398	481	306	195
% of All Delays		45%	55%	35%	22%

Note: Percentages will not add to 100% as delays "over 6 weeks" are also over 2/4 weeks etc.
Source: ISD Scotland Delayed Discharges Census

1. Health Board figures are based on NHS board area of treatment. Local Authority figures are based on Local Authority of residence. There are a small number of patients experiencing a delay in discharge who are residents of local authorities out with the NHS Board Areas in which they are being treated. This may mean that the NHS board area of treatment is not responsible for the patient's post hospital discharge planning. This also means that the combined figures for local authorities within a particular NHS board area might not be equal to the corresponding total for that NHS board area.

Table 6.4b shows the number of standard and code 9 delays in Falkirk in the current financial year. Code 9 was introduced in July 2006, following discussions between ISD, the Scottish Government, health and local authority partners. This code was introduced for very limited circumstances where NHS Chief Executives and local authority Directors of Social Work (or their

nominated representatives) could explain why the discharge of patients was out with their control.

Table 6.4b – All delayed discharges for Falkirk April 2015 to August 2015

Delay Type	April 2015	May 2015	June 2015	July 2015	August 2015
Standard Delay[1]	6	19	24	23	25
Code 9 Delay[1]	11	9	9	7	8
Total Delays	**17**	**28**	**33**	**30**	**33**

Source: ISD Scotland Delayed Discharges Census

Table 6.4c - Bed Days Occupied by Delayed Discharge Patients by age group and delay type – July 2015

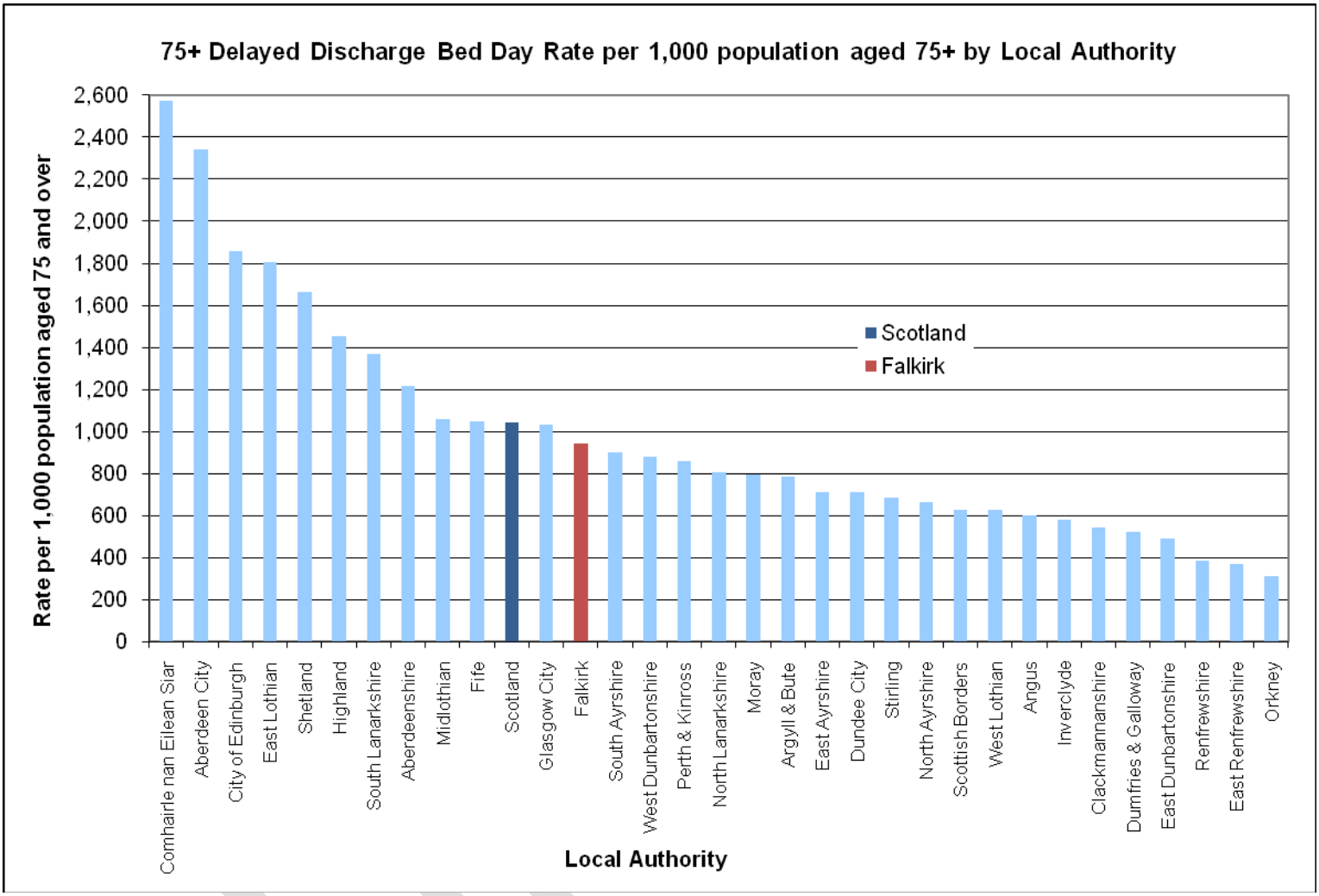
	All Ages					18 - 74 years					75 + years				
Local Authority of residence [1]	Total	Std Delay	%	Code 9	%	Total	Std Delay	%	Code 9	%	Total	Std Delay	%	Code 9	%
Falkirk	1,034	810	**78.3**	224	**21.7**	163	125	**76.7**	38	**23.3**	871	685	**78.6**	186	**21.4**
Scotland	47,797	37,844	**79.2**	9,953	**20.8**	14,081	10,580	**75.1**	3,501	**24.9**	33,716	27,264	**80.9**	6,452	**19.1**

Source: ISD Scotland Delayed Discharges Census

The number of bed days occupied by delayed discharge patients in the July 2015 census is shown in the table above. There were in total 810 bed days occupied by delayed discharge patients in Falkirk with 84% of those patients aged over 75 years (compares to 69% at Scotland level). Code 9 delays made up a smaller proportion of 18-74 delays compared to Scotland though there was a greater percentage in the 75+ age group, on the whole Falkirk recorded a slightly greater percentage of Code 9 delays.

Figure 6.4a shows how the Delayed Discharge Bed Day Rate for Falkirk compares to the Scotland average and neighbouring local authorities. The rate for Falkirk was slightly lower than Scotland on the whole.

Figure 6.4a –Delayed Discharge Bed Day Rate per 1,000 population aged 75+, July 2015



Source: ISD Scotland Delayed Discharges Census

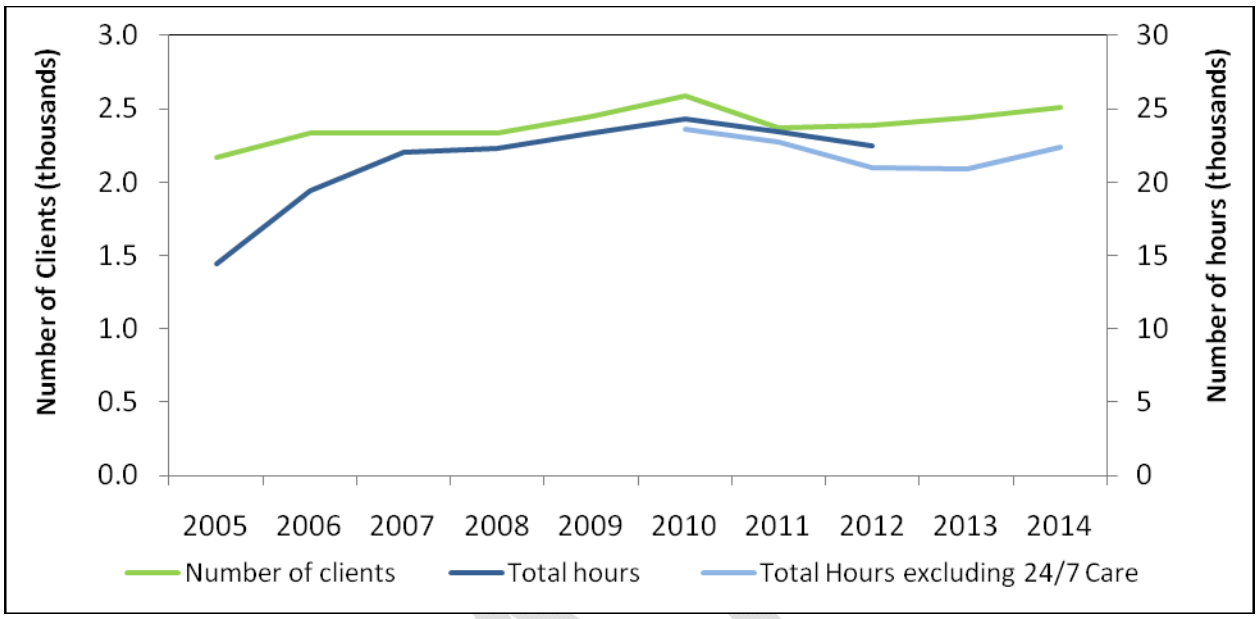
6.5 Care at Home

The 2014 Social Care Survey identified that there were 5,543 unique social care clients in the Falkirk area, of those clients 2,511 were recorded as receiving care at home.

Figure 6.5a shows the number of home care clients and the number of hours of home care provided over the period 2005-2014. Between 2005 and 2010 there was a clear rise in the number of hours of care at home, this coincided with a rise in the number of people in the Falkirk area receiving care at home. In the following years there was a drop in people receiving care at home and a subsequent drop in hours of care provided. Number of people requiring care is again on the rise and in the past year the number of hours has followed suit.

In 2014 people receiving home care were provided with, on average 8.93 hours of home care.

Figure 6.5a – Home Care Clients and Hours provided, 2005-2014



* from 2013 local authorities were asked to class 24-7 care as Housing Support, not Home Care.
Source: Social Care Survey 2014

Table 6.5a: Home Care clients and age, 2014

	0-64		65-74		75-84		85+		Total
Local Authority	No	%	No	%	No	%	No	%	
Falkirk	608	24.2	405	16.1	782	31.1	716	28.5	2511

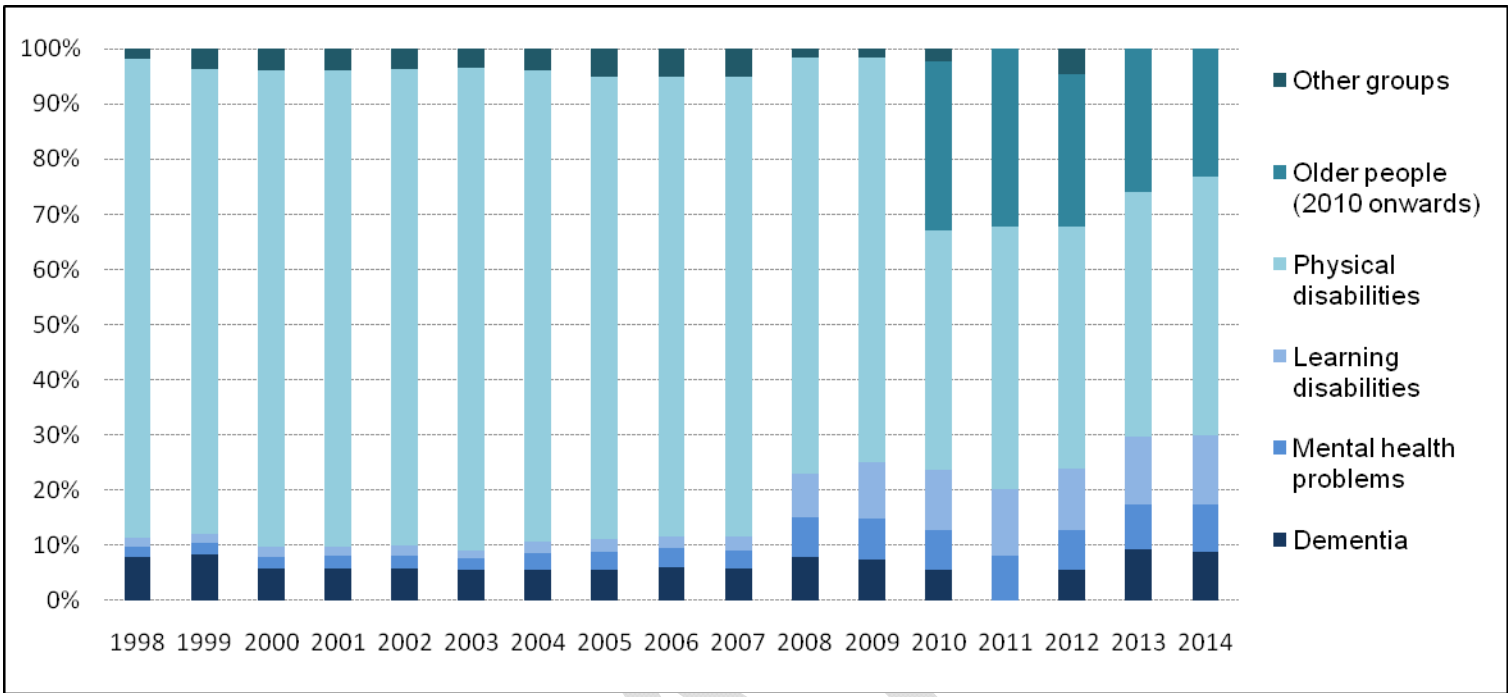
Source: Social Care Survey 2014

In 2014, nearly 60% of patients were over 75+ years and there was almost twice as many people receiving home care in the age bracket 75-84 years compared to 65-74 years.

The older age groups (65+) received on average 7.1 hours of home care per week in 2014, while those in aged 0-64 received on average twice as many hours home care per week (Mean = 14.7 hours).

The chart shown below indicates that the people with a physical disability are the main users of home care services in the Falkirk area followed by older people. Dementia, Mental health problems and Learning disabilities make up around a third of the home care client base.

Figure 6.5b – Client group breakdown of Home care services in Falkirk, 1998-2014



Source: Social Care Survey 2014

Home Care reported in the Social Care Survey excludes people receiving home care with a direct payment. Only 63 people received a direct payment in Falkirk during the 2013/14 financial year, down from 128 two years previously.

6.6 Intermediate Care – In progress – Required?

6.7 Self-Directed Support

In 2013 the Scottish Parliament passed a new law on social care support (the Social Care (Self-directed Support)(Scotland) Act 2013) which gives people a choice in how their social care and support is provided to them. Self-Directed Support (SDS) gives people control over an individual budget and allows them to choose how that money is spent on the support and services they need to meet their agreed health and social care outcomes

Option 1: Taken as a Direct Payment (a cash payment)

Option 2: Allocated to a provider the individual chooses. The council or funder holds the budget but the person is in charge of who it is spent.

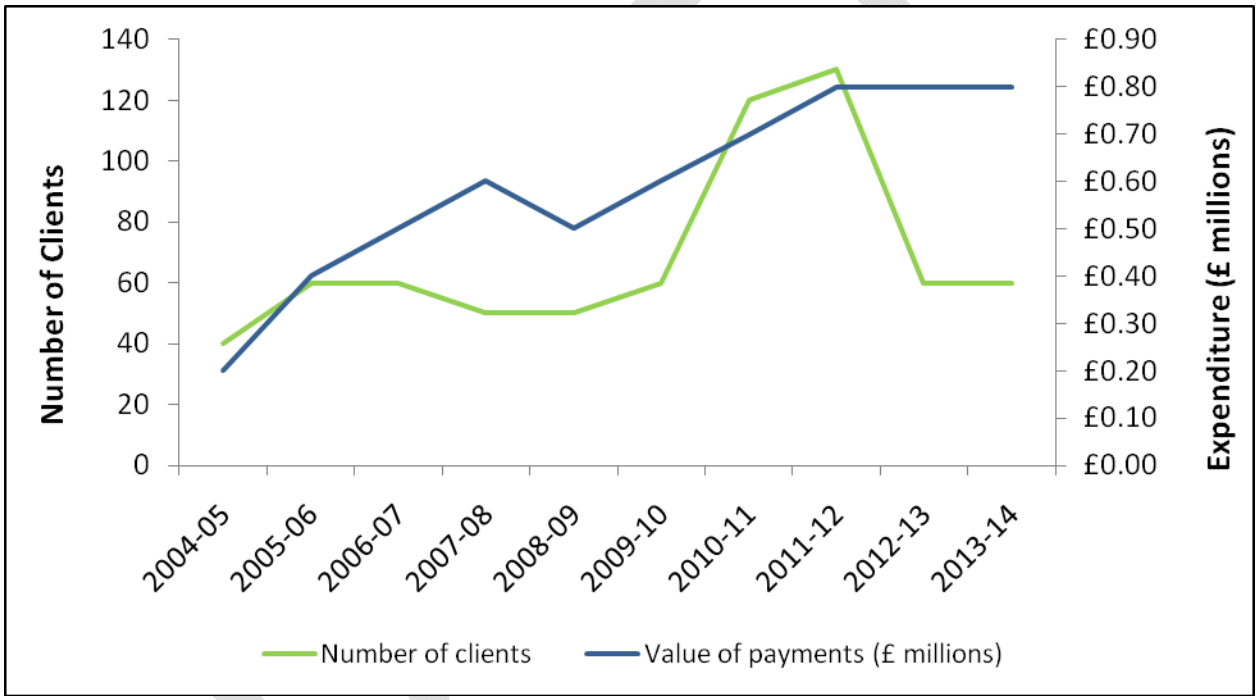
Option 3: The council can arrange a service chosen by the individual.

Option 4: The individual can chose a mix of these options.

Direct Payments (Option 1)

Home Care reported in the Social Care Survey excludes people receiving home care with a direct payment, in recent years the Social Care Survey has combined Home care data with SDS data due to increasing numbers of people receiving direct payments. Falkirk has bucked the trend in the past 2 years with Only 63 people received a direct payment during the 2013/14 financial year, down from 128 two years previously. Notably the expenditure on direct payments has remained the same.

Figure 6.7 – Number of people receiving Direct Payments (and value of payments) 2004-05 to 2013-14



*Clients can receive more than one Direct Payment in the year.
Source: Social Care Survey 2014

6.8 Care Homes

The 2014 Care Home Census reported a total of 36 care homes currently operating in the Falkirk local authority with the facilities for 1121 residents. The total number of residents in these care homes at the time of the Census was 967, giving an occupancy rate of 86% (Scotland occupancy rate – 86%). The vast majority of patients were long-stay residents with only 3% short-stay residents across NHS/LA, Private and voluntary care homes.

Table 6.8a – Summary of Care home facilities in Falkirk, 2014 (Year as at 31st March)

Care Home Type:	Number of care homes	Patient Capacity	Current Residents	Occupancy (%)
LA/NHS	8	184	144	78
Private	20	848	737	87
Voluntary	8	89	86	97
Total	**36**	**1121**	**967**	**86**

For 2014 the number of long stay residents remained similar to Care homes to 2013 and was lower than the figure in 2012. Nearly 70% of the long-stay residents required nursing care and over half of care home residents suffer from dementia (Med. Diagnosed), rising to over 60% when those not yet medically diagnosed are included.

Table 6.8b – Key Statistics for Long Stay Residents in Care Homes for Falkirk, 2012-2014 (Year (as at 31st March)

Type of Resident	2012	2013	2014
Total Number of Long Stay Residents	**982**	**927**	**932**
Characteristics of Long Stay Residents	**%**	**%**	**%**
Requiring Nursing Care	62	68	69
Visual Impairment	23	25	26
Hearing Impairment	14	15	17
Acquired Brain Injury	2	2	2
Other Phys.Dis. Or Chronic Illness[2]	35	38	41
Dementia (Medically Diagnosed)	53	57	56
Dementia (Not Medically Diagnosed)	4	4	5
Mental Health Problems	15	12	11
Learning Disability	15	12	9
Alcohol Related Problems	*	*	*
Drugs Related Problems	*	*	*
None of these	*	*	*

2. The guidance for the physical disability/chronic illness question changed in 2009/2010 to include all age groups, therefore comparison with previous years is not appropriate.

* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain resident confidentiality

Source: Source: Scottish Care Homes Census, 2014

In 2014 the care home population in Falkirk was 69% female (31% Male), identical to the Scotland population as a whole. The Mean age of a care home resident in Falkirk was 81.5 years

and the Median age was 85 years. At the time of the 2014 census, the Mean complete length of stay at a Falkirk care home was 2.5 years while the incomplete length of stay (for those still living at the care home at the time of the census) was 3.2 years

6.9 Telecare

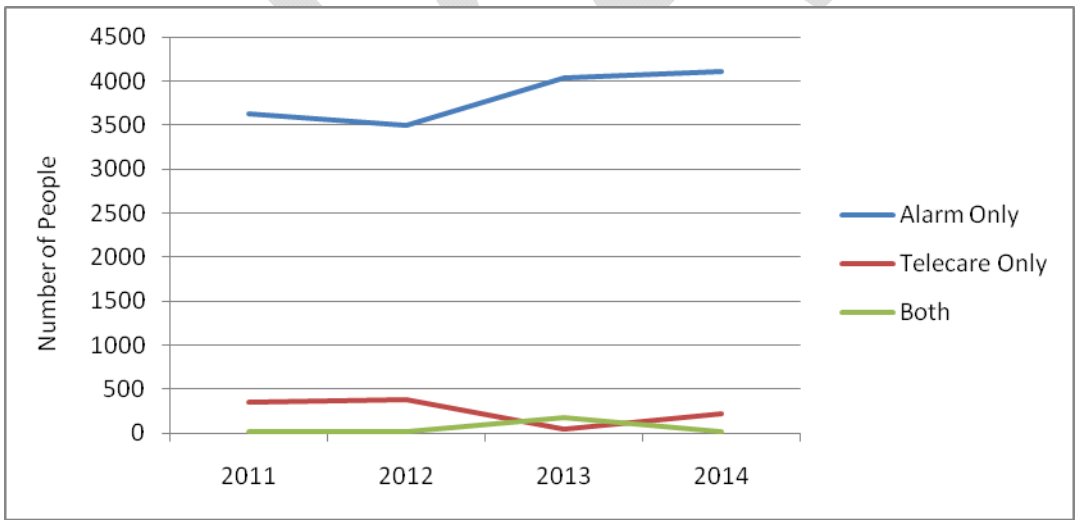
Telecare is a 24-hour monitoring system that uses a range of sensors and alarms to help people live safely and independently in their own home, with the reassurance that help is at hand in an emergency. A Telecare service can consist of a community alarm, a Telecare phone or a combination of both.

According to the 2014 Social Care Survey there were 4353 people receiving some form of Telecare services in the Falkirk area in 2014, this is up by nearly 10% on the 2011 figure. The vast majority of these people (94%) had a community alarm in their home, and the remaining 6% had either Telecare only, or a combination of both.

The vast majority who receive Telecare services are elderly, disabled or vulnerable people. In 2014 85.5% of the recipients of the service in Falkirk were aged over 65.

The chart below shows the provision of Telecare services over the past 4 years.

Figure 6.9 – Breakdown of Telecare Services in Falkirk, 2011-2014



Source: Social Care Survey 2014

6.10 Equipment – In Progress

6.11 Day Care – In Progress

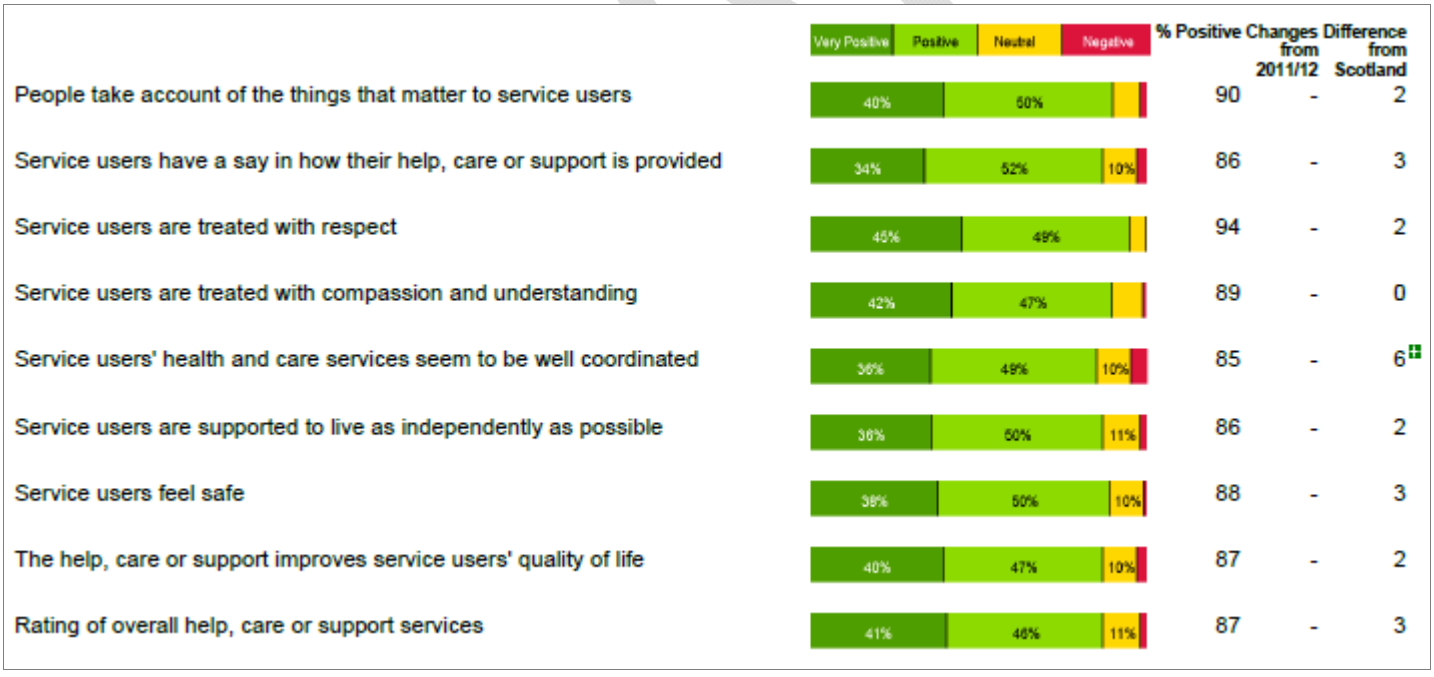
6.12 Supported and Sheltered Housing – In Progress

6.13 Experience of Care Recipients

The Health and Care Experience Survey 2013/14 was commissioned by the Scottish Government as part of the Social Care Experience Survey Programme which aims to use the public's views on health and care services as a means to improve those services. This survey was sent to 15146 people registered with a GP in the Falkirk area and received a total of 3054 responses (44% Male, 56% Female). On the whole, service users responded very positively to the survey and the overall rating for Help, Care or Support Services was 87% positive.

A summary of the relevant indicators is presented below in Figure 6.13.

Figure 6.13 – Summary of Care Recipients Experience in Falkirk – 2013/14



Source: Health and Care Experience Survey 2013/14

6.14 End of Life Care

End of life care is an important measure to indicate whether adequate plans and structures have been put in place to allow patients to spend their last six months of life at home or in the community and not in an acute hospital setting.

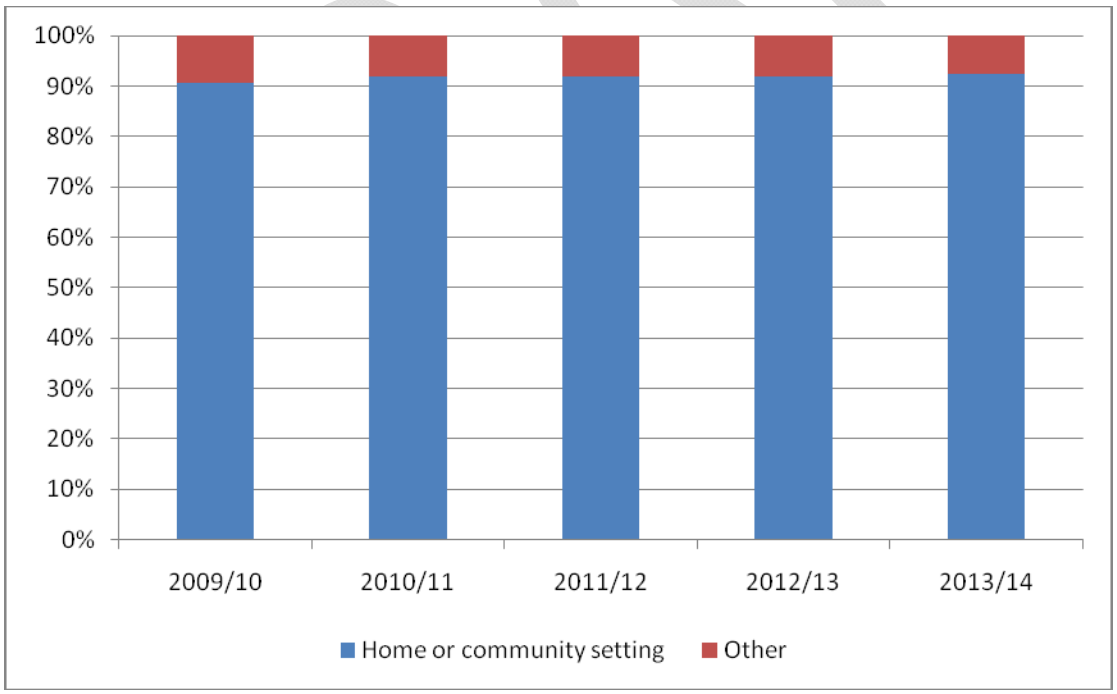
Just over 9 out of every 10 patients in Falkirk spend the last six months of their life at home or in the community, this has been the case for every year between 2009/10 and 2013/14. The percentage nationally is similar.

Table 6.14a - Percentage of last six months of life spent at home or in a community setting

Council Area	2009/10	2010/11	2011/12	2012/13	2013/14
Falkirk	90.6%	92.0%	91.9%	91.8%	92.3%
Scotland	**90.5%**	**90.6%**	**91.0%**	**91.1%**	**90.8%**

Source: ISD Scotland and National Records of Scotland

Table 6.14b - Percentage of last six months of life spent at home or in a community setting in Falkirk



Source: ISD Scotland and National Records of Scotland

6.15 – Respite Care – In progress

6.16 – Community Care Assessments In progress

6.17 - Provision of Health & Social Care Services Considerations/Implications

- The number of GPs in the Falkirk area is on the rise (130 in 2014 compared to 109 in 2006), however the percentage of those aged over 65 is also increasing (up to 17.2% in 2014).
- The average monthly attendance at A&E and MIU has increased by 8.8% over the years 2007-2015. The rate of emergency admissions has also increased over the past decade though it remains below the Scotland rate.
- The increase in rate of emergency admissions is accompanied by a greater proportion of over 65's being admitted, 39.5% in 2004/5 up to 44.0% in 2013/4.
- Over 65's also show a much greater rise in multiple admissions (38.6% from 2004/5-2013/4) compared to just a 22.3% rise for All ages.
- 1034 bed days were lost in July 2015 due to delayed discharges, over 75's accounted for 84% of those bed days.
- Home care clients in Falkirk are largely over 65's (75.8%), receiving on average 7.1 hours of home care per week.
- Expenditure on Direct Payments has risen considerably from £0.1 million in 2004/5 to £0.8 million in 2013/14.

7. Carers

7.1 Overview

A Carer is a person who provides unpaid help or support to a family member, friend or neighbour who suffers from a disability, a long-term physical or mental illness or problems related to old age. There is no distinction made about whether that person provides that care within their own household or out with the household.

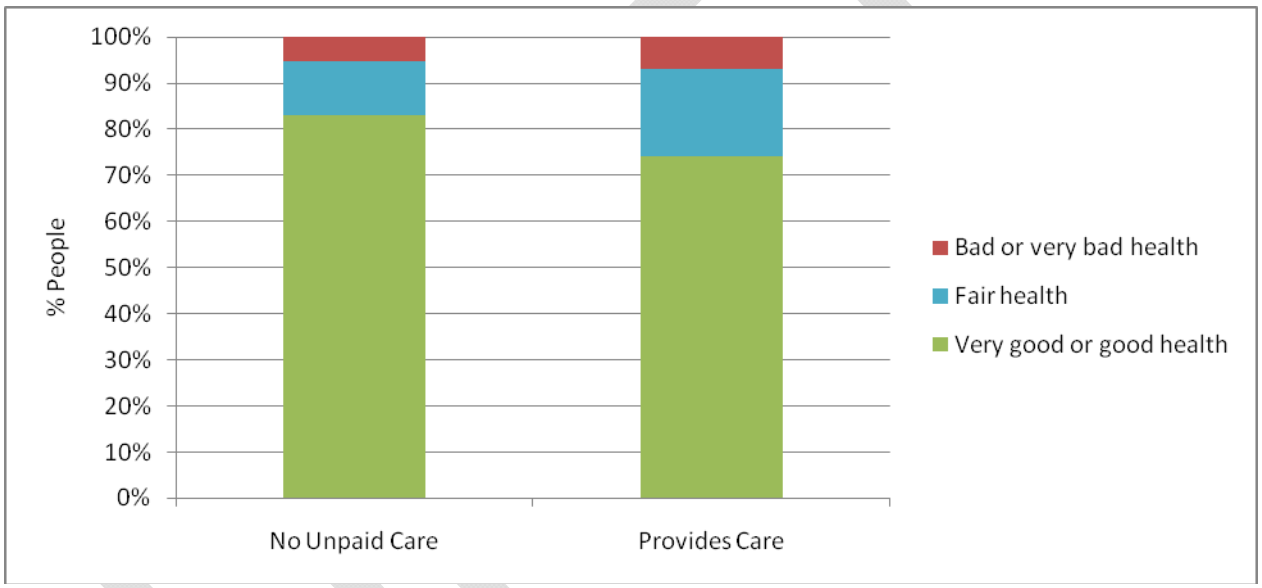
The provision of unpaid care is a key indicator of care needs and has important implications for the planning and delivery of health and social care services.

7. 2 Characteristics of Carers

Utilizing data from the 2011 Scotland census, an overview of Carers in the Falkirk area is presented below:

- A total of 15056 people were found to be providing unpaid care in Falkirk, 9.7% of the local population. The carer population was 59.5% Female and 40.5% Male.
- Approximately 2/3rds (65.4%) of those providing unpaid care are in the age band 35-64 years with those 65 years and over accounting for nearly a fifth (18.2%) of the carer population.
- Over a third (35.7%) of carers in Falkirk provide in excess of 35 hours unpaid care per week with 27.2% of those providing over 50 hours unpaid care.
- 29% of those providing in excess of 35 hours care are aged 65 and over.
-

Figure 7.2a: Provision of unpaid care & general health in Falkirk, Scotland's Census 2011

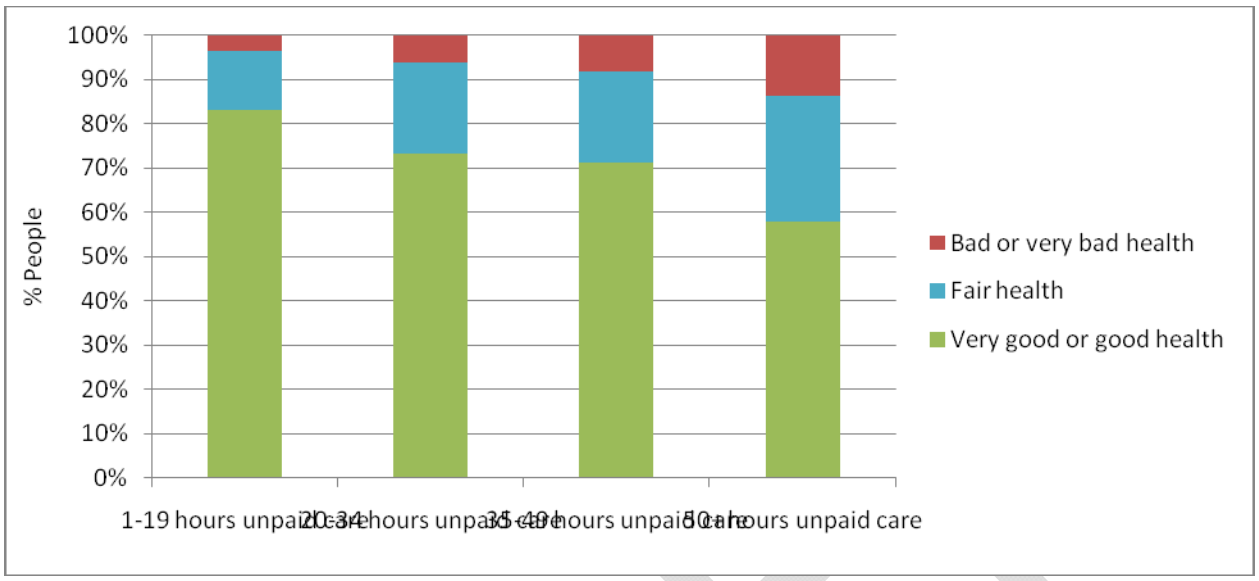


Source: Scotland Census 2011

Figure 7.2a shows that the proportion of those who'd class themselves as being of fair or bad/very bad health is greater for those providing unpaid care. Of the 18.2% of over 65s who provide care, only half (49.7%) would class themselves in good or very good health.

The chart below (Figure 7.2b) builds on the idea that the health of carers is ultimately worse than the population who do not provide unpaid care. There is a clear pattern showing that the health status of the carer deteriorates as the level of care provided increases. Less than 60% of those providing the highest level of care (50+ hours a week) consider themselves to be of good or very good health, compared to over 80% who do not provide unpaid care.

Figure 7.2b: General health by level of unpaid care provision - Falkirk, Scotland's Census 2011

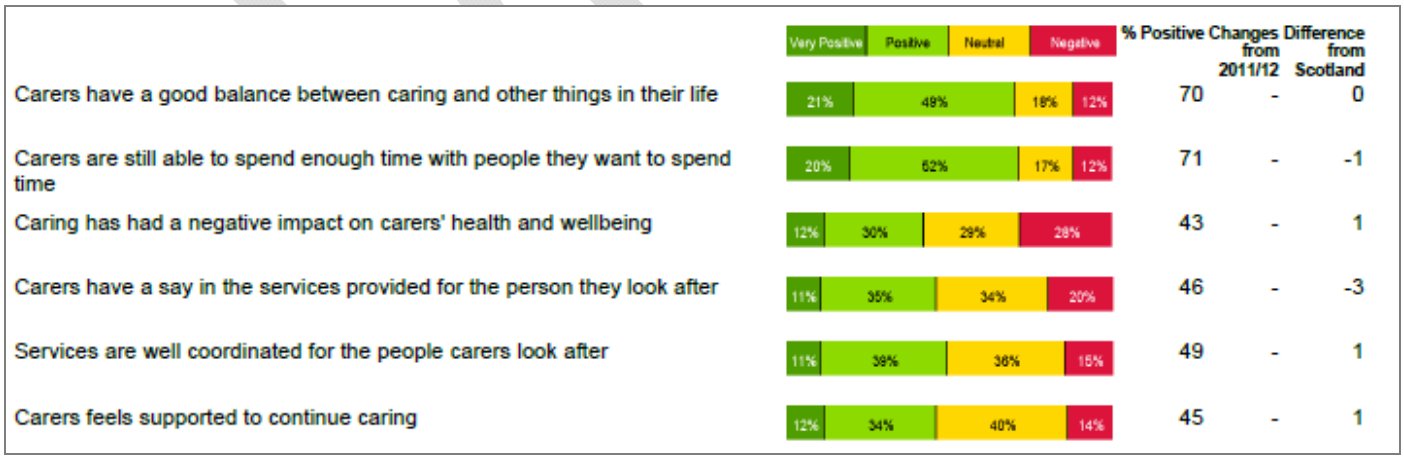


Source: Scotland Census 2011

7.3 Experience of Carers

The Health and Care Experience Survey not only looks at the experience of the care recipients but also the experience of those who provide unpaid care. Figure 7.3 provides a summary of responses from carers in Falkirk. Despite the majority of carers (70%) being positive about their caring/life balance, over 50% of people are neutral/negative about the impact caring has on their health and wellbeing. Less than 50% of carers responded positively when surveyed about the coordination of local care services and only 45% feel supported to continue caring.

Figure 7.3 – Summary of Carer Experiences in Falkirk 2013/14



Source: Health and Care Experience Survey 2013/14

7.4 Carers Implications/Considerations

- Over a third of carers in Falkirk (35.7%) provide greater than 35 hours care and nearly a third of those are over 65's.
- The majority believe that being a carer has a negative effect on their health and wellbeing, less than 50% of over 65's considered themselves to be good health.
- The Carer data from the 2011 Census showed a clear relationship between poor health and a greater number of hours care provided.
- The Health and Care Experience Survey 2013/14 highlighted that carers in Falkirk feel there is room for improvement in the services and support they receive.

8. Conclusions and Next Steps

This needs assessment has provided information describing current health and social care needs in Falkirk, and forecast a significant increase in these needs.

Underpinning these needs are engagement and redesign needs which are fundamental to making a real difference through integration.

Engagement with all stakeholders will also be required in identifying how to progress. A process of needs prioritisation is required – through multi-criteria decision making and similar democratic processes – the two main categories of criteria being importance and feasibility.

This paper relates to
Agenda Item 9

Title/Subject: **Delayed Discharge**

Meeting: **Transitional Board**

Date: **6th November 2015**

Submitted By: **CHP General Manager**

Action: **For Noting**

1. INTRODUCTION

1.1 The purpose of this paper is to update Transitional Board members on progress with meeting the national target that no-one who is ready for discharge should be delayed by more than 2 weeks. This paper also presents an action plan for discussion.

2. RECOMMENDATION

2.1 The Transitional Board is asked to note current performance and the action plan contained in the report.

3. BACKGROUND

3.1 As of 15th October census date, there were 23 people delayed in their discharge, 19 of whom were delayed for more than 2 weeks. These relate to delays which count towards the national, published delayed discharge target (standard delays).

3.2 Trend analysis from April 2015 shows an improvement in the position from September 2015 with a reduction in the numbers of people waiting over 2 weeks at the census point.

Table 1 (excluding Code 9 & Code 100)

	Apr 15	May 15	Jun15	Jul 15	Aug 15	Sept 15	Oct 15
Total delays at census point	6	19	24	23	25	36	23
Total number of delays over 2 weeks	1	9	11	11	16	25	19

3.3 In addition to the published delays, there are patients whose discharge is complex (code 9) or who have been in hospital for more than a year and whose discharge is part of a longer discharge planning process (code 100). The latter tend to be patients who are in long stay learning disability or mental health inpatient services.

Table 2 shows the total picture of delays in Forth Valley across all categories expressed as occupied bed days.

Table 2 total occupied bed days

	July	August	September	Equivalent Beds (September)
Standard Delays	796	897	1097	36
Complex Delays/ Guardianships (Code 9)	162	207	268	9
Code 100 Delays	217	217	210	7

3.4 **Table 3** shows the **weekly** position for the last four weeks.

Ta**ble 3**

	Total Delays (excl. Code 9 & 100)	Delays Over 2 Weeks	Delays Over 6 Weeks	Longest Wait (days)	Code 9 (incl guardianship)	Code 100	Total Delays
24th Sep	34	23	5	148	10	7	51
1st Oct	32	23	10	155	9	7	48
8th Oct	28	19	10	162	9	7	44
15th Oct	23	19	6	59	9	7	39

3.4 **Table 4** shows availability of care homes across Forth Valley in the past 2 weeks.

Table 4

	7th Oct	12th Oct	14th Oct	19th Oct
Falkirk	2	4	5	8
Stirling	10	9	9	18
Clacks	1	0	0	4

3.5 The availability of care homes in Falkirk to support patients first choice remains very limited. In addition, there has been limited availability of interim places across Forth Valley in the last month. Although improving, the number and length of delays continue to be challenging with **11** patients delayed for more than **4** weeks and **6** delayed for more than 6 weeks.

3.6 The discharge of **7** patients is currently been taken forward under the policy on choice, an improvement on the September position (15).

4. ACTION PLAN

4.1 An action plan has been developed for the Board's consideration and is attached.

4.2 The action plan focusses on medium to longer term actions which will help to support people to live at home safely and where possible avoid admission to hospital.

4.3 It will also support the "home first" ethos whereby on admission all staff should be working towards getting the patient home with appropriate support if required and care homes should not be considered until full assessment has been undertaken.

5. CONCLUSIONS

5.1 Although the position has improved in the last month the delayed discharge position continues to be a significant challenge for the Partnership.

5.2 Ongoing actions are required to continue to improve current performance in the short term together with the implementation of the plans contained in the Action Plan to build sustainability for the medium to long term.

5.3 There are no additional resource implications arising from this report.

5.4 This report identifies the current position in relation to the National Target for Delayed Discharges.

5.5 There are no additional Legal and Risk implications associated with this report.

5.6 No additional consultation has been undertaken for the purpose of this report and no equalities implications have been identified.

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Approved for Submission by: Title and Organisation

Author – Kathy O'Neill
Date: 15/09/15
List of Background Papers

Issue	Action	Responsible Person	Timescale
There are a number of services which are currently being delivered which are having an impact on small numbers of the population but are not having the impact required across the area to reduce ED attendances or acute admission	• Re model and implement where necessary services which meet the needs of the total population in a planned and sustained way. Services will include the Frailty Clinic, Closer to Home, ALFY, OOH 24/7 services. This is not an exhaustive list but a systematic review of current and required services will be undertaken.	Tracey Gillies and Kathy O'Neill	
	• Closer to home and ALFY will begin to be rolled out in December.	Kathy O'Neill	December 2015
	• Recruit Community Physicians to work across Forth Valley to support building Community Resilience	Tracey Gillies	
	• Use the data provided by LIST (Local Intelligence Support Team) to identify the population who are the biggest users of our resources across H&SC and plan services for the future which reduce their needs and support them to live well at home.	Tracey McKigen	
	• New ARBD Team supported by ICF will assist with this for this particular high resource patient group.	Kathy O'Neill	Early 2016 (subject to recruitment of Team)
There are patients in hospital whose pathway is	• Identify the current patient pathways from admission to discharge and	Ian Aitken/Tracey Gillies	

delayed for a variety of reasons and whilst not delayed in their discharge their Length of stay could have been shorter	complete analysis of the pathways to streamline the journey. Work has already started to look at patient points in discharge pathway • Review model of Intermediate Care in Falkirk to support discharge. Review and agree pathway for use of additional short stay assessment beds • Use Estimated Dates of Discharge on admission proactively	Deirdre Cilliers Ian Aitken	December 2015
There are a number of patients whose discharge becomes delayed as they fall within the scope of the adults within capacity act	• Promote power of Attorney through publicity/ GPs/ early interactions with H&SC staff (e.g. ACP plans). Educate the general public that this is a positive step for the future • Identify patients early in the hospital stay who are likely going to fall within the remit of the adults with incapacity Act and take steps to have early conversations with families • Involve MHO staff Early in patient journey • Meet with Sheriff Principals and local Solicitors to try and influence timeline for legal process re. guardianship	Kathy O'Neill/Deirdre Cilliers Ian Aitken Tracey Gillies Kathy O'Neill/Deirdre Cilliers	In discussion/planning stage for roll out during 2016 In planning stage for implementation early 2016
There is a lack of an appropriate number of	• Embed Home First Ethos. On admission the first destination for patients is home	Tracey Gillies	

Care Home beds available in Falkirk	with support as required. Care home should be considered in a non-acute environment once the patient has moved on for assessment • Identify Current Care Home admission rate per head of population in comparison to Scotland. LIST team will provide this. • Step down beds/short stay assessment beds as an alternative to direct admission to care home. Step up beds as an alternative to acute admission. These will be part of a pathway including closer to home/ frailty clinic and other agreed services	Tracey McKigen Deirdre Cilliers	 November 2015

This paper relates to Agenda Item 10

Title/Subject:	**Forth Valley Winter Plan**
Meeting:	**Integration Joint Board**
Date:	**6th November, 2015**
Submitted By:	**Director of Public Health and Strategic Planning**
Action:	**For Noting**

1. INTRODUCTION

1.1 NHS Forth Valley is required to produce a Winter Plan as part of the National Unscheduled Care Programme. Guidance and a self assessment reporting template were published by the Scottish Government on 6 August 2015 to provide direction and support to Boards. Further guidance was received on 18th September and 1st October 2015.

1.2 The Forth Valley Winter Plan has been developed jointly by a Forth Valley wide working group with representatives (see Appendix 1) from NHS Forth Valley, Falkirk Council and organisations who have a direct role in delivering care.

1.3 As requested by the Scottish Government (SG), to illustrate progress, the first outline draft plan was returned to the SG by end August 2015. The SG also requires the Final Plan to be approved by the NHS Board and agreed by Integration Joint Boards. In addition, the Winter Plan also requires to be tested through a multiagency exercise, returned to Scottish Government and posted on NHS Forth Valleys public web site by the end October 2015.

2. RECOMMENDATION

2.1 The Integration Joint Board is asked to discuss and note the Forth Valley Winter Plan for 2015/16 noting the requirement for NHS Board approval.

3. BACKGROUND

Winter Planning Process

3.1 A multi-agency Winter Planning Steering Group was established to support the development of the Winter Plan 2015/16. Lead contributors to the plan were identified and participated in the Steering Group. The draft Winter Plan was tested at a winter planning exercise on 9 October and following the exercise, the plan was finalised for approval and submission to Scottish Government.

3.2 The NHS Forth Valley Winter Plan 2015/16 has been prepared in line with Scottish Government guidance "National Unscheduled Care Programme: Preparing for Winter". The main focus of the Winter Plan deals with the period from November 2015 to March 2016 and in particular, detailed arrangements for the festive holiday fortnight, in December and the predicted post festive surge in January.

3.3 The Board's arrangements for managing all year round capacity and flow have been augmented to include winter planning, in order to deal with the additional pressures placed on services during the winter period. This incorporates local contingency plans and ensures formal links with the plans of key stakeholders from the Local Authorities, Scottish Ambulance Service, Third and Independent Sector, NHS 24 and SERCO.

3.4 During the winter period, it is also essential that elective activity meets the relevant access targets.

_____

Approved for Submission by: Dr Graham Foster, Director of Public Health and Strategic Planning

Author - Robert Stevenson, Senior Planning Manager, NHS FV
Date: 08/10/2015

List of Background Papers

1. **Appendix 1 Forth Valley Winter Planning Group**
2. **Appendix 2 Forth Valley Winter Plan 2015/16 (to follow)**

Appendix 1 Forth Valley Winter Planning Group

Name	Designation
Robert Stevenson (RS)	Senior Planning Manager (Chair)
Deirdre Anderson (DA)	Service Manager, Medicine
Gail Bell (GB)	Senior Midwife/Deputy Head of Midwifery
James Cassidy (JC)	Service Manager, Community Health Partnership
Deirdre Cilliers	Adult Care Head, Falkirk Council
Leslie Cruickshank (LC)	GP (Clinical Lead, Falkirk)
Antony Devine (AD)	Area Service Manager
Val De Souza	Head of Social Services, Stirling-Clackmannanshire Council
Simon Dryburgh (SD)	Assistant Director of Finance
Amanda Forbes (AF)	Clinical Service Manager (Orthopaedics)
Mark Hamilton (MH)	Senior Planning Manager
Anna Lamont (AL)	GP (Forth Valley Out of Hours Specialist Lead)
Olwyn Lamont (OL)	Lead Respiratory Nurse Specialist
Karen McKay (KM)	Linen and Transport Manager
Tracey McKigan (TMc)	Interim Chief Officer, Falkirk Health & Social Care
Trisha Miller (TM)	Lead Nurse (Infection Control)
Henry Prempeh (HP)	Consultant in Public Health Medicine
Richard Reynolds (RR)	Head of Ambulance Services (Forth Valley)
Alison Richmond-Ferns (ARF)	Associate Director of HR
Diane Sharp (DS)	District Nursing Team Leader (Stirling)
Shiona Strachan	Chief Officer, Health & Social Care, Stirling/Clackmannanshire
Irene Warnock	Head of Nursing in Community
Scott Williams (SW)	GP (Clinical Lead, Stirling)
Paul Woolman (PW)	Information Service Manager

Appendix 2

Forth Valley

Winter Plan

2015/ 2016

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Executive Summary

This plan sets out what NHS Forth Valley and our partners, are doing to prepare for the additional pressures during winter. The plan focuses on November 2015 to the end of March 2016, with a particular focus on the festive holidays and the immediate post-festive period.

Whilst winter is traditionally a busy period for health and social care services it is also a time when there can be sudden and unpredictable increases in demand. This Winter Plan is backed up by a series of contingency plans for unexpected events.

The Winter Plan sets out:-

Actions that have been taken to strengthen NHS capacity across Acute, Primary and Community Services.

Examples of Actions in Plan for 2015/16

- **All partners will have plans in place for predicted activity over the festive period (to prevent backlog developing) and enhanced activity levels through January 2016.**
- **We will work to ensure that all GP Out of Hours rotas are fully staffed.**
- **We will consider alternative uses for all existing assets that could increase our emergency capacity during surges in demand.**
- **We will ensure that SERCO, our soft FM partner, has robust and rehearsed escalation plans in place to meet demand.**
- **We have reviewed the arrangements in Community Hospitals and will staff to ensure every bed can provide a level of rehabilitation, "every bed is a rehab bed".**
- **Transport arrangements will ensure that patients' discharge plans focus on use of the Scottish Ambulance Service (SAS), independent providers and the existing NHS FV transport fleet.**
- **A pharmacy-first service in the community will encourage patients to attend pharmacy first for advice and treatment of common clinical conditions.**

A balanced approach to admissions and discharges, with the aim of reducing avoidable delays, maintaining services and delivering treatment time guarantees.
This involves capacity planning and close working with health and social care partners and care closer to home, in line with the Scottish Government's 2020 vision. A key element of this is providing services to support patients before they become unwell or present as an emergency. This will involve prevention services, primary care and anticipatory care planning.

Examples of Actions in Plan for 2015/16

- **Establish a 24/7 support line "Advice Line For You" (ALFY) for those aged 65 and over.**
- **In conjunction with ALFY, establish an enhanced community team "Closer to Home" (C2H) supporting individuals with higher needs to remain well at home and reduce avoidable ED attendances and hospital admissions.**
- **We will ensure that the Frailty Clinic, piloted at FVRH, is available Monday to Friday during the predicted period of peak seasonal demand.**
- **We will conduct a regular "Point of Care" audit to identify and reduce the numbers of people who are inappropriately receiving their care in an acute hospital setting.**
- **We will deliver a robust public awareness campaign for norovirus and ensure that effective control measures are continually in place at all NHS clinical sites.**
- **We will deliver a population wide influenza vaccination campaign achieving high uptake amongst adults aged 65 and over, at risk groups, pre-school and primary school children, and health and social care staff.**

Plans for creating additional capacity.

When additional pressures occur it will not always be possible to manage these within routine resources and so the plan sets out a number of pre-planned responses to increase capacity when required. These measures cover a range of possible scenarios from bringing on additional winter capacity beds to substantial re-organisation of services providing short-term emergency capacity in an extreme situation.

Examples of Actions in Plan for 2015/16

- **Additional winter capacity beds have been identified and are prepared for utilisation during surges in activity.**
- **We have identified additional contingency measures to maintain services in the short term should these be required "in-extremis" (for example short-term use of existing clinical areas).**
- **We have detailed contingency plans that are well tested and exercised to cover a range of contingencies including severe weather and major infrastructure failures.**
- **Additional Local Authority short stay assessment beds in Falkirk and rural Stirlingshire are being commissioned for contingency purposes.**
- **We will implement a structured early warning system as successfully used at Hairmyres Hospital.**
- **We will work with Strathcarron Hospice to increase the availability of hospice and hospice at home services (as successfully achieved in 2014/15).**
- **We will ensure that additional clinical capacity, used in winter 2014/15, is fully staffed from the festive period until the end of February 2016.**

Increase elective capacity ahead of December.
As well as providing for the anticipated increase in unscheduled and emergency care over the winter months the NHS must also maintain our capacity to provide routine and elective services. These services can range from pre planned elective surgery to renal dialysis services and specialist cancer care. The Winter Plan sets out how NHS Forth Valley will work to ensure elective capacity is maximised ahead of predicted increases in emergency demand. This ensures both planned and unplanned needs can be met.

Examples of Actions in Plan for 2015/16

- **Elective activity will be profiled over the winter to minimise the risk of TTG breaches during the festive and post festive period.**
- **Elective services will focus on day cases, urgent cancer and urgent in patient activity during the first two weeks of January 2016.**
- **We will have simple boarding criteria in place to minimise boarding and prevent transfers at night.**
- **We will develop a plan to implement and monitor criteria-led discharge to increase discharges at weekends.**

Ensure staff capacity is in place over the festive period.
The festive holidays and especially the post festive period can be particularly challenging due to the need to balance staff holidays and care needs with the needs of the service. The Winter Plan sets out how NHS Forth Valley is thinking ahead to ensure we have sufficient staff capacity at busy periods and enough additional staff are available when unpredictable pressures occur.

Examples of Actions in Plan for 2015/16

- **We will request that "safe-base" arrangements are in place for the drunk and incapable during predictable festive celebrations.**
- **We have extended our festive planning to cover the first three weeks of January and to include the Festive Period Control Room (as used in winter 2014/15).**
- **We will ensure rotas for early January are staffed to reflect anticipated demand.**
- **We will review the capacity of our staff bank to ensure we have sufficient staff for times of extra demand.**
- **We will agree additional consultant cover on Saturdays and Sundays over the festive and post-festive period to support weekend discharges.**
- **We will staff the discharge lounge seven days a week over the festive and post festive period.**

As well as planning for the pressures of winter, NHS Forth Valley also work with our local population to promote initiatives that reduce ill health and ensure that individuals

know the best place to seek help. NHS Forth Valley will deliver an extensive communication plan in Autumn 2015 linked to the National “Be Health-Wise this Winter” campaign. This will cover a wide range of issues from supported self care, community pharmacy and dentistry services to promoting uptake of immunisation and the Stirling Minor Injuries Unit.

Each year the Scottish Government makes available additional funding to tackle anticipated winter pressures. This year the available funds are targeted at delayed discharges and unscheduled care as well as joint working with the new Integration Joint Boards. The plan sets out in detail how the additional funding will be used to supplement the existing measures in our annual financial plan.

1 Introduction

1.1 Background

NHS Forth Valley's management arrangements for all year round capacity and flow management, have been augmented to include winter resilience planning to deal with the additional pressures placed on services during the winter period. Consistent with Scottish Government guidance *"National Unscheduled Care Program: Preparing for Winter" (2015)* NHS Forth Valley has subsequently produced this Winter Plan for 2015-2016.

As with previous years during the winter period, it is expected that a number of pressures will be prevalent which will impact on NHS Forth Valley's ability to manage demand and capacity which includes:

- Increased demand for unscheduled care
- Higher rate of admissions to hospital
- More patients waiting to be discharged from hospital
- Decreased workforce resilience (festive holidays and sickness absence)
- Requirement to continue to meet Treatment Time Guarantees
- Need to provide additional health and social care capacity in acute hospital and community settings.

Health and social care integration also provides an opportunity to enhance service provision during the winter months and the role of Integrated Joint Boards (IJBs) will become increasingly important in this process.

1.2 Purpose and Scope

This plan focuses on the period from November 2015 to March 2016 highlighting particular detailed arrangements for the festive holiday periods in December and January. Furthermore the Winter Plan will be supported by daily reporting to the Scottish Government, Directorate for Health Workforce and Performance and internal daily reporting and performance management arrangements.

This plan represents a whole-system approach, incorporating local contingency plans and ensuring formal links with the plans of key stakeholders from the Local Authorities, Scottish Ambulance Service, NHS 24, the Third and Independent sectors (including Serco).

1.3 National Context

The Scottish Government requires all NHS Boards to address the following six areas in the Winter Plan:

1. Safe & effective admission / discharge continues in the lead-up to **and** over the festive period and also in to January
2. Workforce capacity plans & rotas for winter / festive period agreed by October
3. Whole system activity plans for winter: post festive surge

4. Strategies for additional winter beds and surge capacity
5. The risk of patients being delayed on their pathway is minimised
6. Discharges at weekend & bank holiday

Further guidance was published, along with additional non-recurrent winter funding, asking NHS Boards to target the following priorities:

- Enhanced Festive Period Staffing
- Increase Weekend Discharges by at least 25%
- Infrastructure to Support Optimum Transfer of Patient Care (between Wards and Departments and Home)

These additional priorities are expected to complement use of the 2015/16 £30m Delayed Discharge allocations by IJBs and HBs across Social, Primary and Hospital Care in Partnership to optimise winter resilience.

1.4 Governance

This Winter Plan has been developed as per national guidance through the work of a multi-agency local Winter Plan Steering Group and supported by the NHS Board Chief Executives Operational Group. Due to the timing of meetings, the NHS Board gave delegated authority to the Boards Performance and Resources Committee to formally approve the Winter Plan. The plan will also be endorsed by the local Integration Joint Boards for Forth Valley, Falkirk IJB and the Clackmannanshire and Stirling IJB.

The plan will be published on the NHS Board website after formal approval by the Performance and Resources Committee and submitted to Scottish Government by end October 2015.

1.5 Main Areas

The main areas covered in this plan are described in detail in the following sections:

- Lessons Learned from 2014 / 2015
- Analysis of Activity, Capacity and Demand
- Improving Service Delivery - Initiatives in Place and Actions for 2015/2016 (including improving discharge, preventing admissions, arrangements for the festive period, responding to surges in demand, GP Out of Hours)
- Managing the Impact of Infectious Diseases
- Resilience
- Communications
- Information Management and Performance Reporting
- Resources

The table below provides a summary of the main actions identified for implementation during 2015/16, grouped under three critical areas:

- Actions intended to either reduce emergency admissions or facilitate discharge
- Actions targeted specifically at the busy festive and post festive season periods

- Actions intended to prevent unpredictable surges in demand.

GP out of hours services are a critical element of the overall approach to managing winter pressures. NHS Forth Valley has a specific Out of Hours Plan, which covers the whole of winter.

Improving Service Delivery		
Preventing Admissions and Supporting Discharge	**Specific Arrangements for the Festive and Post-festive Period**	**Preventing and Responding to Surges in Demand**
Provide rapid response "Closer to Home" service in the community supporting individuals with higher needs to remain well at home.	Additional winter capacity beds (36) have been identified and will be made available January/ February. Falkirk Ward 5, Stirling Ward 1 and Stirling Ward 5.	Review Anticipatory Care Plans and ensure that these are targeted towards our most appropriate care groups.
Establish a 24/7 support line "Advice Line For You" (ALFY) for the public for those aged 65 and over.	Plan festive and post festive rotas to ensure sufficient staff are on duty to cope with anticipated periods of high demand.	Provide intensive support for our most vulnerable respiratory patients including self-management plans, specialist review and direct access to community pharmacy prescriptions.
Conduct 'Point of Care' audit two weekly based on NHS Borders model to identify and reduce the numbers of people who are inappropriately receiving their care in an NHS acute hospital setting.	Increase elective activity pre-festive period to enhance capacity to cope with post festive surge. Manage elective activity in the post festive surge to free capacity for unplanned activity whilst maintaining TTG.	Deliver an intensive pre-winter Norovirus awareness campaign and maintain intensive infection control arrangements as used successfully in previous years.
Review multi-agency input including SAS and social work to the daily hospital huddle in order to support earlier discharge.	We will ensure that the Frailty Clinic, piloted at FVRH, is available Monday to Friday during the predicted period of peak seasonal demand.	Deliver a comprehensive population wide seasonal influenza immunization campaign covering children, older adults, at risk groups and health and social care staff.
Review "discharge to assess" arrangements to promote early discharge and improve how services are delivered.	Extend availability of discharge lounge to provide a service that will open until 20:00 seven days a week during predicted peaks of demand.	Deliver relevant population immunization campaigns including Herpes Zoster, Pneumococcal pneumonia and the full range of vaccine preventable diseases.
Rollout criteria led discharge to empower front line staff in risk based decision making.	Additional Consultant cover at weekends over the festive and post festive period to support discharges and ensure appropriate patients are reviewed by a consultant every day.	Ensure appropriate access to community services including GP Out of Hours, extended access to GP over holidays, community pharmacy, community dental services etc.
Transport arrangements will be finalised to ensure patient discharge plans focus on the use of SAS, independent providers and the existing NHS fleet.	Provide admin support for production of Immediate Discharge Letter, pharmacy script and transport and directly employ Nursing Auxiliaries to support discharge especially food prep at home.	Prepare contingency plans for the temporary use of other clinical areas to accommodate unplanned and emergency care patients in extreme circumstances.
Deliver a comprehensive communication plan advising staff and the public about the arrangements for winter 2015/16		

2 Lessons Learned from 2014 / 2015

2.1 Health and Social Care: Winter in Scotland 2014/15

Scotland wide, lessons have been learned from winter 2014/2015 that we can draw upon for winter 2015/2016. In 2014/15 there were increases in activity and increasing demands on capacity within the NHS in Scotland due to increased rates of influenza and respiratory illness. These two factors impacted on the ability of local systems to meet targets for 4-hour discharge from our Emergency Departments, Delayed Discharge and Time to Treatment Guarantees. A summary of the main findings from 2014/15 is provided below:

- Measures were taken to strengthen capacity, by increasing the available workforce in line with expected demand, increasing acute medical beds temporarily, and making more intermediate care places available.

- There was a rise in calls to NHS24 (up 17 per cent on 2013/14), an increase in Scottish Ambulance Service Category A-C calls (up 3.8 per cent on 2013/14) and a higher rate of A&E presentations (up 0.5 per cent on 2013/14),

- Higher levels of cancelled elective activity impacted adversely on inpatient and day case treatment times.

- The highest number of hospital admissions as a result of respiratory illness in a decade (up 22.5 per cent on 2013/14).

- Substantial and prolonged increase in influenza admissions (with 2014/15 levels of the previous three years combined).

- Norovirus incidence was comparable with seasonal averages but less of a factor in terms of winter pressures during 2014/15.

- Delayed discharge bed days increased through Winter 2014/15 with December accounting for 55,000 days (up on around 40,000 in December 2012 and 45,000 in December 2013).

- While better in Scotland than in other areas of the UK, waiting times were significantly impacted in Winter 2014/15, particularly in January and February 2015. The impact was more severe than the previous two winters and the position was not recovered across Scotland until May 2015.

- Seasonal ‘flu” vaccination up-take by NHS staff improved on the previous year but remained below the target level of 50 per cent across Scotland.

2.2 Local Lessons Learned

Towards the end of November 2014 services in Forth Valley were experiencing higher levels of emergency activity than anticipated which resulted in the service coming under increasing pressure with insufficient capacity in the system to cope with demand. This was the experience across the whole of the UK at this time resulting in some NHS

systems evoking major contingency arrangements to cope with the increased demand resulting in the suspension of routine activity. The main issues were:

- The majority of actions in the Winter Plan 2014/15 were implemented in full. For the two, four day breaks activity was actually lower, apart from one day, than previous similar four day breaks. Services found the winter period challenging due to the sustained increase in activity experienced across the full 2014/15 winter.

- There were a significant number of breaches of the four hour A&E target indicating a need to improve patient flow in the system and ensure people ended up at the appropriate part of the system.

- Although influenza vaccination rates for staff in FV were typically above the Scottish average (preschool, carers and those over 65), recorded rates for staff (39%) and primary schoolchildren (62%) were lower.

- Additional inpatient contingency capacity in Falkirk Community Hospital (21 winter beds) was brought into use form 04 January 2015 and remained open for the rest of the winter.

- As winter issues became prolonged the following additional steps were introduced:
  - Third Sector capacity was increased for example Strathcarron Hospice agreed to relaxing their patient criteria making available additional inpatient and hospice at home capacity.
  - The specialist community nursing team for complex care extended its role to provide care packages to all patients during January 2015.
  - Additional staff were recruited from the community nurse bank.

- Additional communications plan activity highlighted access into the emergency care service and use of alternatives such as minor injuries services and use of NHS 24.

3 Analysis of Activity, Capacity and Demand

We have completed a detailed analysis of activity, capacity and demand across the care system in Forth Valley. This has allowed us to analyse the possible impact on care services and identify options for managing surges in demand across the festive period and potential increases in activity due to other issues, such as increases in respiratory illness or severe weather. The key findings are summarized below.

3.1 Demographic Change

We are anticipating annual rises in demand of almost 4% each year until 2020 based on the increase in attendances over the past 7 years. However there are differences in the actual annual rise in first attendances, with a range covering 0.3% to 5.8% from 2007 to 2014. Since 2013/14 to 2014/15 this rate of increase has been almost 3%.

3.2 Impact of Influenza and Respiratory Illness

Although the level of activity during the winter of 2014 was as anticipated, the impact of influenza and respiratory illness on the acuity of patients admitted was more marked than expected. The number of available beds to cope with this impact proved insufficient requiring planned contingency beds to be fully utilized.

In 2014/15, pressures from respiratory illness were the highest seen in the last ten years. Compared to the same period in 2013/14, there was a 22.5 per cent increase, with high levels sustained for many weeks. Provisional data for 2014/15 show an increase, compared with previous seasons, in number of hospital admissions with any diagnosis of influenza. The levels were sustained over many weeks in the January and February of the 2014/15 season and this is in contrast to the more pronounced peak, but less sustained activity, seen in 2010/11. The number of hospital admissions with any diagnosis of influenza in 2014/15, were higher than the previous three years combined.

3.3 Seasonal Variation and Impact of the Festive Break

The Festive period and in particular the post festive period are predictable “pinch-points” when service pressures may be at their greatest. This is particularly so in years when holidays are concentrated into two four day periods. This will be the case in winter 2015/16.

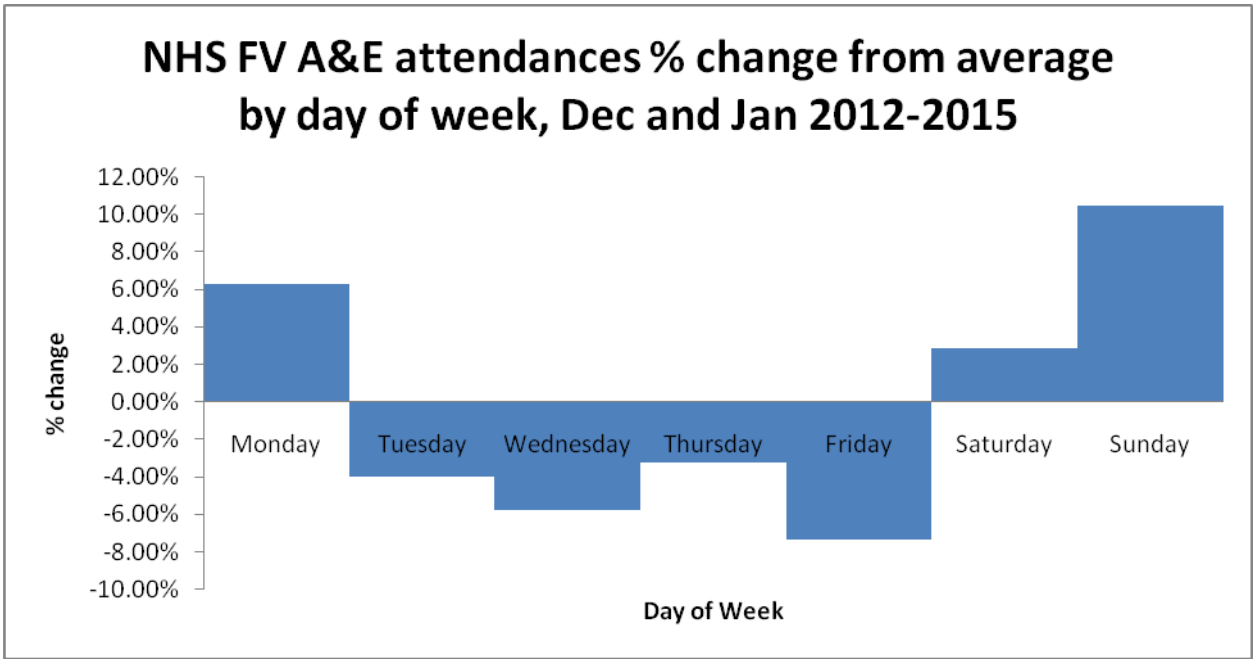
In order to plan effectively for capacity over the festive and post-festive it is important to have a good understanding of likely demand. Whilst levels of demand can appear to vary considerably from day to day the overall pattern of demand is fairly consistent with predictable maximum and minimum levels of attendances and admissions.

3.4 Actual Attendances at Accident & Emergency and Minor Injuries Unit

Although background demographics show an ageing and increasingly infirm population the actual level of hospital attendances at MIU and A&E over the past four years has remained stable and largely predictable.

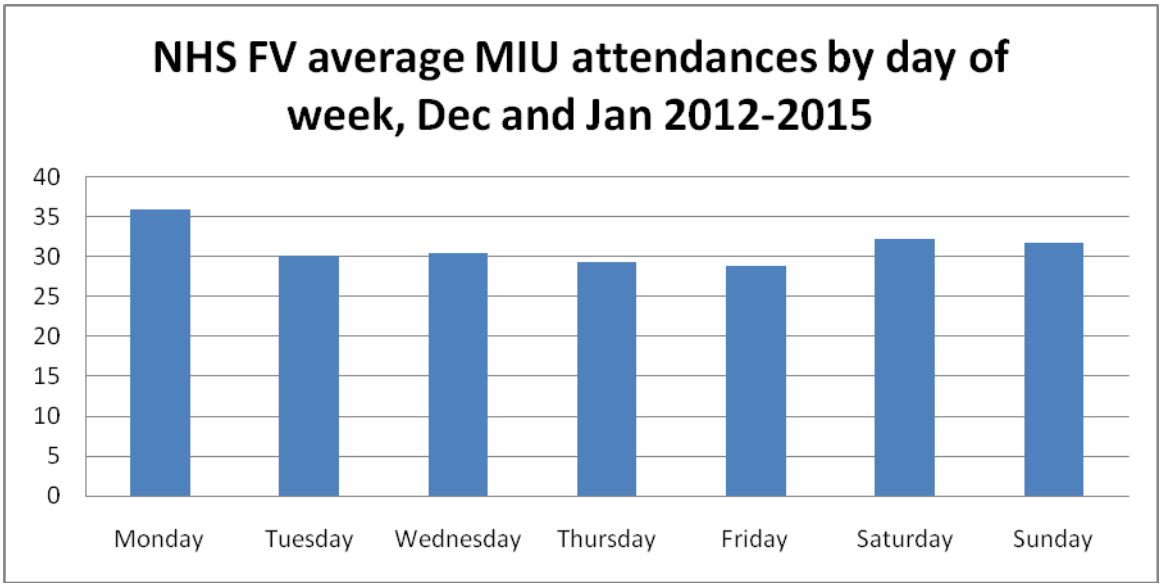
NHS FV Actual A&E and MIU attendances in January and December, 2011/12-2014/15				
Total in December and January	11589	11473	11468	11757
Average total per day	187	185	185	190
MIU Average per day	32	31	32	32
A&E Average per day	155	154	153	158

Within these data there is a clear weekly pattern allowing the prediction of the likely busy days. For both A&E and for MIU the historical data shows a similar pattern with peak demand on Mondays and at weekends although interestingly ED is busy on a Sunday whereas MIU is busiest on Mondays. The distribution of demand between A&E and MIU appears to remain fairly consistent with no clear trend to favour either service on any particular day.

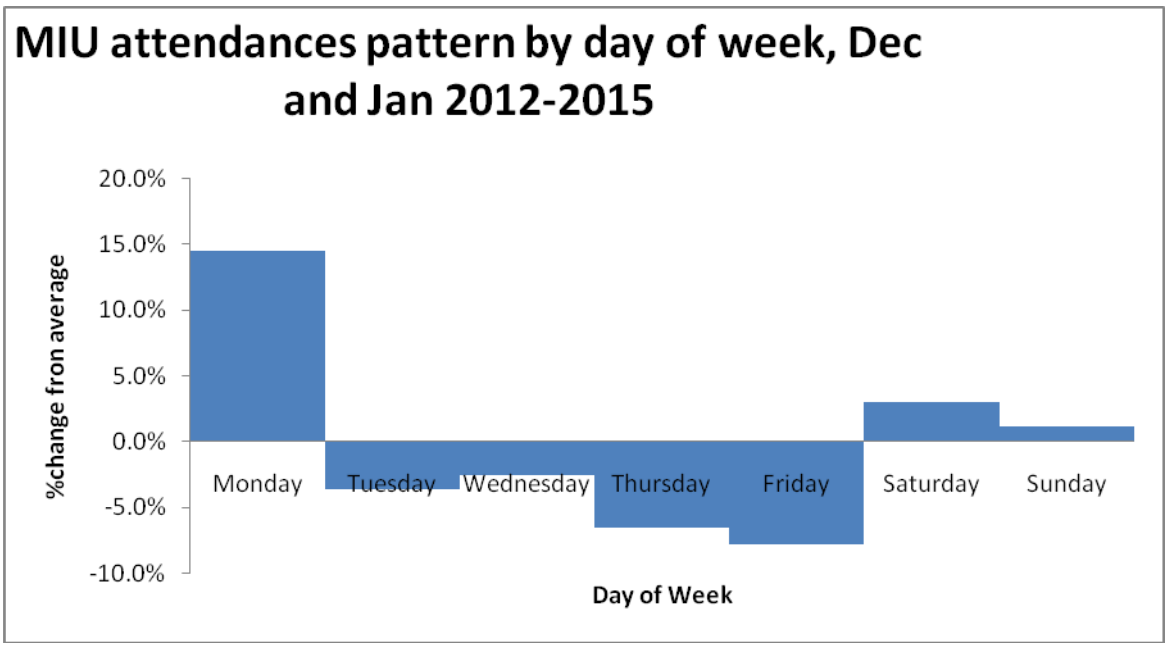


The average number of A&E attendances in December and January has remained fairly stable at 155 attendances per day although the actual numbers on any given day have varied considerably. January 01 is traditionally one of busiest days of the year for A&E. The highest level in the recorded data was 208 attendances on 01 January 2014 compared with 203 and 190 on the same days in 2013 and 2015 respectively. In 2015 there was an unusual peak of 207 attendances on January 3rd which would appear to reflect the timing of the holiday period that year. January 3rd 2015 was a Saturday immediately following two days of public holiday.

A very similar pattern can be seen in MIU attendances.



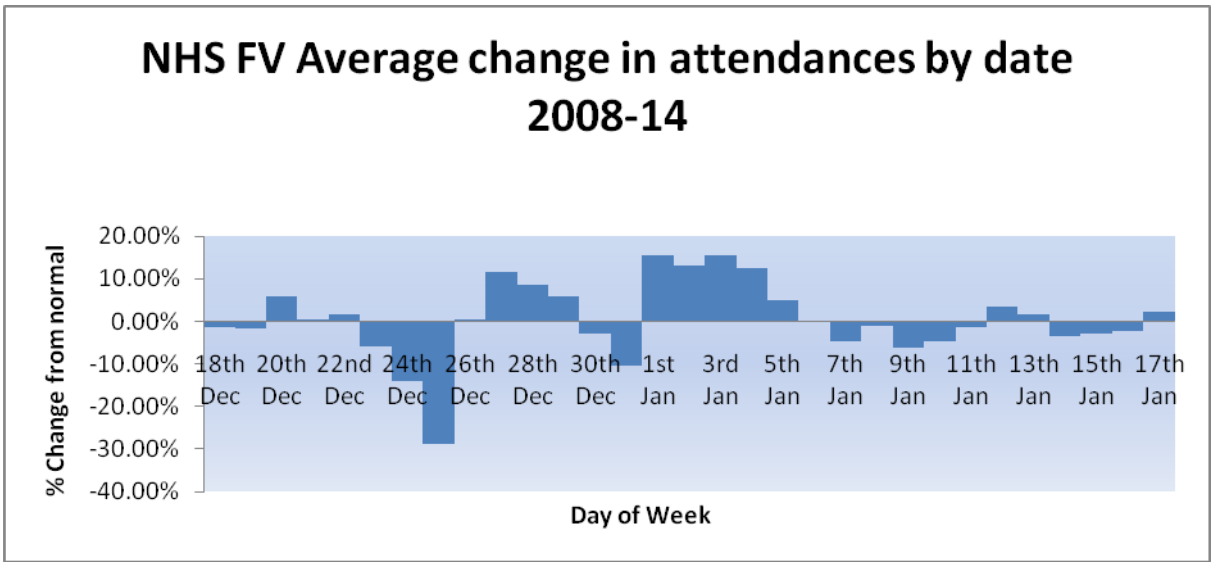
Although MIU attendances appear more stable with an average of 32 per day, for MIU Monday is clearly the peak of demand.



Both Christmas Day and Hogmanay tend to be the quietest days of the year in both MIU and A&E. For MIU, attendances have fallen to single figures on Christmas Day in each of the last two years although in these years Christmas was a Thursday and a Wednesday.

For A&E any number of attendances below 130 would be seen as unusually quiet with the lowest recorded numbers in the last four years being 112 on Hogmanay 2014 and both Christmas Eve and Christmas Day 2013 with 113 attendances each day.

By analysing both the typical variance from normal on each of the public holidays and other traditionally busy days over the festive period and combining these data with the analysis of typical activity by days of the week, it is possible to build a likely picture of the pattern of future demand. Whilst such a planning model cannot exclude unforeseen events such as a major outbreak or an infrastructure failure, it does assist with identifying predictable peaks of demand.



By combining the known pattern of demand by days of the week (Monday, Tuesday etc.) with the usual increase or decrease on typical holidays and events over the festive period a model can be built to give a predicted total number of attendances across the festive and post festive period.

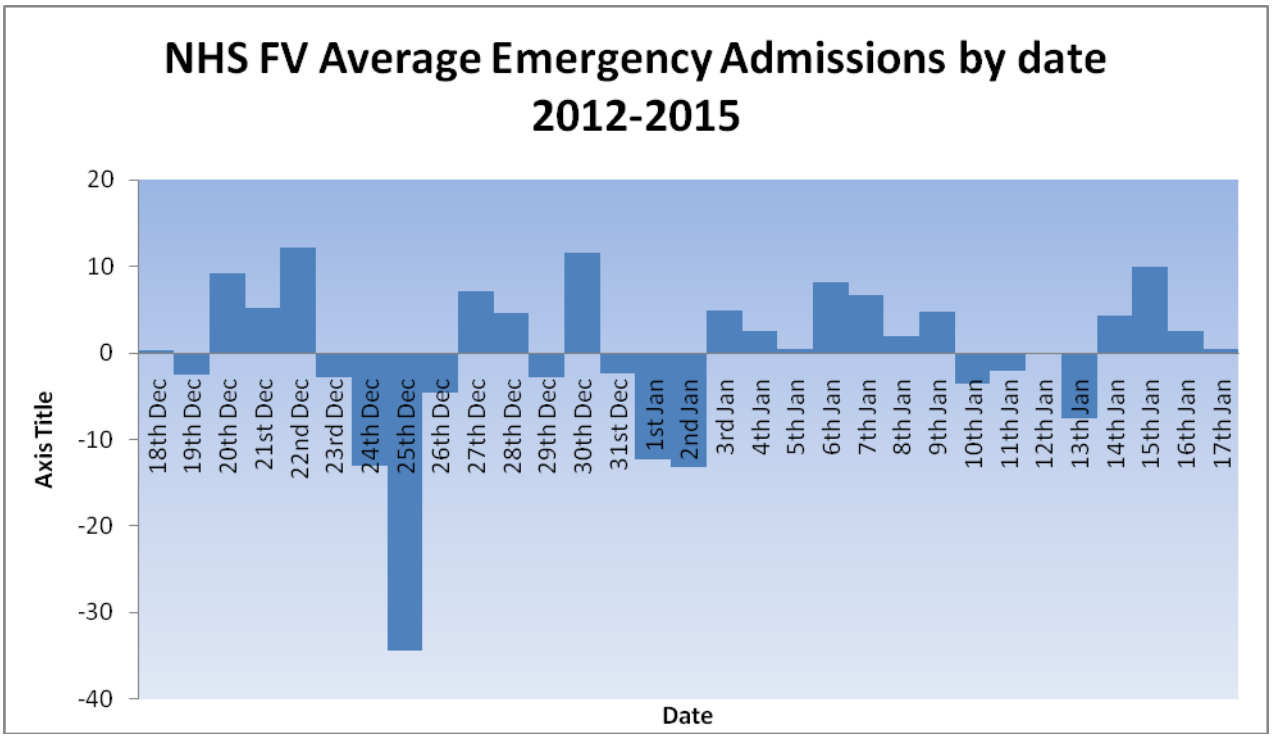
In line with national analysis, data available for the Forth Valley area shows that there is typically a “post-festive” period surge in activity for emergency care and admissions.

3.5 Emergency Admissions Data.

By analysing data over the past three years it is possible to predict the typical weekly pattern of emergency admissions in January and December. The average daily emergency admissions in January and December from 2012-2015 were as follows: -

All Emergency Admissions	
Day of week	Daily Average
Mondays	102
Tuesdays	82
Wednesdays	87
Thursdays	89
Fridays	96
Saturdays	69
Sundays	69
Total	85

From analysis of the data over the past three years, it is also possible to establish the typical pattern of emergency admissions over the festive and post festive periods. By, comparing the actual number of admissions with the expected number for that day of the week it is possible to chart the expected impact of festive holidays occurring on any particular day of the week. The following chart uses historical data to show how emergency admissions have varied above or below expected levels for each day of the festive and post festive period over the past three years.



By combining the historical data on admissions by date above with the data on predicted nember of emergency admissions by day of the week a prediction model can by constructed to plan for peaks in demand around the festive period.

4 Improving Service Delivery - Initiatives in Place and Actions for 2015/2016

This section of the Forth Valley Winter Plan presents the main focus of winter planning for 2015/16 and also indicates how *DL (2015) 20 National Unscheduled Care Programme: Preparing for Winter 2015/16* guidance from the Scottish Government will be addressed.

The key actions identified, will be delivered by health and social care services working in partnership and will involve close collaboration with the Scottish Ambulance Service, NHS 24, Social Work services and the Third and Independent sectors. The actions are summarised under the following areas of activity:

- *Preventing admissions and supporting discharge*
- *Specific arrangements for the festive period*
- *Preventing and responding to surges in demand*
- *Specific arrangements for GP Out of Hours*

4.1 Preventing Admissions and supporting discharge

If we maintain admission and discharge rates at normal levels over Christmas and New Year we reduce the potential for post-festive pressures. These pressures are particularly acute in the immediate post-festive period due to the combination of increased emergency demand, restarting elective activity and clearing any post-festive backlog. The main areas that have been identified for improvement are:

- The risk of patients being delayed on their pathway is minimised
- Discharges at weekend & bank holiday
- Shift of Care to Community and Primary Care Settings
- Safe & effective admission/discharge continues in the lead-up to and over the festive period and also in to January

4.1.1 The risk of patients being delayed on their pathway is minimised

Reducing patients delayed in their discharge from hospital is a key priority for the Scottish Government. Reducing delays not only helps patients who benefit from getting home or to a more appropriate, more homely setting as soon as possible, it is also essential to maintain flow through the hospital system.

In June 2015, 45,356 NHS Scotland bed days were occupied by patients delayed in their discharge. In Winter 2014, there were 27% more Delayed Discharge patients than in 2013.

Actions for 2015/16

- **A 'Point of Care' audit will be conducted every two weeks, based on NHS Borders' model, to identify and reduce the numbers of people who are inappropriately receiving their care in an acute hospital setting to ensure that every person is in the most appropriate place of care.**
- **Review multiagency input, including SAS and Social Work, into the daily**

hospital 'Huddle'.

- **Increase the fortnightly Delayed Discharge tactical group meetings to weekly over the winter period and escalate to a daily discharge huddle when required.**
- **Additional Ward rounds will be in place in evenings and at weekends.**
- **Any patients over 2 week LOS have will have an action plan agreed with an appropriate member of senior staff.**
- **Additional senior input will be provided to individuals with a hospital LOS over 4 weeks as case management team develops.**
- **All partners have in place plans for predictable activity levels over festive period (to avoid delayed discharges developing) and enhanced activity levels through January 2016.**
- **The Choice Policy (step 1, step 2, step 3) will be reviewed and an action plan implemented to ensure that patients are cared for in the most appropriate place of care.**
- **Transport arrangements will be finalised to ensure patients discharge plans focus on use of SAS, independent providers and the use of existing NHS FV transport fleet.**
- **We will complete a review of Discharge Hub arrangements and make any necessary changes to improve the efficient operation of the Hub.**
- **'Discharge to Assess' arrangements will be reviewed to promote early discharge and improve how the service is delivered.**
- **Refresh the clinically sensitive discharge target by ward, matching predicted demand. This will be used to monitor performance at the morning and afternoon huddles, 7 days a week**.
- **We will ensure roll out of criteria led discharge to empower front-line staff in risk based decision making.**

4.1.2 Discharges at weekends & bank holidays

The Scottish Government has set a target of increasing weekend discharges by 25%. If weekend and early week (including Bank Holiday) discharge rates can be increased crowding and backlogs can be greatly reduced. Data clearly shows predictable drops in discharge rates at weekends which do not reflect patient need.

Actions for 2015/16

- **AHP staffing has been augmented at weekends in both acute and community to increase the number of weekend discharges.**
- **We will provide a rapid response "Closer to Home" (C2H) service in community to facilitate earlier discharges.**
- **Enhanced weekend cover will extend the Discharge Lounge opening hours, enhance OT cover through the REACH service and provide Community Nursing and additional carers via the C2H approach.**
- **We will agree additional Consultant cover at weekends over the festive and post festive period both to support weekend discharges and to ensure a consultant review can be provided every day for all appropriate patients.**
- **We will develop a plan to implement and monitor criteria led discharge across FV to increase levels of discharges at weekends.**

- **We will review the provision of radiology services at weekends to identify and reduce avoidable delays.**
- **Weekend pharmacy services help to facilitate weekend discharges, including the out of hours on-call pharmacy service.**
- **We will develop a plan to implement and monitor criteria-led discharge across Forth Valley, which will also help us to increase weekend discharges.**
- **We will develop a plan to operate the Discharge Lounge at FVRH until 8:00pm, seven days per week over the festive and post festive period.**
- **Additional local authority short stay assessment beds in Falkirk (14 beds) and in rural Stirlingshire (five beds) are being commissioned for contingency purposes.**

4.1.3 Shift of Care to Community and Primary Care Settings

As part of NHS FV Clinical Services Review, national and international best practice was considered. A key conclusion was that many patients would clearly benefit from an NHS and Social Care System that provides the right care, in the right place, at the right time. For many patients, especially the elderly and infirm, the Acute Hospital is not always the best option and should only be used when absolutly required.

Actions for 2015/16

- **Establish a 24/7 support line for the public for those aged 65 and over (Advice Line For You).**
- **Review the potential to implement a 24/7 co-ordination point for professionals (GPs, SAS, social care etc) to find co-ordinated support for/actions required to help individuals remain well at home.**
- **In conjunction with ALFY establish an enhanced community team "Closer to Home"(C2H) supporting individuals with higher needs in a co-ordinated way to remain well at home, minimising social crisis and reducing avoidable ED attendance and hospital admission.**
- **C2H Team will follow up vulnerable clients post ED attendance and discharge (those over 65 with a SPARRA risk score >40%).**
- **We will develop and introduce an integrated approach to "un-injured fallers" in partnership with SAS and the C2H Team.**
- **Community Pharmaceutical Services will support service delivery over the winter and specifically the festive and post-festive period:**
  - **Community pharmacy will provide 'Unscheduled Care Patient Group Directive (repeat medication)' provision of emergency hormonal contraception and opiate replacement therapy and;**
  - **provide advice and treatment via the Minor Ailments Service and;**
  - **palliative care services through a network of community pharmacies that provide advice and hold specific medicines and**
  - **support exacerbations of COPD via the PGD for provision of appropriate medication.**
- **A 'Pharmacy First' service in community pharmacies will encourage patients to attend community pharmacy first for treatment and advice for common clinical conditions.**

- **We will review Anticipatory Care Plans and ensure that these are targeted towards our most appropriate care groups.**
- **We will review historical requirements for packages of care and plan with local partners for predicted demand.**
- **We will ensure capacity for discharge to District Nursing and Reach Team is maintained over the festive period and through January 2016.**

4.2 Specific Arrangements for the Festive Period

We have focused our festive period activity on addressing the issues identified earlier in this plan and Scottish Government Winter Planning Guidance. The intention is to build on work already underway in the move towards developing seven day working for critical services. The areas in this section include:

- Workforce capacity plans & rotas for winter/festive period.
- Safe & effective admission/discharge continues in the lead-up to and over the festive period and also in to January

4.2.1 Workforce capacity plans & rotas for Winter and the Festive Period

It is possible to predict levels of festive and post-festive demand based on previous experience. It is also possible to plan appropriate staffing levels. Agreeing rotas and staffing levels early increases the time available to recruit and train additional staff if required. We expect that workforce capacity plans & rotas for winter/festive period will be agreed and in place by end October 2015.

Actions for 2015/16

- **Each clinical and social care service including the Scottish Ambulance Service, Third Sector and Independent Sectors will have staffing plans in place, including rotas, by end of October 2015 to ensure appropriate capacity over the festive period and during January and February 2016.**
- **We will ensure that our Estates and Facilities staff and SERCO our soft FM partner have adequate staffing in place and robust and rehearsed escalation plans in place to meet demand.**
- **We have reviewed arrangements in Community Hospitals to ensure every bed can provide a level of rehabilitation. "Every bed is a rehab bed".**
- **Both hospital and community pharmacy plans are in place for provision of services over the winter period. All services open as normal except on the public holidays when provision is made for limited access only. Exceptions to normal opening times will be notified to the public during our winter communications campaign.**
- **Community Pharmacy opening on public holidays will be notified to partners (Out of Hours, NHS 24, Substance misuse service etc.) via the Primary Care Contracts Team and corporate communications.**
- **Community dental services will be provided over the festive period and details will be circulated via corporate communications.**

- **Review the capacity of the staff bank against the known and likely demands and recruit additional staff as necessary to staff planned contingency beds and address any gaps (including highly specialist areas such as ED, ITU and Theatres).**

4.2.2 Safe & effective admissions/discharges continue in the lead-up to and over the Festive Period and also in to January

Actions for 2015/16

- **Safety briefings take place daily at 08.30 am.**
- **Daily huddles are in place to consider the impact of patient needs, staff needs, bed capacity and safety issues. All wards and departments are represented.**
- **We will introduce a structured system for early warning and escalation at FVRH (as used at Hairmyres Hospital).**
- **Daily discharge meetings are in place.**
- **We will introduce an escalation plan which includes the the use action cards to clearly define, share and educate appropriate staff about the key staff roles involved in flow management (across consultants, charge nurses, lead person on each ward, flow co-ordinators etc).**
- **We have extended our festive planning to cover the first three weeks of January to include the Festive Period Control Room as used successfully in winter 2015.**
- **Within the acute sector, pharmacy department opening information and service levels will be provided directly to wards and clinics in the lead up to the festive period.**
- **We will maintain discharge rates over festive period at normal levels and enhance staffing levels in the post-festive period to manage predictably high demand.**
- **We will plan for discharges to take place early in the working day and aim for at least 40% discharges in place by midday.**
- **We will ensure roll out of criteria led discharge to empower front-line staff in risk based decision making.**

4.3 Preventing and responding to surges in demand

It is possible to predict levels of festive and post-festive demand based on previous experience. It is therefore possible to predict required levels of care packages, ambulance transfers, nursing home placements, social work assessments etc. in the post-festive surge period and all year round. The main areas covered are:

- Actions to enhance elective capacity
- Strategies for additional winter beds and surge capacity

4.3.1 Actions to enhance elective capacity

Actions for 2015/16

- **Elective activity will be profiled over the winter to minimise the risk of TTG breaches during the festive and post festive period.**
- **Elective services will focus on day cases, urgent cancer and urgent inpatient activity during the first two weeks in January 2016.**
- **We will ensure that the Frailty Clinic, piloted at FVRH, is available Monday to Friday during the predicted period of peak seasonal demand.**
- **All partners have in place plans for predicatable activity levels over festive period (to avoid backlog developing) and enhanced activity levels through January 2016.**
- **Increase the fortnightly Delayed Discharge tactical group meetings to weekly over the winter period and escalate to a daily discharge huddle when required.**
- **Information management systems are being developed to monitor and predict activity (See Section 7)**

4.3.2 Strategies for additional winter beds and surge capacity

Whilst it is possible to predict patterns of activity it is also important to have access to additional contingency capacity should this be required due to unpredictable or unforeseen circumstance such as outbreaks, fire or flood.

Actions for 2015/16

- **Ensure planned additional winter capacity beds (36) are available from early January 2016.**
- **We have identified additional capacity needed to reduce waiting times in preparation for the post festive surge.**
- **We will ensure rotas for early January are staffed to reflect anticipated demand and will balance staff leave appropriately.**
- **Additional local authority short stay assessment beds in Falkirk (14 beds) and in rural Stirlingshire (five beds) are being commissioned for contingency purposes. These contingency beds will offer step-up and step-down options.**
- **We will work with Strathcarron Hospice to increase the availability of hospice and hospice at home services as successfully achieved in 2014/15.**
- **We will ensure that additional clinical capacity used in winter 2014/15 is fully staffed from mid December until the end of February 2016.**
- **We will have simple boarding criteria in place to minimise boarding and especially transfers at night.**
- **Provide admin support for production of Immediate Discharge Letter,**

pharmacy script and transport and directly employ Nursing Auxiliaries to support discharge especially food prep at home.

4.4 Specific Arrangements for GP Out of Hours

GP Out of Hours Services are a critical element in the overall approach to managing winter demand pressures. We have considered the preliminary recommendations from Professor Lewis Ritchie's Review. We will have a GP OOHs plan that covers the whole winter period (with particular emphasis on the festive period and January).

Actions for 2015/16

- **We will work to ensure that all GP Out of Hours rotas are fully staffed.**
- **We have reviewed demand and capacity models and developed a service staffing plan (medical, nursing and ancillary staff), which covers the pre festive, festive and post festive period. A structured plan for escalation is also in place for short notice GP rota gaps.**
- **We have reinforced existing protocols between services (MIU, ED, mental health).**
- **We will support professional to professional referral (including working closely with SAS).**
- **Pharmacist support and pharmacist access to doctors for professional to professional advice are available.**
- **Promote the use of the palliative care line.**
- **Work with local primary care teams will increase the times that patients can directly access primary care.**
- **We have ensured primary care has a pro-active approach to supporting vulnerable patients through anticipatory care plans and will conduct planned visits to vulnerable patients over the festive period.**
- **We will deliver a communications plan, which highlights the availability of and appropriate use of services.**
- **The OOH plan refers to both NHS24 communication plan and sharing of information through NHS 24/ OOH National Operational meeting.**
- **Business continuity plans are in place for other potential issues with the Out of Hours service e.g. IT and telephony.**

5 Managing the Impact of Infectious Diseases

The impact of influenza and respiratory illness had a major impact on the delivery of care services in Forth Valley and across the whole of Scotland during the winter of 2014/15. As well as these two areas of action highlighted by the Scottish Government there is a continued emphasis on the potential impact of Norovirus and the contribution of infection control in maintaining service provision during the winter months.

We have been asked, over the past year to

- Review our infection control procedures in line with the outcomes from the Vale of Leven report.
- Update our influenza plans and processes as part of a national review process which is due to be completed in November.
- Deliver a comprehensive and expanded vaccination programme, including influenza.
- Ensure that our care arrangements for managing respiratory illness are effective.

The following areas describe how we will manage these issues in Forth Valley:

- Managing Norovirus
- Seasonal Flu
- Respiratory Care

5.1 Managing Norovirus

NHS Forth Valley has extensive infection control arrangements in place, which have been reviewed following the publication of the Vale of Leven report. There have been no significant changes from the Health Protection Scotland (HPS) guidance published in 2014. We recognise that ward closures would have a major impact across the service. Therefore, a range of well-tested actions are already in place, including:

- All patients with symptoms of diarrhoea and vomiting are isolated promptly and reviewed by the Infection Prevention & Control Team.
- An Integrated Care Pathway for Enteric Illness including Clostridium Difficile is available to ensure all patients with symptoms of diarrhoea and vomiting are managed appropriately.
- There is a robust ward / clinical area visit programme for the Infection Prevention & Control Team (IPCT) to ensure that the IPCT are available for all staff.
- Folders are in place in all wards providing Infection Control Information.
- Information providing useful Infection Control Information is provided on the intranet to all staff.
- The IPCT are involved in the daily hospital safety brief
- An on call doctor (microbiologist) is available 24/7 for IPCT advice.
- Systems in place for a holding statement/ advice for a norovirus outbreak.
- Closely monitored hand hygiene measures are in place for all visitors to wards and clinical areas.

Actions for 2015/16

- **An annual norovirus prevention campaign for staff and public is underway alongside the seasonal flu awareness campaign as in 2014.**
- **IPCT are involved in daily hospital safety brief.**
- **The Weekly point prevalence for norovirus is circulated to key stakeholders during outbreak season.**
- **Infection Prevention & Control Nurses will be available 3rd & 4th January 2016 for telephone advice via the on-call microbiologist.**
- **NHS Forth Valley will use HPS debrief tools in the event of any outbreak.**
- **During incidents / outbreaks of norovirus within NHS Forth Valley Hospital settings, the IPCT will communicate closely with Public Health team.**
- **IPCT will ensure the regular norovirus information tweets from Health Protection Scotland are re-tweeted.**
- **Outbreak Folders and relevant material will be distributed to clinical areas around week 37 when the 'month to go' alert comes out.**
- **A new quick reference guide for alert organisms and conditions will be placed in the outbreak folder.**
- **Following a local pilot, our outbreak guides use quick reference pictures and pictograms to assist staff in speedily following correct procedures.**

5.2 Seasonal Flu

We have recently reviewed our Pandemic Influenza planning processes in conjunction with our East of Scotland Resilience Partners. We are updating our local plans and process based on the outcomes from Exercise Silver Swan held on 1 September 2015.

NHS Forth Valley has consistently performed well in terms of vaccination rates for identified groups in national guidance. Given the expectation that NHS FV is expected to deliver a significant increase in vaccinations for a range of conditions, we have invested in the establishment of an immunisation team.

Actions for 2015/2016

- **Implement Seasonal Flu Vaccination program for all identified groups.**
- **Participate in the national Pandemic Influenza Exercise Silver Swan, Health and Social Care Event and the Excess Death Event.**
- **Review and update our Pandemic Influenza plans and processes based on the outcomes from exercise Silver Swan, Excess Deaths and incident leads session.**
- **All GPs within Forth Valley have signed up to the DES to deliver the Seasonal flu program to over 65s those in 'at risk' groups and pre-school children.**
- **A new Immunisation Team will deliver the seasonal flu vaccine to Primary School aged children.**
- **The new Immunisation Team will be available to provide targeted vaccination sessions to Care Homes or other high risk settings if required.**

- **Undertake a trial to increase accessibility of the Flu vaccine to staff within departments in FVRH.**
- **Aim for at least 50% of NHS Forth Valley staff to be vaccinated for Flu.**
- **Encourage all health and social care staff to be vaccinated for Flu.**
- **Antiviral prescribing will be recommended on advice from Chief Medical Officer**
- **HPS weekly updates are widely circulated within NHS Forth Valley.**

5.3 Respiratory Care

NHS FV has a well-developed Respiratory MCN with a lead clinical and nurse who provide a focus for local developments. Respiratory Nurse Specialists, based in FVRH, provide an early supported discharge service for patients having an exacerbation of COPD and an outreach service to prevent a hospital admission. The criteria for referral to this service are included in the COPD guidelines, which are published on the intranet. Monitoring arrangements are already in place to monitor the impact on the cohort of people with respiratory conditions (to include ED attendance, emergency admission or re-admission and LOS).

Actions for 2015/16

- **Respiratory pathway guidelines are under review.**
- **The service is provided Mon-Fri and during winter months with additional weekend cover when required including festive and post festive period.**
- **Patients with COPD or asthma have a written self-management plan and relevant patients have a hand held record, which allows them access to pharmacy out of hours to be provided with steroids/ antibiotics.**
- **Patients have an Anticipatory Care Plan on KIS/EDIS/Clinical Portal Alerts.**
- **All members of the Respiratory Team give COPD education and advice.**
- **Prevention posters will be available in Primary Care. We will link in with National Advertising Campaigns.**
- **Respiratory Nurse Specialists see all respiratory patients admitted to hospital. Discharge checklists are used for people with COPD and Asthma.**
- **All Asthma patients with a presentation to ED are notified to the Respiratory Nurse Specialists and appropriate follow up arrangements are made as per National Review Asthma Death guidance.**
- **Patients with severe COPD known to the respiratory team have access to community palliative services for specialist palliative care and are involved in completing anticipatory care plans with patients, specifically discussing ceilings of care, Non – Invasive**

Ventilation (NIV) and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR).

- **Patients with end stage COPD are visited regularly at home by the respiratory specialist nurses and a case management approach taken.**
- **All patients identified as at risk of CO2 retention are given an Oxygen Alert Card to guide emergency administration of oxygen. The ambulance service has an electronic list of all patients holding a CO2 retention alert card.**
- **The NHS Forth Valley NIV guideline available on the intranet also gives direct advice on managing Acute and Chronic Respiratory Failure with decompensation (raised CO2 and acidosis).**

6 Resilience

NHS Forth Valley and our local partners have a range of plans in place for dealing with surges in demand and subsequent impact on capacity throughout the system. However, one of the main learning points from last year's unprecedented levels of activity was that previous exercise programmes had not taken these potential levels of into account.

The following plans are in existence for dealing with major disruption to service provision:

- Managing Flow and Capacity in Emergency Department & Internal Escalation Plan
- NHS Forth Valley Pandemic Influenza Plan
- Major Infrastructure and Service Failure Plans
- Severe Weather Plan
- Service Business Continuity Plans

These plans include details of critical service provision, staff, equipment and services that can be temporarily suspended to allow resources to be targeted to essential areas. We also have a number of multiagency continuity plans in existence with our local Forth Valley Local Resilience Partners (FVLRP) including:

- FVLRP Response and Escalation Plans (Contingency, Severe Weather etc.)
- Pandemic Influenza Response Arrangements
- Third Sector - Single Point of Contact
- Festive Period Plans which focus on requirements of major events around Christmas and New Year.

The guidance this year has identified that escalation plans and business continuity arrangements should be tested with partners. The expected outcomes from this approach are:

- *The Board has business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather.*

We also intend to model the impact on capacity and flow throughout the whole system and identify solutions to address surge and capacity issues on a multi-agency basis.

In extremis (Actions taken as per Businees Continuity Plan):

- **We have identified additional contingency measures to maintain services in the short term should these be required "in-extremis." For example, extened expanded use of existing clincial areas and in extreme circumstances suspension of non essential activity.**

Actions for 2015/16

- **We have reviewed our surge and capacity arrangements based on the outcomes from our Local Winter Planning Exercise held on 9th October 2015 and identified further actions, on a multiagency basis, to address winter pressures.**
- **We will review and develop our pandemic influenza planning and support mechanisms based on the out comes from Exercise Silver Swan – to take account of outcomes following national session scheduled for 12 November.**
- **With the LRP we are developing a more integrated approach for escalation of service response across the whole care system.**
- **We regularly review the effectiveness of resilience plans and response arrangements for the winter of 2015/2016.**
- **We will ensure that Serco has a robust and well rehearsed escalation plan in place for FVRH.**
- **We will ensure that the NHS Forth Valley Estates and Facilities Department has a robust and well rehearsed escalation plan in place including measures to support primary care and community services.**
- **The FVLRP group will implement a work program to ensure multiagency processes in place.**
- **We will liaise with the Emergency Planning Officers across Falkirk, Stirling and Clackmannanshire to request that "safe bases" are established for the drunk and incapable during the organised festive celebrations.**

7 Communications

A wide range of communications activities will be undertaken to provide advice and information to local people across Forth Valley on how to stay well this winter and highlight the range of services and support available. This will include specific work to promote local alternatives to A&E such as the Minor Injuries Unit at Stirling Community Hospital and community pharmacies as well as guidance on health services available over the festive period.

We will use all existing internal and external channels to provide targeted winter health messages, information and advice and additional work will be undertaken with local partners, including local councils, to reach as wide an audience as possible. Social media will be used extensively to provide relevant information and updates alongside a new local awareness campaign using local radio and outdoor advertising.

Promotional material will be distributed to a wide range of locations across Forth Valley including local libraries, health centres, churches and leisure centres. Information will also be shared with key stakeholders such as GPs, community councils and NHS staff to update them on local plans and ensure they are able to direct local patients to the most appropriate service throughout the winter period.

Key aims:

- Ensure the general public are aware of local health service arrangements and throughout the winter period, including the festive public holidays, and know where to turn to for health service information and advice

- Increase awareness of alternatives to the Emergency Department for minor, non-urgent illnesses and injuries and encourage local people to make use of local MIU, GP, and pharmacy services

- Raise awareness of the 2015/16 flu campaign which includes children aged between 2 and 11 years of age, and encourage local people in the eligible groups to take up the offer of a free flu vaccination

- Ensure national winter campaigns, key messages and services (including NHS 24 and NHS Inform) are effectively promoted across Forth Valley and supported by relevant local information and advice

- Ensure staff and independent contractors are informed about preparations for winter including arrangements for staff flu vaccinations, local winter planning, staffing and contingency arrangements and winter

- Effectively manage the response to increased media interest over the winter period and provide reassurance that appropriate plans and contingency arrangements are in place to manage demand throughout the winter period

A high profile awareness campaign will be undertaken to provide advice and information to local people across Forth Valley on how to stay well this winter and highlight the range of services and support available. This will include a wide range of actions to promote local alternatives to A&E such as the Minor Injuries Unit at Stirling Community Hospital and community pharmacies as well as information and advice on where to turn to for health services and support over the festive period.

Actions for 2015/16

- **Existing internal and external communication channels will provide targeted winter health messages, information and advice and additional work will be undertaken with local partners, including local councils, to reach as wide an audience as possible. Social media, online communications and video clips will be used throughout the period to promote local services and provide details of local healthcare professionals who can provide treatment and support.**

- **A new local awareness campaign using local radio and outdoor advertising will promote the MIU and encourage people from across Forth Valley to make use of this facility during the festive break and throughout the winter period.**

- **A dedicated communication plan will support the roll-out of the ALFY nursing support line across Forth Valley from the beginning of December 2015.**

- **A Local radio advertising campaign in run up to festive period will highlight alternatives to the Emergency Department.**

- **Ongoing use of social media, online communications and video clips will promote local services and provide details of local healthcare professionals who can provide treatment and support.**

- **The distribution of new promotional material to healthcare and other facilities including local libraries, churches and leisure centres will encourage greater use of the MIU by local people across Forth Valley.**

- **Information will be shared with key stakeholders such as GPs, community councils and NHS staff to update them on local plans and ensure they are able to direct local patients to the most appropriate services throughout the winter period.**

- **A new high-profile Winter Zone will be created on the NHS Forth Valley website with links to relevant national and local information and advice, including winter advice issued by local councils, voluntary organisations, and Police Scotland. Reciprocal links will be arranged with partner agencies.**

- **We will work with NHS 24 to link in with the national 'Be Health-Wise This Winter' campaign. This will**
  - **Ensure national campaign resources and messages are cascaded locally across NHS Forth Valley internally and externally;**
  - **Tailor and amend national messages to tie in with local Forth Valley arrangements and priorities;**
  - **Arrange local 'Be Health-Wise This Winter' launch to tie in with national launch in November 2015.**

- **We will provide customised features articles in local council newspapers with advice and information on how to keep well over the winter period and details of local services and alternatives to A&E – these will be distributed to all homes across the Falkirk and Clackmannanshire Council areas.**

- **We will provide media briefings and interviews with key NHS spokespeople.**

- **There will be feature articles and public information in the winter issue of NHS Forth Valley community health news.**

- **We will provide information on TV screens at Forth Valley Royal Hospital, council owned information screens and the Wall of Wellbeing, which will be projected onto the wall outside Forth Valley Royal Hospital.**

- **A major flu vaccination campaign will see 24,000 primary school pupils across Forth Valley invited for vaccination between September and December 2015 (local media, promotional resources, social media and direct communication with parents).**

- **Local PR will support the yearly HPS national norovirus campaign, which aims to encourage visitors who are unwell to stay away from hospital to help prevent D&V outbreaks.**

- **Our Communications plan will include education and support for the public to encourage self directed planning to help individuals and their families to be more prepared –the aim of this service is to provide support and signposting to help people to remain well at home where ever possible.**

8 Resources

The majority of resources to support services over the winter period are based on existing arrangements including core service funding augmented by elements of national funding such as Delayed Discharge, LUCAP (Local Unscheduled Care Action Plan) and Integrated Care Funds.

In early October 2016, SGHD confirmed NHS Forth Valley would receive £0.318m additional funding for winter 2015. Funds of £0.628m had already been approved in the local Financial Plan providing total additional resources of £0.946m.

These resources are planned to be utilised as follows:

Description	£'m
Workforce Capacity	**0.038**
Improving Discharges	**0.111**
Enhance Elective Capacity	**0.135**
Additional Winter Beds	**0.458**
Funds retained for contingency/ unforeseen events	**0.200**
Communications	**0.004**
Total	**0.946**

9 Information Management and Performance Reporting

High quality management information is a core part of winter planning to ensure effective analysis, provide the ability to monitor winter capacity, identify and predict activity pressures and manage overall performance. Performance Management is also a critical component of the Winter Plan in order to ensure that our efforts are clearly targeted and that the intended outcomes are achieved. Delivery of the Winter Plan will be overseen by the Chief Executive's weekly Operational Management Group and the Corporate Management Team, reporting upwards to the Performance and Resources Committee and the Board.

In addition to the routine reporting regime in place, a suite of indicators against each measurable action is being created cross linking to relevant core HEAT standards and extant local KPIs which will be performance managed as described. This is underpinned by routine management information supported through the IM team and the development of the 'Weekly Winter Monitoring' pack. There requires to be a balance between timely management information to aid decision making on the ground and targeted performance metrics. Detailed measurement will be put in place as specific initiatives are introduced. Some key additional actions are noted below.

Actions for 2015/2016

- **Monitor Predicted Discharge Dates (PDDs) comparing daily PDDs with actual discharges, each day for each acute wards**
- **Review the current Bed Prediction model and refine as required**
- **Review current delayed discharge reporting to support daily decision making including information on delayed packages of care**
- **Ensure use of emerging IHO data to inform ongoing requirements**

This paper relates to Agenda Item 11

Title/Subject:	**Organisational Development Update**
Meeting:	**Integration Joint Board**
Date:	**06-11-2015**
Submitted By:	**Interim Chief Officer**
Action:	**For Noting**

1. INTRODUCTION

1.1 The purpose of this paper is to provide the Integration Joint Board with an update on the range of Organisational and Workforce Development activity underway to support the establishment of the Partnership and the Integration Joint Board.

The main focus of this paper will be the development of the Integration Joint Board and on initial themes from the Staff Engagement work underway.

2. RECOMMENDATION

2.1 The Integration Joint Board is asked to note the update detailed below and, specifically the work completed in these areas:

- Integration Joint Board development session delivered in September and planned for December.
- The Staff Engagement Sessions held during May – July and the summary themes from those detailed under Appendix 1.
- The establishment of the Area-wide Workforce Group and work to develop a Partnership Workforce Strategy and set of 'Workforce Plans'.
- The range of Organisational and Workforce Development work taking place across the Partnership.

3. BACKGROUND

3.1 The Transitional Board supported a paper in January 2015 and in May 2015 which suggested a range of Organisational and Workforce Development activities to be taken forward during 2015/16. Many of these activities are now underway and progressing well. The Integration Programme Board received Workstream Progress Reports in October which briefly described areas of work and priorities. I would like to draw the Integration Joint Board's attention to the following areas of note:

3.2 **Transitional Board Development**

Following a scoping exercise completed with Board Voting members earlier in the year an initial development session was held with the Board Members in September. This session helped the Board work on the following:

- The Vision and Values for the Integration Joint Board
- The Board's top 10 High Impact Behaviours for Collaborative Working
- Ways of working for the Board both within and out with the Board Room and how the Board will prepare for and manage the most difficult of discussions.

The outcomes and report from this session will be shared separately and will be taken forward to inform the next session of the Board planned for December 3rd. This session will include the advisory members of the Board and will revisit the Board Vision, Values, Behaviours and ways of working; focussing more specifically on the Board purpose, individual roles as Board Members and the role of the Board as a Team.

3.3 **Staff Engagement Sessions:**

During April and May 2015, 7 staff engagement sessions took place, attended by 213 staff from across the Partnership. These sessions engaged with staff in a workshop approach and were very well received. Please find a short summary of the process involved and the themes emerging from the sessions as ***Appendix 1***. The full report upon which this summary is based has been used to inform the contents of the Strategic Plan, as well as the resulting implementation plans.

This was not a 'one off exercise' and we are committed to an ongoing process of extensive engagement in order to ensure that staff are kept up-to-date with, and able to influence, future developments.

This process of informing and involving staff has also been enhanced further with the establishment of a Forth Valley-wide Joint Staff Forum with the inclusion of staff representatives from the Forum on the Integration Joint Board and the OD and Workforce Development Partnership Group. This Forum has also been supported with a Development Session in September.

3.4 **Area-wide Workforce Group:**

The Human Resources Workstream Group has now evolved to include the chair of the Partnership OD & Workforce Development Groups. This Workforce Group will now lead on developing an approach to confirming a Workforce Strategy for the Partnership and to provide leadership and a joint HR/OD approach to developing Workforce and OD Plans to support the development of the Partnership and delivery of the Strategic Plan. These plans will be drafted in consultation with the Joint Management Team and the Integration Joint Board. A workshop was progressed in October to begin this process.

3.5 Range of OD and Workforce Development Work Underway:

Whilst the development of the medium to longer term Workforce and OD Plans progress, a wide range of OD work continues within the Partnership. This includes:

- Development processes to support the joint and respective partner's Management structures and groups;

- The planning of an Appreciative Enquiry process with a locality team to identify current strengths and engage in visioning what good integrated practice would look like for the future;
- The development and delivery of a development programme for key senior and middle managers and leaders who will be working within the partnership; This Programme; *Playing to Your Strengths* will run in November 2015;
- A scoping exercise to develop a Workforce Development and Training Framework, with an initial draft expected in December 2015.

4. CONCLUSIONS

The current OD and Workforce development activity has been designed and approved with a focus on supporting the Partnership and its staff within this transitional year. Some of this work will inform wider ranging Plans which will support change and development processes during the next 3 years.

4.1 Resource Implications

The delivery of the above activity has required dedicated Organisational Development support as will future OD and Workforce Plan delivery. This work is supported by the dedicated OD Advisor post for Falkirk Partnership

4.2 Impact on IJB Outcomes, Priorities and Outcomes

The contents of this paper support the commitments made both nationally and locally within the Falkirk Integration Scheme to support the development of the Partnership and the Workforce therein.

Approved for Submission by: Tracey McKigen, Interim Chief Officer

Author – Morag Mclaren; Associate Director of HR; OD & Learning, NHS Forth Valley

Date: 6th November, 2015

List of Background Papers:
The papers that may be referred to within the report or previous papers on the same or related subjects.

Agenda Item 6.5
Falkirk Partnership Board *Workforce Development Paper 09-01-15*
Agenda Item 6
Falkirk Transitional Board OD Update Paper 01-05-15

Appendix 1

Falkirk Partnership Staff Engagement Sessions - High Level themes from feedback

What we did

Recognising the critical role that the workforce will play in determining the success of health and social care integration, and the need to ensure that our planned approach is appropriately informed, and importantly 'owned', by those people who work most closely with our patients and service users, their families and carers and their local communities; during the spring and summer of this year, a series of staff engagement events took place with the 'workforce for integration' in relation to the Falkirk Partnership. In total, 213 staff from across health, local authority, third and independent sector organisations came together to share their views on how services are currently being delivered and the types of changes they wish to see in order to realise the vision for the future of health and social care services within the Partnership. Focussing on the person at the centre of health and social care (i.e. ***'Sam', a typical service user***, used as an example), these events aimed at exploring:

- ***What is working well already*** in supporting the vision for health and social care integration and ***what could be better.***
- ***What an integrated future might look like*** for a typical service user and ***what would need to be in place*** for that future to be realised.
- What ***hopes and fears*** staff have ***in relation to the process*** of seeking to realise that future, and what they foresee as being some of the ***key challenges*** which will need to be overcome.

Participants identified many existing examples of effective collaborative working between different disciplines and agencies which are already contributing to improved outcomes for service users. However, there are also many areas where things are not as integrated as we would wish and where participants identified changes which could be made to how services are delivered amongst partner organisations to enable outcomes to be improved further still.

Detailed below are the high level themes relating to what participants described as an 'integrated future' looking like for 'Sam' and what would need to be in place to realise that future (building upon what was described as working well at present, and in response to what could be better). Also listed is a summary of participants' hopes and fears in relation to the process of moving to that 'integrated future'. The full reports from the Partnership upon which this summary is based will be published in due course.

What might an integrated future look like for a typical service user (i.e. Sam)?

- Sam receives ***high-quality, holistic, person-centred, outcomes-focussed*** care, which
  meets his individual needs and is ***effectively coordinated and streamlined.***
- Sam can ***access services easily and quickly.***
- Sam is ***informed and involved,*** and has ***choice and ownership*** of his care.

- Sam's ***carer*** is recognised as a ***key partner*** in his care and is ***well-supported***.
- Sam has a ***single, shared care plan.***
- Care providers ***proactively identify any change*** in Sam's condition to ensure ***early intervention.***
- Sam is ***able to stay at home and maintain independence***, being supported by ***assets within his community*** and ***technology*** solutions. He is ***supported to self-manage*** and has ***fewer unnecessary intrusions*** in his life.
- When Sam does require ***acute care***, effective joint planning ensures a ***smooth, safe and timely discharge***. This is supported through availability of ***rehabilitation and reablement*** services (which equally help prevent avoidable admission to hospital).

What would need to be in place to enable that future to be achieved?

- ***Resources (including staff) and funding*** would be more ***appropriately allocated*** and more ***efficiently and effectively used.***
- ***Systems*** would be ***clear and easy to navigate***, with ***staff*** being ***clear on their own and others' roles.***
- There would be a ***multi-disciplinary, multi-agency team*** approach (including third and independent sector services), with commitment to a ***shared vision*** and demonstrating ***shared values*** (including trust and respect for one another).
- **C*ommunica*tion** between all staff would be ***easier and better***, with ***consistent, up-to- date sharing of information.***
- ***Efficient, easy to use, integrated IT systems*** would be in place.

Hopes and fears about the process of moving towards that 'integrated future'?

Participants expressed hope that the process is ***properly executed*** to ensure a ***smooth and effective transition***, citing the following points:

- That it is ***well led***, with a ***focus on our vision and outcomes*** throughout.
- There should be a ***clear plan and effective structures*** in place to facilitate the process.
- The process should be subject to ***regular review***.
- Timely identification and ***resolution of difficulties***.
- There should be ***regular and informative communication*** to update on progress (both with staff and the general public).
- Staff should have ***sufficient opportunity to influence*** the shape and direction of the process.
- We need to learn from, sustain and spread ***what is already working well***.
- We need to ***manage expectations***.
- That ***everyone takes responsibility*** to make it work.

A number of participants expressed fears in relation to uncertainty about what the future will look like, with specific worries about ***job security, dilution of skills/loss of professional identity,*** changes to ***terms and conditions*** of employment and additional ***workload***.

Participants also acknowledge a number of existing or potential future challenges in relation to ***recruitment and retention*** of staff, overcoming ***cultural barriers***, and ***changing established ways of working***.

These hopes and fears will be taken into account in the development of appropriate change management and OD approaches within the Partnership.

This paper relates to
Agenda Item 12

Title/Subject:	**Scottish Government Consultations** **Scottish Public Service Ombudsman** **Amendment to Integration Joint Board Order**
Meeting:	**Integration Joint Board**
Date:	**6th November 2015**
Submitted By:	**Chief Governance Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1 This report brings to the board's attention two consultation documents that have been issued by the Scottish Government and which link to the work of the board. The first of these concerns making the board subject to the powers of the Scottish Public Services Ombudsman. The second relates to a proposed amendment to the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 (the "IJB Order") in relation to declarations of interest at board meetings. The consultation documents are attached as appendices 1 and 2, respectively.

2. RECOMMENDATION

2.1 The board is asked to consider the consultation papers and the proposed responses to them.

3. SCOTTISH PUBLIC SERVICES OMBUDSMAN

3.1 The matter on which the board is being consulted is an Order proposed by the Scottish Government which would make Integration Joint Boards listed bodies for the purpose of the Scottish Public Services Ombudsman Act 2002. The effect of this would be to make the board a body which would be subject to the SPSO's investigatory powers. The board would also require to adopt a complaints handling procedure, with the SPSO as the final independent stage of that process.

3.2 It should be noted that the proposal relates to complaints against the board itself and not in relation to complaints in relation to service delivery which will continue to be made through the current council and health board arrangements. Members may wish to note that there is a separate consultation currently underway in relation to a proposed revision of the procedures for complaints about Social Work Services which, if implemented, would bring to an end Social Work Complaints Review Committees and bring

the substance social work decisions within the investigatory remit of the SPSO.

3.3 In relation to the consultation document before the board is it suggested that there would be merit in replying to the consultation in support of the proposal from the government. Although it is not anticipated there will be many complaints directed against the board itself, the board is nevertheless a public body and the SPSO should have the opportunity to investigate complaints against it in the same way as other public bodies.

4. PROPOSED MODIFICATION OF THE IJB ORDER

4.1 The IJB Order which sets out many of the procedural requirements for the operation of the board contained an obvious error. It required boards to include within their standing orders a provision which would have placed in the hands of the board as a whole the question of whether a member declaring an interest was to be prohibited from taking part in discussion or voting on the item of business. This is inconsistent with the approach required by the Codes of Conduct under which the current councillors and members of the health board serving on the board require to operate and will be inconsistent with this board's own Code of Conduct which it will, in due course, require to adopt. These codes place, or will place, the emphasis on the individual board member making that decision on his or her own behalf.

4.2 The government has recognised the concerns that have been raised in relation to its initial drafting. They propose instead to revise the mandatory provision for standing orders to reflect the position contained within current Codes of Conduct. It is suggested that the board welcome the recognition by the government that the approach contained in the IJB Order is not correct. It is also suggested that the Board responds by indicating that no mandatory provision is required in the IJB Order in relation to conflict of interest. It is a matter that will be dealt with within the board's Code of Conduct and it follows that there is no need to provide for this in standing orders.

Approved for Submission by: Colin Moodie, Depute Chief Governance Officer

Author – Colin Moodie, Depute Chief Governance Officer
Date: 27 October 2015

List of Background Papers
None

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Integration and Reshaping Care Division

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Chief Officers of Integration Joint Boards;
NHS Chief Executives (Territorial Boards);
Healthcare Improvement Scotland;
Local Authority Chief Executives;
SOLAR;
SOLACE;
COSLA;
Care Inspectorate;
Scottish Local Government Partnership;
Scottish Public Service Ombudsman.

14 October 2015

Dear Colleagues

Consultation letter

The Public Bodies (Joint Working) (Scotland) Act 2014[1](the Act) puts in place arrangements for integrating health and social care, in order to improve outcomes for patients, service users, carers and their families. Integration Joint Boards will be new public bodies and as such they will not be covered by existing legislation in relation to complaints raised against their duties.

The Scottish Government has issued guidance on the Roles, Responsibilities and Membership of the Integration Joint Board[2]. This details the arrangement and principles by which Integration Joint Boards are currently expected to handle complaints against them.

The Scottish Government however proposes to make an amendment to Schedule 2 of the Scottish Public Services Ombudsman Act 2002 ("the 2002 Act") to add Integration Joint Boards to the 'listed authorities' set out in Schedule 2 of the 2002 Act, which will mean there will be a legal requirement for Integration Joint Boards to establish a complaints procedure. This letter sets out the reasons for the proposal, explains the effect of the changes, and seeks views on the proposal.

Proposed Legislative changes

The Scottish Public Services Ombudsman Act 2002[3] ("the 2002 Act") sets out, among other things, a list of public bodies [and persons] subject to investigation by

[1] The Public Bodies (Joint Working) (Scotland) Act 2014
[2] Roles, Responsibilities and Membership of the Integration Joint Board

the SPSO. Investigation by the SPSO is, in the view of the Scottish Government, an appropriate final independent stage for an IJB complaints procedure. For an IJB to have a complaints procedure which complies with the SPSO model complaints procedure, it is necessary for complaints to be able to be referred to the SPSO.

As new bodies, Integration Joint Boards do not currently appear on the list of bodies, set out in Schedule 2 of the 2002 Act, which may be investigated by the SPSO. The Scottish Government are proposing to make an Order in Council under section 3(2)[4] of the 2002 Act to amend this list. Adding Integration Joint Boards to Schedule 2 to the 2002 Act provides for the SPSO to have the investigatory powers set out in section 5(1)[5] of the 2002 Act, subject to the restriction in section 7[6].

Effect of the proposed legislative changes

The above changes will have the effect of providing for the SPSO to investigate actions of the Integration Joint Boards in carrying out its duties, or any service failure attributable to an Integration Joint Board. The SPSO cannot, however, investigate the merits of a decision taken within the Integration Joint Board's discretion, unless there has been maladministration in the taking of that decision.

Within these limitations it is expected that there will only be a small number of complaints against an Integration Joint Board that can be investigated by the SPSO – most issues raised about, for example, strategic planning, will likely be about the merits of a decision rather than in relation to carrying out a consultation.

Additionally, including Integration Joint Boards in Schedule 2 would also place a legal requirement on Integration Joint Boards to have a complaints handling procedure in place for complaint in relation to their duties (as required by section 16A (2)(a) of the
2002 Act). Currently there is no such legal requirement for Integration Joint Boards. The complaints procedure will also have to comply with the SPSO's principles on complaints handling procedures.

Views

We are taking this opportunity to invite comments on the proposal to add Integration Joint Boards to the list of the bodies set out in Schedule 2 of Scottish Public Services Ombudsman Act 2002 which will mean there will be a legal requirement for Integration Joint Boards to establish a complaints procedure.

You are asked to indicate whether or not you support the proposed amendment to the Scottish Public Services Ombudsman Act 2002 and the inclusion of Integration Joint Boards in the list of bodies set out in Schedule 2. If you do not support the proposals we would ask you to provide details outlining your concerns about the proposed amendment.

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[3] The Scottish Public Services Ombudsman Act 2002
[4] Section 3 and schedule 2 – Persons liable to investigation.
[5] Matters which may be investigated
[6] Matters which may be investigated: restrictions

A full list of those who have been invited to respond has been set out at **Annex A**

I would be grateful if you could send your response, using the template provided at **Annex B** to the following e-mail address IRC@scotland.gsi.gov.uk **by 12 November 2015.**

If you have any queries in relation to this letter please contact me via e-mail brian.nisbet@gov.scot or on 0131 244 3588.

Yours sincerely

Brian Nisbet
Integration and Reshaping Care Division

Annex A List of invited respondents

1. East Ayrshire Integration Joint Board
2. North Ayrshire Integration Joint Board
3. South Ayrshire Integration Joint Board
4. Argyll and Bute Integration Joint Board
5. East Dunbartonshire Integration Joint Board
6. East Lothian Integration Joint Board
7. East Renfrewshire Integration Joint Board
8. Edinburgh City Integration Joint Board
9. Inverclyde Integration Joint Board
10. Midlothian Integration Joint Board
11. North Lanarkshire Integration Joint Board
12. Renfrewshire Integration Joint Board
13. Shetland Islands Integration Joint Board
14. West Dunbartonshire Integration Joint Board
15. South Lanarkshire Integration Joint Board
16. West Lothian Integration Joint Board
17. Perth and Kinross Integration Joint Board
18. Dundee City Integration Joint Board
19. Angus Integration Joint Board
20. Dumfries and Galloway Integration Joint Board
21. Fife Integration Joint Board
22. Clackmannanshire and Stirling Integration Joint Board
23. Falkirk Integration Joint Board
24. Western Isles Integration Joint Board
25. Glasgow Shadow Integration Joint Board
26. Orkney Shadow Integration Joint Board
27. Scottish Borders Shadow Integration Joint Board
28. Moray Shadow Integration Joint Board
29. Aberdeen City Shadow Integration Joint Board
30. Aberdeenshire Shadow Integration Joint Board
31. NHS Ayrshire and Arran
32. NHS Borders
33. NHS Dumfries and Galloway
34. NHS Fife
35. NHS Forth Valley
36. NHS Grampian
37. NHS Highland
38. NHS Greater Glasgow and Clyde
39. NHS Lanarkshire
40. NHS Lothian
41. NHS Orkney
42. NHS Tayside
43. NHS Shetland
44. NHS Western Isles
45. Aberdeen City Council
46. Aberdeenshire Council
47. Angus Council
48. Argyll and Bute Council
49. City of Edinburgh Council
50. Clackmannanshire Council
51. Comhairle nan Eilean Siar
52. Dumfries and Galloway Council
53. Dundee City Council
54. East Ayrshire Council
55. East Dunbartonshire Council
56. East Lothian Council
57. East Renfrewshire Council
58. Falkirk Council
59. Fife Council
60. Glasgow City Council
61. Highland Council
62. Inverclyde Council
63. Midlothian Council
64. Moray Council
65. North Ayrshire Council
66. North Lanarkshire Council
67. Orkney Islands Council
68. Perth and Kinross Council
69. Renfrewshire Council
70. Scottish Borders Council
71. Shetland Islands Council
72. South Ayrshire Council
73. South Lanarkshire Council
74. Stirling Council
75. SOLAR
76. SOLACE
77. COSLA
78. Care Inspectorate
79. Healthcare Improvement Scotland
80. Scottish Local Government Partnership
81. Scottish Public service Ombudsman

Annex B – Consultation Response

Name:

Organisation:

Position:

Question 1: Do you support the proposal to add Integration Joint Boards to the list of the bodies set out in Schedule 2 of Scottish Public Services Ombudsman Act 2002 which will mean there will be a legal requirement for Integration Joint Boards to establish a complaints procedure.?

Please place an X in one of the boxes below to indicate your views on the proposal.

Yes		**No**	

Question 2: If you do not support the proposed amendment, please outline the reasons for this below.

Health and Social Care Integration Directorate
Integration and Reshaping Care Division

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The Scottish Government
Riaghaltas na h-Alba

Local Authority Chief Executives
Health Board Chief Executives
Integration Joint Board Chief Officers
COSLA
Commissioner for Ethical Standards in Scotland
Standards Commission for Scotland
SOLAR

Dear Colleagues

Consultation letter

Executive Summary

The Scottish Government is considering making an amendment to the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 and to the Public Bodies (Joint Working) (Integration Joint Monitoring Committees) (Scotland) Order 2014, to resolve an existing conflict between the Integration Joint Board and Integration Joint Monitoring Committee Standing Orders, and the statutory Codes of Conduct for Councillors and members of devolved public bodies. This letter sets out in more detail the reasons for the proposed amendment, explains the effect of the changes and seeks views on the proposal.

Background

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) put in place arrangements for integrating health and social care, in order to improve outcomes for patients, service users, carers and their families. The Act requires Health Boards and local authorities to work together effectively, to agree a model of integration to deliver quality, sustainable care services. Where partners agree to put in place a Body Corporate model, an Integration Joint Board will be established and will be responsible for the integrated arrangements and onward service delivery. Where partners have agreed a Lead Agency model, they are required to establish an Integration Joint Monitoring Committee for the purpose of monitoring the carrying out of the integration functions for the integration authority area.

Integration Joint Boards are “devolved public bodies” for the purposes of the Ethical Standards in Public Life (Scotland) Act 2000. As such members must discharge their duties in a manner that is seen to be honest, fair and unbiased and public bodies must ensure that conflicts of interest are identified and managed in a way that

maximises public confidence in the organisation's ability to deliver public services properly.

While Integration Joint Monitoring Committees are not independent entities in the same way as Integration Joint Boards are, any members who are Councillors or Health Board members will be required to comply with the Councillor's Code or a Health Board members Code.

Integration Joint Boards and Integration Joint Monitoring Committees are required to make standing orders for the regulation of their proceedings and business. Certain provisions which must be included in these standing orders are set out in the schedules to the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 and the Public Bodies (Joint Working) (Integration Joint Monitoring Committees) (Scotland) Order 2014. While these standing orders will govern the treatment of conflicts of interest, members may also be subject to the Councillors Code or a Health Board members Code. This results in a conflict between the standing orders for Integration Joint Boards and the Codes of Conduct for both Councillors and Health Board members.

Issue

The Model Code of Conduct for Devolved Public Bodies, on which Health Boards' Codes of Conduct for their members are based, places a requirement on members to declare any conflicts of interest and to apply the "Objective test" before taking a decision on whether they should have an involvement in discussions on the matter in question. The Councillors' Code of Conduct also takes this approach. Currently the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 and The Public Bodies (Joint Working) (Integration Joint Monitoring Committees) (Scotland) Order 2014 both require the standing orders of these bodies to include provision on members' conflicts of interest which place the decision making power on the other members of the Integration Joint Board. Accordingly, when a member of an Integration Joint Board or Integration Joint Monitoring Committee is also a Councillor, or a Health Board member, and faces a potential conflict of interest, they are subject to two different sets of rules as to how they should deal with this.

Proposed Legislative Changes

The Scottish Government intends to amend section 5, paragraph 2 of the Schedule to the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 and to section 5, paragraph 2 of the Schedule to the Public Bodies (Joint Working) (Integration Joint Monitoring Committees) (Scotland) Order 2014. These amendments will bring the required content of Integration Joint Board and Integration Joint Monitoring Committee standing orders into line with the provisions of the Councillors Code and Model Members' code. The amendments will be made by Order under section 12 of the Public Bodies (Joint Working) (Scotland) Act 2014.

Effect of the Proposed Legislative Changes

The legislative changes will have the effect of changing the process where a decision is taken with regards to a potential conflict of interests. A member who has

a potential conflict of interests will apply an “Objective test” to determine whether they can participate, as opposed to submitting the conflict for decision by the other members there present.

Views

We are taking this opportunity to invite comments and views on the proposal to bring the Integration Joint Board and Integration Joint Monitoring Committee standing orders into line with the Codes of Conduct for Councillors and members of devolved public bodies.

You are asked to indicate whether or not you support the proposed amendment to the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 and the Public Bodies (Joint Working) (Integration Joint Monitoring Committees) (Scotland) Order 2014. If you do not support the proposals we would ask you to provide details outlining your concerns about the proposed amendment.

A full list of those who have been invited to respond has been set out at Annex A.

I would be grateful if you could send your response to the email address below, by 9 November 2015.

Email: IRC@gov.scot

Yours sincerely

Lauren Glen
Integration and Reshaping Care Division

Annex A: List of invited respondents

1. East Ayrshire Integration Joint Board
2. North Ayrshire Integration Joint Board
3. South Ayrshire Integration Joint Board
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70. Scottish Borders Council
71. Shetland Islands Council
72. South Ayrshire Council
73. South Lanarkshire Council
74. Stirling Council
75. West Dunbartonshire
76. West Lothian
77. COSLA
78. Commissioner for Ethical Standards in Scotland
79. Standards Commission for Scotland
80. SOLAR