AGENDA ITEM 3
DRAFT

FALKIRK INTEGRATION JOINT BOARD

Minute of Meeting of the Falkirk Integration Joint Board held in the Learning Centre, NHS Forth Valley Royal Hospital, Larbert on Friday 4 December 2015 at 9.30am.

Voting Members:	Councillor Allyson Black, Falkirk Council (Chair) John Ford, Non-Executive Member, NHS Forth Valley (substitute) Councillor Dennis Goldie, Falkirk Council Councillor Linda Gow, Falkirk Council Jim King, Vice Chairman, NHS Forth Valley (Vice-Chair) Alex Linkston, Chairman, NHS Forth Valley
Non-voting Members:	Margo Biggs, Service User Representative (Substitute for items IJB20 to IJB25) Sandra Burt, Staff Representative, Falkirk Council Claire Crossan, Carer Representative Leslie Cruickshank, GP Medical Representative Tracey Gillies, Medical Representative Jane Grant, Chief Executive, NHS Forth Valley Tom Hart, Staff Representative, NHS Forth Valley Karen Herbert, Third Sector Interface Representative Kathy McCarroll, Chief Social Work Officer Tracey McKigen, Interim Chief Officer Martin Murray, Service User Representative Mary Pitcaithly, Chief Executive, Falkirk Council
Officers:	Jack Frawley, Committee Officer, Falkirk Council Jennifer Litts, Head of Housing, Falkirk Council Liz McGhee, Service Manager, Falkirk Council Colin Moodie, Depute Chief Governance Officer, Falkirk Council Susan Nixon, Service Manager, 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 Karen Strang, Strategy & Development Co-ordinator, Falkirk Council Suzanne Thomson, Programme Manager – Health and Social Care Integration

IJB13. Valedictory Remarks

The Chair stated that Tracey McKigen, interim Chief Officer, would be returning to her substantive post from 15 December 2015 and today was her last Integration Joint Board. Councillor Black thanked Ms McKigen on behalf of the Integration Joint Board for her contribution to the work of both the Transitional and Integration Joint Boards, and commended her leadership through a challenging transitional period. The members wished her well for the future.

IJB14. Apologies

Apologies were received on behalf of Julia Swan and Angela Wallace.

IJB15. Declarations of Interest

No declarations were made.

IJB16. Minute

Decision

The minute of meeting of the Integration Joint Board held on 6 November 2015 was approved.

IJB17. Matters Arising

None.

IJB18. Strategic Plan

The Integration Joint Board considered a report by the Interim Chief Officer providing an update on strategic planning arrangements. Appended to the report were the Housing Advice Note and Housing Contribution Statement. The Programme Manager – Health and Social Care Integration and the Head of Housing provided an overview of the report.

The Board asked how this work would be taken forward. Jennifer Litts stated that lots of the work would need to be completed jointly, she commented that housing resources would help to inform the Strategic Plan and noted that further work would need to be commissioned to get other important pieces of information. Stirling University was highlighted as an organisation which could assist with information gathering. She also advised that Housing would provide any information and data that it held which would be of use. In response to a question from the Board, she suggested that a short life working group could help to prioritise work. Members commented that a short life working group was a good idea. Suzanne Thomson advised that Housing were represented on the Strategic Planning Group. In terms of funding, Mary Pitcaithly suggested that some Integrated Care Funds could be considered to support this work.

Decision

The Integration Joint Board:-

(1) noted the contents of the report, and

(2) approved the draft Housing Contribution Statement for consultation as part of the Strategic Plan.

IJB19. Delayed Discharge

The Integration Joint Board considered a report by the CHP General Manager and the Head of Adult Social Care Services providing an update on progress with meeting the national target that no one who is ready for discharge should be delayed by more than 2 weeks. The CHP General Manager provided an overview of the report and an update on the most recent position of delayed discharges. It was important to understand the demand being placed on the hospital, extended lengths of stay for people in Choice Policy process, and the challenges of managing patients, and keeping people in the best care setting for their needs.

The Board asked what processes were in place for the monitoring of care homes. Mary Pitcaithly stated that there was a process for working with care homes to shorten the length of any moratorium. The Council was strongly involved with the Care Inspectorate to facilitate homes being re-opened. She commented on the impact of a period of bad publicity for a care home, as there was a long term impact on the willingness of families to use such a home even after issues have been addressed. She advised the Board that there was no cap to Falkirk Council funding in this area and that the issue was the availability of beds. Susan Nixon stated that contracts and commissioning were quickly involved to create an action plan with a home's owner where a moratorium is put in place but the owner needed to agree to Council involvement.

Decision

The Integration Joint Board noted the contents of the report.

Martin Murray, Service User Representative, left the meeting during consideration of the previous item of business.

IJB20. Closer to Home Presentation

The Integration Joint Board were provided with a presentation from the CHP General Manager and Susan Nixon on Delayed Discharges in Falkirk – Actions for Improvement, which covered:

- key issues;
- improving the discharge and guardianship/AWI processes;
- the Closer to Home model and its aims;
- the anticipated long term outcomes of Closer to Home;
- the benefits of the enhanced community team;
- building community capacity, and
- the Advice Line For You (ALFY) project.

The Board thanked Kathy O'Neill, Susan Nixon, Liz McGhee, Tracey Gillies and Leslie Cruickshank for their contributions and informative presentation. The members commented that it was important to be able to demonstrate the impact of the closer to home and Alfy projects and asked if there was enough baseline information available from which progress could be measured. Kathy O'Neill stated that there had been robust data collection in Bo'ness where ALFY had been piloted and this had allowed effective monitoring.

Members asked for the timescales regarding improvements to the guardianship process. Kathy O'Neill stated that there had been some educational work carried out with staff this year but that the major campaign was planned for spring 2016. Training was being co-ordinated with CVS Falkirk and in the meantime implementation of anticipatory care planning and Closer to Home would help in promoting the use of power of attorney.

The Board asked if there was joint training in place for nurses from Falkirk Community Hospital and social workers, as they were often dealing with the same patients and families it would be good if they understood each other's roles. Kathy O'Neill stated that a review of the admissions and discharge policy was being considered. Once the policy was refreshed, then there would be engagement with all staff and an opportunity to better understand roles and to strengthen the role of the discharge hub. It was important that staff understood how to access the additional short stay capacity at Summerford and Oakbank.

Members asked if there was training for staff to help families complete a power of attorney and encourage families to consider it more actively. Following discussion on the role of solicitors and the legal process around power of attorney, Colin Moodie confirmed that a solicitor was a required part of the process. He advised that officers would look into what proactive approach could legally be taken after the meeting. It was highlighted that the Falkirk and Clackmannanshire Carers Centre gave information to carers on what was needed to complete a power of attorney. Karen Herbert stated that the Forth Valley Adult Support and Protection Team had undertaken work in this area and advised that a local solicitor offered reduced rates for over 65s to complete a power of attorney.

Decision

The Integration Joint Board noted the presentation.

IJB21. Clinical Negligence and Other Risks Indemnity Scheme

The Integration Joint Board considered a report by the Interim Chief Officer seeking approval to apply for the IJB to become a member of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). The Interim Chief Officer provided an overview of the report and highlighted that CNORIS was at this time the only insurance scheme available to IJBs.

The Board agreed that it was worthwhile to join the scheme while the risk was low and that the position could be reviewed in four years, which was the minimum period of commitment.

Decision

The Integration Joint Board agreed to apply to Scottish Ministers to join the Clinical Negligence and Other Risks Indemnity Scheme.

IJB22. Partnership Funding

The Integration Joint Board considered a report by the Director of Finance providing a summary of the financial resources available to the partnership and commitments agreed to date. The Director of Finance provided an overview of the report.

Members commented that reports must be provided to the Board on time so that there was adequate time to consider their contents. They also highlighted that budget information needed to be made available as soon as possible.

The Board discussed the need to maintain clear oversight of financial commitments, this would be of particular importance as the Board may wish to finance additional projects in the near future. They commented that in the longer term Closer to Home should provide financial savings as the balance of care shifted to communities.

Decision

The Integration Joint Board noted the report.

IJB23. Draft Integrated Care Fund Mid-Year Report to Scottish Government

The Integration Joint Board considered a report by the Interim Chief Officer updating on the Scottish Government request for a mid-year progress report on the Integrated Care Fund and to seeking approval for the draft report, appended to the report, to be formally submitted. The Programme Manager – Health & Social Care Integration provided an overview of the report.

Decision

The Integration Joint Board approved the Draft Integrated Care Fund Mid-Year Report for submission to the Scottish Government.

IJB24. Health and Social Care Integration Programme Plan Update

The Integration Joint Board considered a report by the Interim Chief Officer providing an update on the programme of work required to implement the integration of health and social care. The interim Chief Officer provided an overview of the report.

Decision

The Integration Joint Board noted the report.

IJB25. Appointment of Chief Officer

The Integration Joint Board considered a report by the Chief Executive, Falkirk Council and the Chief Executive, NHS Forth Valley providing an update on the outcome of the Transitional Board Appointments Panel. The

Chief Executive, Falkirk Council provided an overview of the report and highlighted that recruitment to the Chief Finance Officer post was on-going.

Decision

The Integration Joint Board agreed to appoint Patricia Cassidy as Chief Officer.

This paper relates to

Agenda Item 5

Report to:	**Integration Joint Board**
Title/Subject:	**Membership of the Integration Joint Board**
Date:	**5 February 2016**
Submitted By:	**Chief Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1 The purpose of the report is to provide Integration Joint Board members with information about a change of representation and to invite the Board to confirm these appointments.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1 Confirm the appointments to the Integration Joint Board as noted at section 4.

3. BACKGROUND

3.1 On 3 October 2015, the Falkirk Integration Joint Board 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 and NHS Forth Valley.

3.2 The Board received a report on 6 November 2015 that set out the required membership of the Board and confirmed the appointment of the members set out in this.

4. MEMBERSHIP OF THE INTEGRATION JOINT BOARD

4.1 Membership as an identified stakeholder group
The Board is invited to confirm the appointment of Kevin Robertson, as substitute staff representative (Falkirk Council).

5. CONCLUSION

In conclusion the Integration Joint Board are asked to confirm the appointment of the substitute staff representative.

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Approved for Submission by:
Patricia Cassidy, Chief Officer

Author: Suzanne Thomson, Programme Manager - Integration (Falkirk)
Date: 17 December 2015

List of Background Papers:
IJB report – 6 November 2015: Establishment of Integration Joint Board

This paper relates to

Agenda Item 6

Report to:	**Integration Joint Board**
Title/Subject:	**Strategic Plan**
Date:	**5 February 2016**
Submitted By:	**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 Integration Joint Board is asked to:

2.1. consider the latest draft of the Strategic Plan which is attached at Appendix 1 for information

2.2. consider the IJB meeting timetable to enable the necessary consideration and approval of the Strategic Plan as noted at section 4.6

2.3. consider the draft Consultation and Engagement report on the development of the Strategic Plan, which is attached at Appendix 2.

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 PLAN

4.1. 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.

4.2. The draft Strategic Plan was approved for consultation by the Integration Joint Board on 6 November 2016. The consultation period was from 16 November to 31 December 2015. Section 5 of this report summarises the consultation process.

4.3. In line with legislative requirements, the Strategic Planning Group (SPG) has supported the development of the draft Strategic Plan. The group met on 15 January 2016 to consider the feedback from the consultation on the draft Strategic Plan. This has informed the development of the plan.

4.4. The Strategic Planning Co-ordinating Group has continued to meet, now on a weekly basis, to ensure the comments from the SPG and consultation process are reflected in the production of the Strategic Plan. The group also supported the consultation and engagement arrangements.

4.5. The amended draft Strategic Plan is attached at Appendix 1 for consideration. There is a separate report on the agenda relating to the financial position. Once this is clearer the final plan will be presented to the Integration Joint Board for approval.

4.6. The Board will be aware that 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. In meet this requirement, the Board may wish to consider the IJB meeting timetable to enable the necessary consideration and approval of the Strategic Plan to be brought forward by the Strategic Planning Group.

5. CONSULTATION AND ENGAGEMENT ARRANGEMENTS

5.1. As noted, the consultation on the draft Strategic Plan took place from 16 November to 31 December 2015.

5.2. The plan was informed and developed through a series of information and consultation methods including:
- Seven staff engagement sessions: April to May 2015
- Transitional Board priority setting workshop: 18 June 2015
- Stakeholder engagement event for staff across all sectors: 30 June 2015
- Strategic Planning Group meetings: August and October 2015 and January 2016
- Distribution of the draft plan through global email distributions to employee groups, partner organisations and through meeting networks
- Presentation and feedback sessions - targeted: November to December 2015
- Online and Citizen's Panel survey.

5.3. A draft Consultation and Engagement report outlining the process to develop the Strategic Plan is attached at Appendix 2 for information and comments. The draft will also be circulated to the Strategic Planning Group for comments. The final consultation report and final draft Strategic Plan will be presented to the Integration Joint Board for approval.

6. CONCLUSIONS

6.1. 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.

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Approved for Submission by: Patricia Cassidy, Chief Officer

Author: Suzanne Thomson, Programme Manager – Integration (Falkirk)
Date: 25 January 2016

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
Integration Joint Board report: 6 November 2015 – Strategic Planning
Integration Joint Board report: 4 December 2015 – Strategic Planning

Appendix 1

DRAFT – FEBRUARY 2016

Falkirk Integrated Strategic Plan 2016-2019

FOREWORD

To enable people to live full, independent and positive lives within supportive communities.

The integration of Health and Social Care will see the establishment of a Falkirk Health and Social Care Integration (HSCI) Partnership with its own Integration Joint Board, developed by Falkirk Council and NHS Forth Valley.

We are pleased to introduce our first Strategic Plan on behalf of the HSCI Partnership. This plan is of interest to everyone living in the Falkirk area as it describes how we will deliver services to adults who use health and social care services. The plan will be reviewed every year.

New legislation requires that a local plan is produced 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.

In the future, we need to build on our existing partnerships and develop new relationships with people, communities, our workforce and other stakeholders. The main purpose of the HSCI Partnership is to put people at the centre of decisions about their care and support. It will build on current good practice to change the way we deliver services that are high quality and joined up to meet individual need.

This will **"enable people to live full, independent and positive lives within supportive communities**" forming Falkirk's Strategic Plan vision.

This is an opportunity for the new HSCI Partnership to use our combined resources in a more effective, efficient and person-centred way. This will mean that we can address the challenges we face. There is an increased demand on services that will exceed available resources if we do not work together in a more integrated way. This will ensure a joint contribution to encouraging, supporting and maintaining the health and wellbeing of people who live in our community.

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. However, there are inequalities within our local communities, which we aim to address by working with our partners to prevent and reduce the impact of poverty, promote equality of access, and improve health and well-being. Equality will be at the heart of everything that we do.

The HSCI Partnership will focus on prevention and early intervention. We will encourage and support self-management so that people are in control of their own health and care to be as independent as possible and enhance their quality of life.

We want to change the way we deliver services and to involve people in how services are redesigned to meet their needs. Our three year Strategic Plan is informed by a range of engagement and consultation activity and local and

national information. We will put people first and combine our resources to provide integrated support, and engage with communities and staff to deliver on locality plans.

On behalf of Falkirk Health & Social Care Partnership

Allyson Black	**Patricia Cassidy**
Chair, Falkirk Integration Joint Board	**Chief Officer**

1 SETTING THE SCENE

People will be at the centre of all decisions about their care and support. When this support is provided, the HSCI Partnership will ensure this is delivered to the highest quality and safety standards. We will work with people with a focus on prevention, anticipation and supported self-management. When admission to hospital is required, there will be a focus on ensuring people are supported to return to their home. This will be done as soon as appropriate to ensure there is minimal risk of re-admission to hospital.

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. This vision will only become a reality by all agencies working together. To make this new way of working successful, it is essential that the views of service users, their carers and families and local communities are taken into account in shaping future services.

The *Public Bodies (Joint Working) (Scotland) Act 2014* requires NHS Boards and Local Authorities to establish Health and Social Care Partnerships. In Falkirk it has been 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.

The Integration Joint Board was established on 3 October 2015 and has representatives from Falkirk Council, NHS Forth Valley, Third Sector, service users and carers. From 1 April 2016, the Integration Joint Board, through its Chief Officer, will have responsibility for the planning, resourcing and the operational oversight of a wide range of health and social care services.

The HSCI Partnership, consists of the Local Authority, NHS Forth Valley, Third and Independent sectors, who will work together to provide effective and joined up services. The partnership will work towards the *2020 Vision* in an integrated way and are responsible for the delivery of targets, called the *National Health and Wellbeing Outcomes*.

The HSCI Partnership will prioritise services in response to the key issues set out in Section 3 and the detailed Joint Strategic Needs Assessment. These are:

- The Falkirk area has an ageing population
- Workforce
- It is projected that the Falkirk area will have growing numbers of people living with long term conditions, multiple conditions and complex needs
- Early intervention and prevention can make a difference
- Carers
- Deprivation, housing and employment.

NHS Forth Valley and Falkirk Council are building on existing working practices that will put in place single working arrangements. These will aim to provide 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 outcomes for people
- There is an opportunity to make better use of public resources while creating increased public value in avoiding duplication of effort.

Falkirk HSCI Partnership and Localities

The HSCI Partnership has identified its locality areas for service planning purposes. This is required in the legislation. There will be three localities within the Falkirk Council area:

- **Falkirk**
  The Falkirk Locality is the smallest and most compact of the three Heath and Social Care Localities with a population (including Hallglen) of just under 40,000. It is centred on the ancient burgh of Falkirk itself which is the main retail and administrative centre for the Council area as well as having the main campus of Forth Valley College. Falkirk town centre is a main source of employment and other major employers are the public sector and vehicle manufacturing. Some of the most deprived areas within the Council area lie in Falkirk, in particular parts of Camelon, Bainsford and Langlees, as well as in Hallglen. The recent major projects of the Falkirk Wheel and the Kelpies have promoted the area across the whole of Scotland and beyond.

- **Grangemouth, Bo'ness and Braes**
  This is the largest of the three Heath and Social Care Localities, both in terms of area (176 sq km) and population (over 65,000). It lies along the coastline of the River Forth and extends southwards into the higher land of the Slamannan Plateau. It contains the former burghs of Grangemouth and Bo'ness as well as the villages of the Braes such as Polmont, Westquarter, Redding and the more isolated villages such as Slamannan and Avonbridge. Grangemouth is a major industrial town based largely on the petro-chemical industry and is also Scotland's premier port. The M9 motorway runs through the area and the Kincardine and Clackmannanshire bridges connect the area to Fife and beyond. The locality includes some the Falkirk Council area's most prosperous estates as well as areas of deprivation in Grangemouth, Bo'ness, Maddiston, Westquarter and Slamannan. The Braes area is a popular location for home buyers and considerable housing development has taken place and is expected to continue.

- **Denny/Bonnybridge/Larbert/Stenhousemuir**
  This Health and Social Care Locality lies in the north west of the Council area and has a population of around 53,000. It includes the towns of Denny, Bonnybridge, Larbert and Stenhousemuir and a number of smaller settlements. The population is growing with major new housing developments in Denny and Larbert. Forth Valley Royal Hospital is a major employer and is located close the motorway network with the M80 and M876 connecting the area to the rest of Scotland.

There are small pockets of deprivation in Denny and Stenhousemuir but this is a fairly prosperous area which has good commuting links.

(replace map with defined locality boundaries)
MAP
Figure 1:

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 and will be reviewed each year. A number of key priorities have been identified, which will help provide a direction and focus for service change and improvement.

2 A PLAN FOR FALKIRK AREA

This section summarises the vision and the connections between this and the principles, outcomes and priorities that have been identified.

2.1 Vision

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

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

2.2 Outcomes and Priorities

The HSCI Partnership has identified five specific outcomes for the Falkirk Strategic Plan and Integration Scheme. These are in line with the Scottish Government's *2020 Vision.*

The local outcomes address the key challenges highlighted in the Joint Strategic Needs Assessment (JSNA) (as outlined in section 2.1). The outcomes are also consistent with the views of people who use services, their carers and communities. This plan is for adults and older people who have a range of health and care needs. These include physical disability, mental health, complex care needs, learning disability, long terms conditions, alcohol and substance misuse, and young people moving into adult services.

The Falkirk HSCI Partnership will focus on the identified priorities in the Strategic Plan to achieve its outcomes. There are also a number of cross-cutting priorities as detailed in the table below:

Outcomes	Priorities
Self-Management: Individuals, carers and families are enabled to manage their own health, care and wellbeing	• Information that enables people to manage their condition is accessible and delivered consistently • Support for carers
Autonomy And Decision Making: Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided	• Person-centred care is reinforced, acknowledging family/carer views • Care and support is underpinned by informed choices and decision making throughout life
Safe: Health and social care support systems are in place, to help keep people safe and live well for longer	• Technology is used in an effective and appropriate way to support care • Risk is acknowledged and managed effectively

Service User Experience: People have a fair and positive experience of health and social care	• 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 HSCI Partnership • Co-location is pursued where appropriate
Community Based Support: Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community	• 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

Table 1

The delivery of these priorities will support the transformational change that will be needed to deliver integrated services.

2.3. What will be different

By services working together in a much more integrated way, the outcomes for people using health and social care services will be improved. This will also avoid duplication, improve communication and understanding of services and reduce dependency.

Current Model of Care	Future Model of Care
Disjointed care	Integrated, seamless care with a single point of contact
Reactive care	Preventative and Anticipatory Care
Hospital centred	Embedded in communities
Services are given to people	Services empower people to self-manage
Service user as passive recipient	Service user as partner
Support for carers is variable	Carers are supported
Under use of technology	Improved use of technology
Acute condition focus	Long-term condition focus

Table 2:
Illustration of old and new care model. Adjusted from Falkirk Joint Commissioning Plan for Older People 2014 - 2107

2.4 Local Outcome One

Self-Management: Individuals, carers and families are enabled to manage their own health, care and wellbeing	
What does this mean for people? People, 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. Services will encourage independence by focusing on reablement, rehabilitation and recovery. People are able to access services quickly via a single point of contact. Information that enables people to manage their condition is accessible and presented in a consistent way. This will include a range of information on services and community based supports. In addition, services are responsive and available consistently throughout the year, on a 24/7 basis, if appropriate. **What does this mean for our communities?** Communities will feel they are involved in decisions that affect them. Their views are gathered and they are listened to. They know what services we are available to provide and have confidence in them. **What does this mean for the HSCI Partnership?** Our shared vision is held across all partners. Our workforce across all sectors is highly skilled and has a focus on promoting independence and improving health and well-being. Joint 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 people.	**What are we going to do?** We will lead the cultural change required across agencies and communities to support the change necessary to deliver integrated care We will redesign services so they are flexible and responsive, ensure feedback drives continuous improvement and are aligned to our outcomes We will continue to develop the ways in which we support carers We will support people to use technology solutions to support them to have more independence and control over their lifestyles and the management of their condition We will implement our Organisational Development and Workforce Plan to support our staff and partners though training and organisational development Communication will be central to everything that we do. We will continue to engage with stakeholders to shape our services to meet needs.

2.5 Local Outcome Two

Autonomy And Decision Making: Where formal support is needed people are able to exercise as much control and choice as possible over what is provided	
What does this mean for people? Health education and information is accessible and readily available to people, their carers and families, which allows them to make informed choices and manage their own health and wellbeing. Person-centred care is reinforced acknowledging family/carer views. Care and support is underpinned by informed choices and decision making throughout life. **What does this mean for our communities?** Communities are enabled to continue to develop and manage a variety of good quality local services to meet community need. **What does this mean for the HSCI Partnership?** Information sharing is critical to good integrated care and is extended across all sectors. Information sharing includes the ability to share single assessments and care plans. These will be co-produced by service 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 securely access and use the system with data sharing procedures in place. Information is shared appropriately to ensure a safe transition between all services.	**What are we going to do?** ▪ We will develop a single point of contact for people and their carers to support access to a wide range of information on services across all sectors ▪ We will develop one Single Shared Assessment as standard across the Partnership ▪ We will promote the uptake of Anticipatory Care Plans that reflect the current views of people and their carers. We will ensure this information is shared where appropriate. ▪ We will continue to design community based models of care, such as Closer to Home and Advice Line For You (ALFY) ▪ Information sharing protocols are in place

2.6 Local Outcome Three

Safe: Health and social care support systems are in place, to help keep people safe and live well for longer	
What does this mean for people? People will be supported to live safely in their homes and communities. People will be involved and consulted on decisions about their care, treatment and support. People will have timely access to services, based on assessed need. Services will improve qualities of lives and be joined up to make best use of available resources. **What does this mean for our communities?** Communities are confident that systems are in place for the identification, reporting, and prevention of harm. **What does this mean for the HSCI Partnership?** The Partnership is able to identify, manage and tolerate risk, and staff are supported in being able to work in different ways, to support personal outcomes. The Partnership recognise the critical link between health and social care provision and the contribution of wider partners, for example, the Community Planning Partnership, Criminal Justice and Housing. The Partnership will continue to work together to reduce avoidable admissions to hospital by ensuring that priority is given to strengthening community based supports.	**What are we going to do?** We will ensure there is a greater focus given to individual case management, enhanced by the provision of advocacy support, where required We will ensure risk is acknowledged and managed effectively and risk based support is in place We will continue to work across the partnership to ensure adults at risk of harm are supported and protected. We will implement our Clinical Care Governance framework We will continue to invest in Technology Enabled Care as an effective and appropriate way to support care. We will pursue co-location of staff and services where appropriate to support integration

2.7 Local Outcome Four

Service User Experience: People have a fair and positive experience of health and social care	
What does this mean for people? People feel services are responsive to their needs and are available to them before reaching a point of crisis. These services are joined up and improve quality of lives. People are engaged and involved across the HSCI Partnership. People will receive feedback and understand what their contribution has influenced. **What does this mean for our communities?** Communities will have the opportunity to be engaged and involved in service redesign and delivery within their local areas. This will be based on a clear understanding of local needs and available resources. **What does this mean for the Partnership?** The Partnership will enable its workforce to be motivated to come to work, feel supported by colleagues and management, and valued by colleagues and people for whom they provide care. We will encourage continuous improvement by supporting and developing our workforce.	**What are we going to do?** ▪ We will ensure consistent high quality services are delivered, informed by a robust service evaluation framework ▪ We will ensure our decision-making processes are consistent, fair and transparent, and are based on reliable information and evidence based good practice ▪ We will complete Equality and Poverty Impact Assessments for all subsequent changes to policies and services to ensure we identify and address inequalities ▪ We will implement our Participation and Engagement Strategy

2.8 Local Outcome Five

Local Outcome Five **Community Based Supports:** Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community	
What does this mean for people? People are more confident, reliant and able to access local services and support to improve and maintain their health and well-being and be more independent. There will be a focus on early intervention and prevention. **What does this mean for our communities?** Communities are informed, involved and supported to work cohesively to develop and manage community based supports. **What does this mean for the HSCI Partnership?** The Partnership will work pro-actively with the Community Planning Partnership and the Third Sector and Independent Sector to plan and deliver solution based and community focussed services to support the delivery of our priorities.	**What are we going to do?** ▪ We will establish locality planning structures within the three local areas agreed which will align with the Community Planning Partnership ▪ We will adopt a consistent framework when commissioning services that will build sustainable capacity within all sectors ▪ We will build on existing strengths within local communities

2.9 Summary table showing the links from the national Health and Well-being Outcomes to local priorities

National Health and Wellbeing Outcomes

Local Outcomes	Evidence	What People Said	Priorities
Self-Management: Individuals, carers and families are enabled to manage their own health, care and wellbeing	⬆ Population, with +75 expected to double by 2037 ⬆ People with multiple conditions ⬆ Life expectancy for people with conditions ⬆ Lifestyle risks such as obesity, smoking and substance misuse • +15,000 Carers in Falkirk area of which 37% provide 35hours care per week	'More prevention work and dealing with the underlying causes of poor physical and mental health. A co-ordinated approach.' '….working with a range of agencies including education […]physical activity providers and retailers to educate on healthy lives.' 'A framework for dealing with medication in the community'	• Information that enables people to manage their condition is accessible and delivered consistently • Support for carers
Autonomy And Decision Making: Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided	• 2.3% patients account for 50% health expenditure - most with 2-4 conditions. ⬆ Emergency admissions to hospital ⬆ Delayed Discharges, with 1,034 bed days lost in July 2015	'IT communication should be improved to allow sharing of information easier.' 'better sharing of information - relatives often have to articulate care needs over and over again' ' More consideration is required for the transition from childrens services (health) to adult services (social work) where disabled are concerned' 'The process of links between the different services has been a great success so far and helped keep my father and mother in law at home longer. It made their lives better and ours too.'	• Person-centred care is reinforced, acknowledging family/carer views • Care and support is underpinned by informed choices and decision making throughout life
Safe: Health and social care support systems are in place, to help keep people safe and live well for longer	• An average of 6,848 items of equipment are provided per annum to support people to live at home ⬆ In 2014, 4,353 people received telecare services • 990 adults with Learning Disabilities in Falkirk area, 51.1% live in mainstream accommodation • 10,868 adults with physical disability, 53% aged 50-74.	'more emphasis placed on technology enabled care to help people self manage their conditions at home.' 'Not all people needing help or re-homing are elderly […] More communication between staff might make a difference' 'Use of technology to support people to articulate their needs, provide feedback and influence services and	• Technology is used in an effective and appropriate way to support care • Risk is acknowledged and managed effectively

Local Outcomes: What They mean and what we're going to do (Section XX)

				plans and improve care'		
		Service User Experience: People have a fair and positive experience of health and social care	⬇ In working age population, which is mirrored in Partnership workforce • Heath & Care recipients survey 13/14 found – 94% respondents felt ' treated with respect' and 85% felt 'health & social care services seem well co-ordinated'	'It's taken me a year to find out where I can find support to cope […]a single point of contact for me would really have helped me during the year since diagnosis.' 'dialogue between client and service staff should be open and honest at all times' 'There also needs to be a culture of open feedback mechanisms, where errors or mistakes and not punished, but seen as learning opportunities for the individuals and the systems'	• 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 HSCI Partnership • Co-location is pursued where appropriate	
		Community-based Supports: Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community	Community engagement over 2 years to inform Falkirk's Community Learning and Development Action Plan found: • People do not always know what services and support is available to them in their communities • Impacts on health and wellbeing include not feeling safe within community, isolation, issues regarding housing and employment • There are 18 datazones in the Falkirk Council area fall within the 15% most deprived in Scotland (SIMD)	'Where to get information on how people can get more involved.' 'Isolation and malnutrition need to be addressed. Incentive social activities /lunch clubs etc' 'We…get together and run a self help group, which I think is very important, since most GP's are just learning about it. I feel we have a lot to offer!'	• 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 and signpost to existing assets within local communities	

Table 3:

3. WHY CHANGE?

The demand and expectations on health and social care services is changing. The challenges highlight a need for changes to service delivery that is driven by increasing complexity of need, greater demand for services, reducing resources coupled with greater public expectation. We therefore need to change the way we deliver services to respond. We also need to continue to deliver services to people in most need within the available resources.

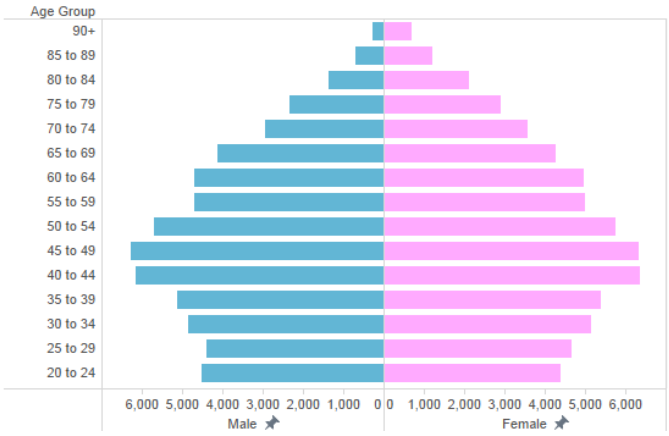
The more traditional ways in which health and social care and support services have been structured and delivered has not always led to improved outcomes for people. Health care and social care systems have traditionally focussed on a reactive approach. This means that care is provided for people rather than supporting people to live more independently in their communities. A reactive approach can lead to unnecessary, expensive and prolonged hospital admissions and to a dependency on care services. This approach is unsustainable and fundamental change is required.

This section outlines the main drivers for the Falkirk Health Social Care and Integration Strategic Plan.

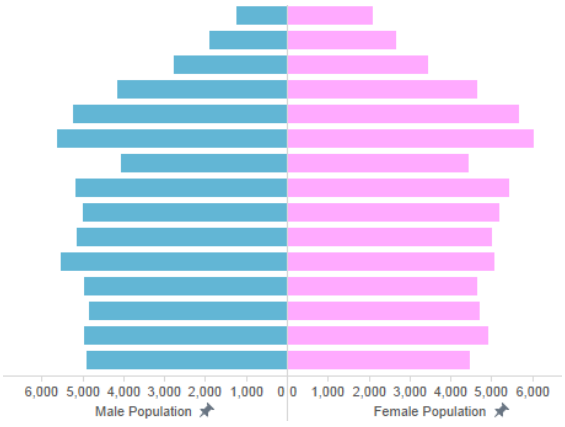
3.1 Local Population

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%. We had the ninth fastest growth rate of all Scotland's councils.

Falkirk Population by Age/Sex 2012



Falkirk Population by Age/Sex 2037



75+ population expected to nearly double by 2037
Older Population = Heavy users of services
Increased Older Population = Increased demand for services
Need for Service Re-design

Figure 4

3.2 Multiple and long-term conditions

Multiple morbidity is common, increases with age, and by age 65 years most individuals will be living with more than one diagnosed condition. It should be noted that currently the number of individuals with multi morbidity is actually higher in those younger than 65 years. This highlights the need for proactive anticipatory care planning and adequate focus on prevention and positive lifestyle interventions.

There are clear links between the onset of long term conditions and mental health problems, deprivation, negative lifestyle factors and the wider determinants of health. People living with a long term condition are likely to be more disadvantaged across a range of social indicators, including employment, educational opportunities, home ownership and income.

Individuals living in a disadvantaged area are more than twice as likely to have a long term condition and more likely to be admitted to hospital because of their condition. Furthermore, the onset of multiple morbidity occurs 10–15 years earlier in people living in the most deprived areas compared with the most affluent.

People living with long term conditions are also more likely to experience psychological problems. Prolonged stress alters immunity, making illness more likely and recovery more difficult, especially for those who are already unwell. Mental health disorders, particularly depression, are more prevalent in people with increasing numbers of physical disorders.

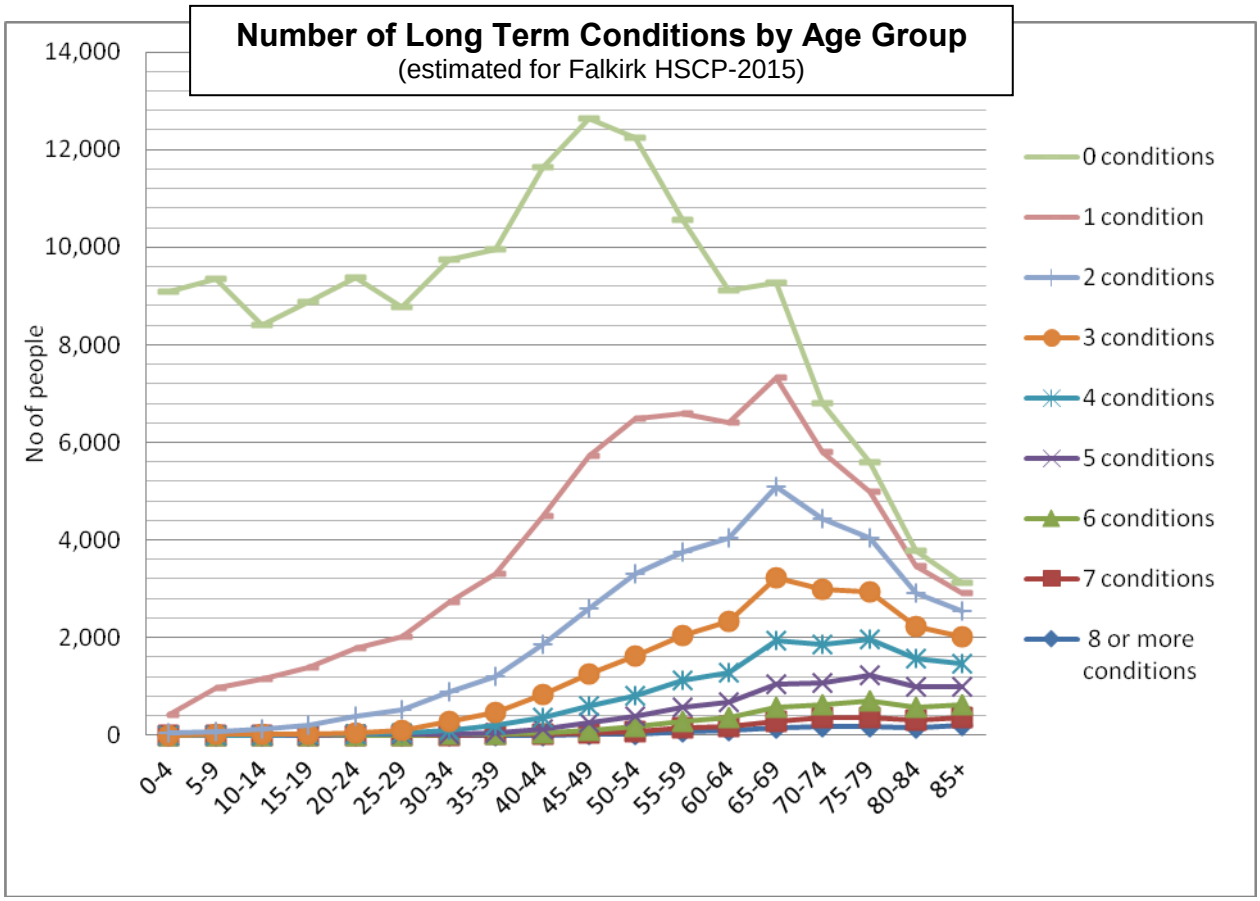


Figure 5:
Estimated number of people within Falkirk with various numbers of long-term conditions - 2015. *Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk*

3.3 Carers

The role of carers is widely recognised as being fundamentally important in supporting people to continue to live in their own homes and communities. Carers often live with the consequences of caring: poor health and wellbeing, financial hardship and the inability to participate in activities that others take for granted, such as work, learning, leisure and family life. 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.

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. An overview of carers in the Falkirk area is presented below:

- 15,056 people providing unpaid care in Falkirk, 9.7% of the local population
- Approx. 2/3rds 35-64 years and nearly 20% over 65 years
- 35.7% of carers in Falkirk provide in excess of 35 hours unpaid care
- 29% of those providing in excess of 35 hours care are aged 65 and over.

The chart below builds on the idea that the health of carers is 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.

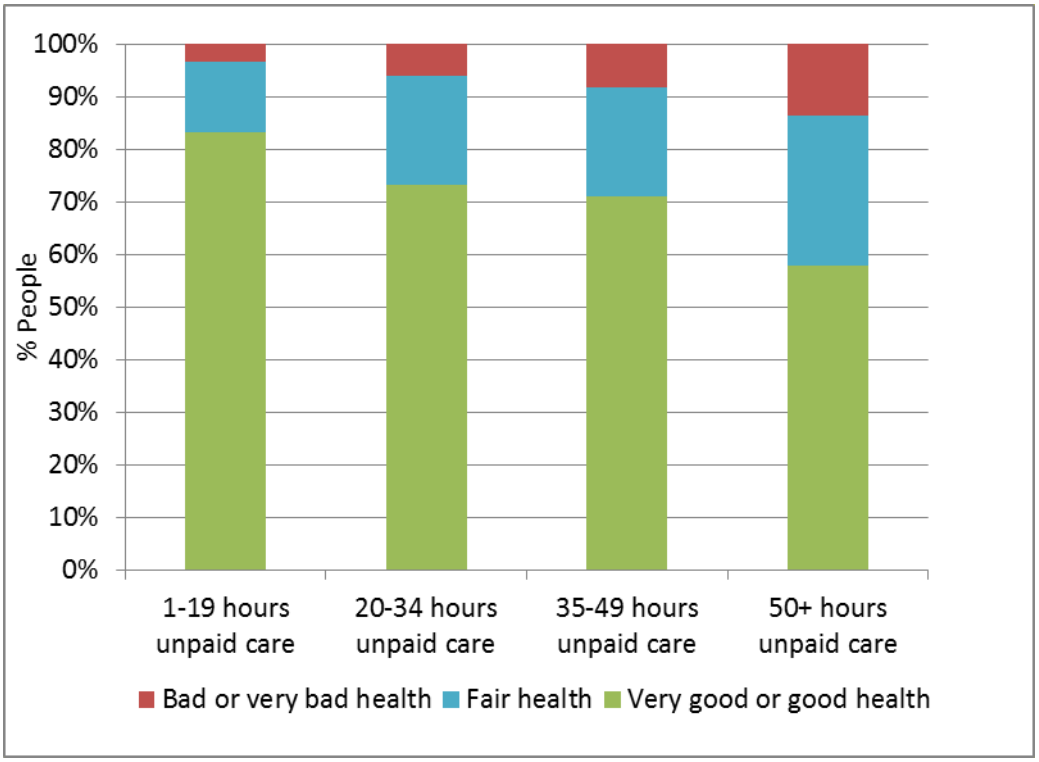


Figure 6:
General health by level of unpaid care provision - Falkirk, Scotland's Census 2011

We 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 enable them 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
- Recognise and support the needs of any young carers who are caring for an adult.

3.4 Deprivation

Deprivation is a risk factor for the vast majority of conditions and we 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 7 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.

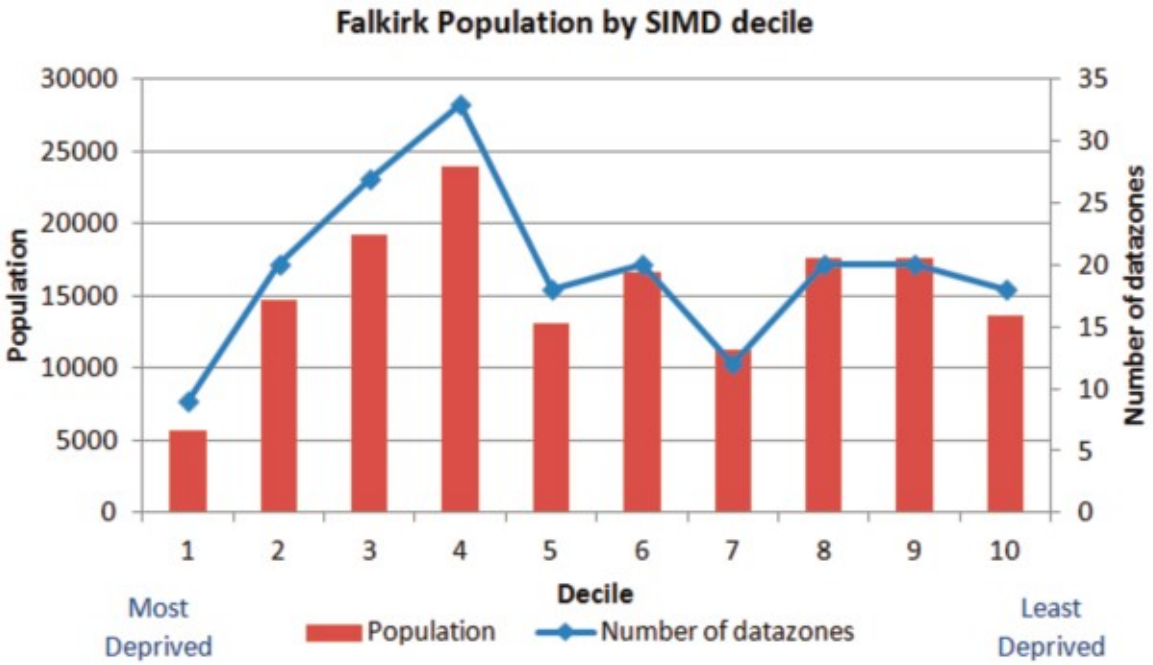


Figure 7:
Falkirk area population by SIMD decile. *Source: SIMD 2012*

3.5 Workforce

The local demographics demonstrate an ageing workforce; subsequently the Falkirk Partnership must consider the workforce to ensure that planned future services are sustainable. The raising of the retirement age also emphasises the need to develop strategies which meet individual and the Falkirk Partnership's expectations; enabling people to work longer with both energy and good health so that vital skills are retained.

The Falkirk Partnership aims to improve working lives through provisions to create better work/life integration. Flexible working practices can enable people to be refreshed and committed throughout their working lives.

The Partnership will support the delivery of new ways of working for services providing health and social care. A Staff-side Framework is agreed and working to achieve positive involvement with staff-side organisations and with all staff. The Partnership continues to work together in developing effective integrated health and social care teams working across systems. Joint Organisational Development work is well positioned and is already supporting the development of joint planning and working.

Mapping the workforce with all partners is key to the delivery of the integration agenda and partners are committed to working together to support this process. A framework of Human Resources metrics has been agreed and in time, integrated workforce plans in support of new and emerging models of care will be developed.

The continuing focus is on the development of relationships and working arrangements with partners which will deliver the conditions required for success in the Integration of Health and Social Care agenda.

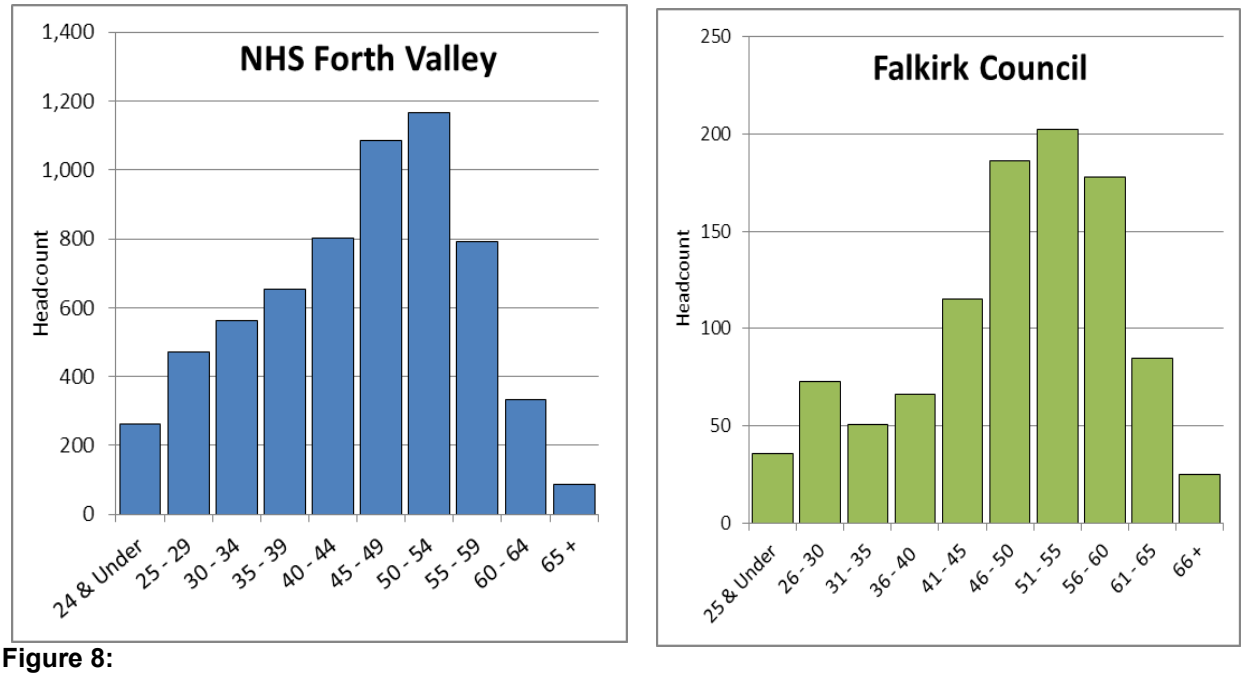


Figure 8:
Workforce age profiles for NHS Forth Valley and Falkirk Council – September 2015 Source: Scottish Workforce Information Standard System (SWISS) & Falkirk Council
Note – NHS Forth Valley figures represent the entire workforce, not just those in scope for integration, it is assumed that the relevant staff will share a similar age profile.

3.6 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 9 demonstrates that the rate and number of admissions remains below the Scottish average. Figure 10 shows the number of emergency hospital admissions for patients aged 65+ from 2004/5 to 2013/14 which has increased.

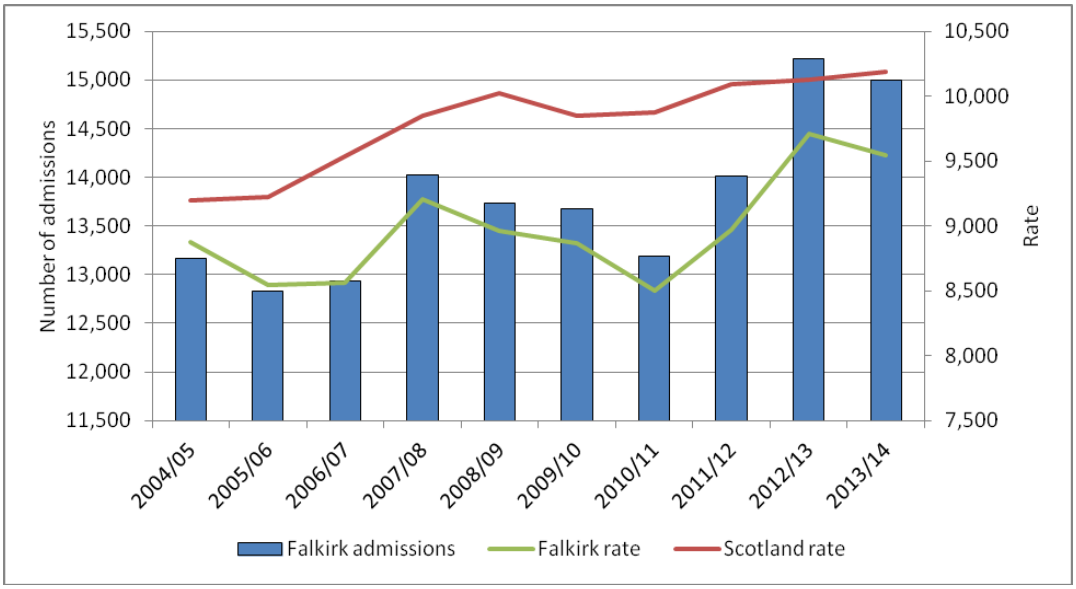


Figure 9:
Falkirk emergency admissions to hospital - 2004/05 to 2013/14. *Source: ISD Scotland*

As the numbers of older people increase, the number of hospital admissions is likely to increase. For example, Figure 10 demonstrates that 65+ year olds represent over a third of emergency admissions. Therefore, there is a need to reduce the rate of avoidable admissions.

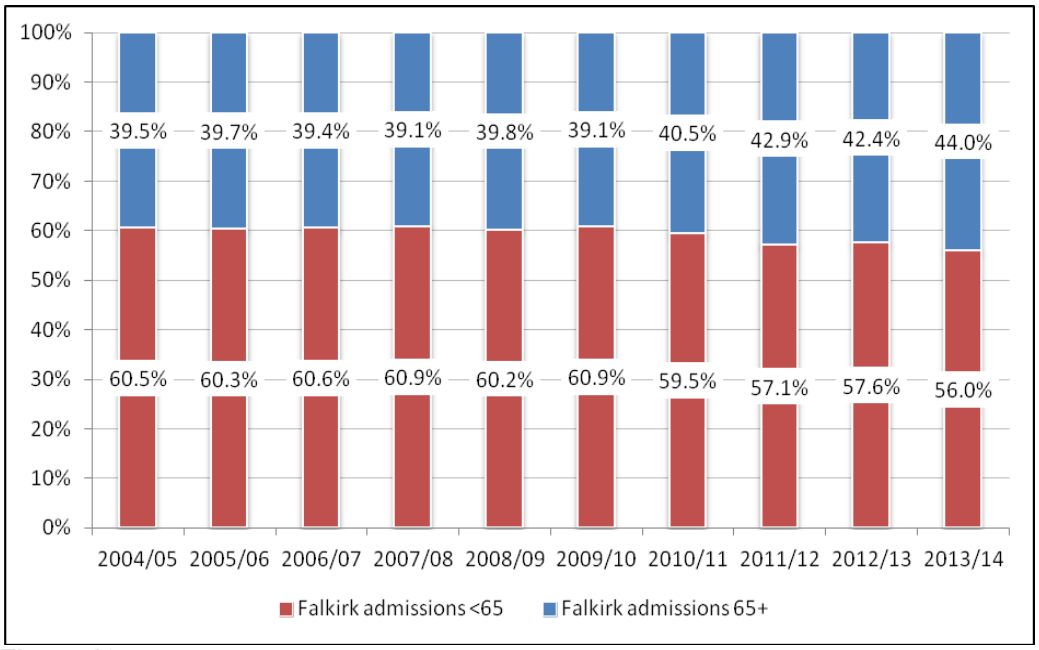


Figure 10:
% Emergency admissions by age group, Falkirk. *Source: ISD Scotland*

3.7 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.

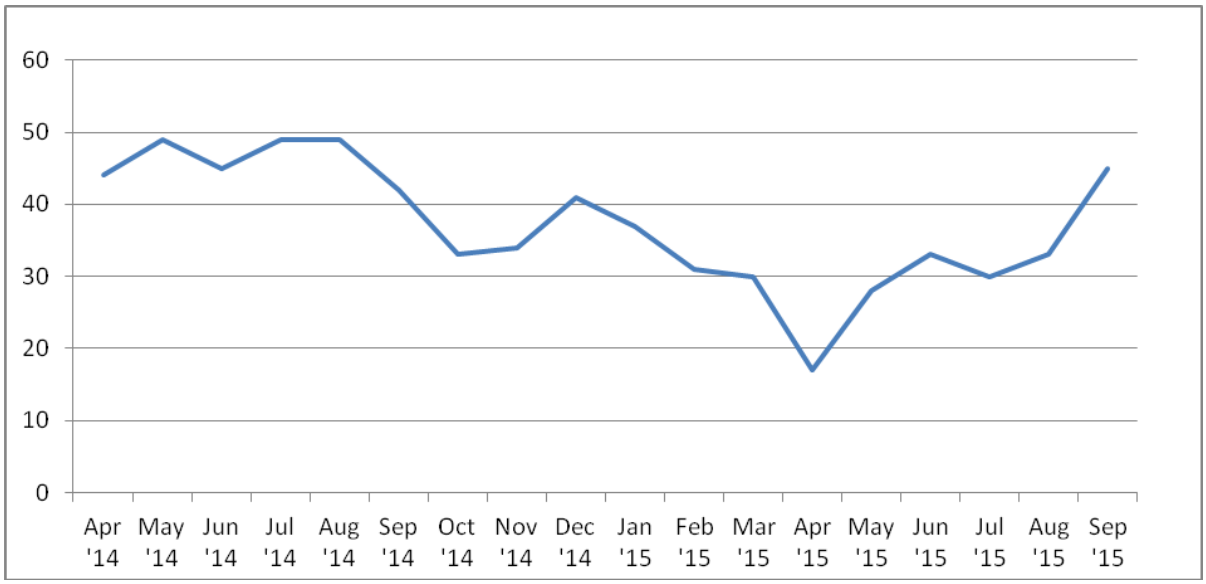


Figure 11:
Delayed Discharges in Falkirk LA, April 2014 – September 2015. Source: ISD Scotland

Figure 11 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.

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.

3.8 Key Issues

A detailed Joint Strategic Needs Assessment (JSNA) has been completed. This provides a comprehensive description of health and social care information for the Falkirk HSCI Partnership.

The key issues for the Partnership are:

- **The Falkirk area has an ageing population.** The 75+ year population is projected to increase by 98% by 2037. This has significant implications for service provision as over 75's are generally intensive users of health and social care. Corresponding with the growth in the older population, the working age population is expected to decrease. This has the potential to affect the ability to provide services. However, it is important to note that people are living longer and healthier lives. Many people aged over 60 years are contributing to society through volunteering within their community and caring for relatives.

- **Workforce.** The local demographics demonstrate an ageing workforce; subsequently, the Falkirk Partnership must consider the workforce to ensure that planned future services are sustainable. The raising of the retirement age also emphasises the need to develop strategies which meet individual and the Falkirk Partnership's expectations; enabling people to work longer with both energy and good health so that vital skills are retained.

- **It is projected that the Falkirk area will have growing numbers of people living with long term conditions, multiple conditions and complex needs.** There is a need to redesign services to better meet the needs of people with complex needs. People with several complex long term conditions are currently making multiple trips to hospital clinics to see a range of specialist services that are sometimes uncoordinated. This would suggest that a focus should be on the holistic needs of people and developing new pathways and guidelines rather than the current disease specific models.

- **Early intervention and prevention can make a difference.** If current disease trends continue then there are likely to be increasing numbers of people requiring support for their disease or condition. These trends could be influenced positively through a continued focus on health improvement, early intervention and prevention.

- **Carers.** One of the aims of Health and Social Care Integration is to keep people living independently in the community for longer. The projected increase in the older population and people with complex care needs is likely to mean there will be an increasing need to support carers.

- **Deprivation, housing and employment.** High levels of public resources are spent each year on alleviating health and social problems related to people and families who are trapped in cycles of ill health *(Christie, 2011)*. Consideration will be given to other important factors, such as housing, unemployment and poverty. The Partnership will adopt a whole-systems approach to improve health and social care outcomes and will work alongside Community Planning partners to address these wider issues.

In summary, the key issues described can have an impact on the delivery and availability of services at a time of reductions in public spending. For example, services associated with emergency hospital admissions and delays in discharge, care at home and community based services. This plan will take account of these issues and address them through integration and new models of service delivery. Further detail on the priorities and how we will achieve this are described in later sections of the plan.

3.9 Policy Context

The challenges described in this section are recognised across Scotland. The Scottish Government has initiated a major legislative programme of reform of public bodies to address these. The Integration of Health and Social Care ensures that those people who use services get the right care and support whatever their needs, at any point in their care journey.

The Falkirk Health and Social Care Integration Strategic Plan is a high level strategic framework. It sets out the reason for change and how we will begin to make the transformational changes and improvements to develop health and social services for adults. This will be over the next three years.

Key national legislation that has been considered in the development of Falkirk's Strategic Plan, and its outcomes and priorities include:

- Public Bodies (Joint Working) (Scotland) Act 2014
- Community Empowerment (Scotland) Act 2015
- Children & Young People (Scotland) Act 2014
- Community Learning and Development (Scotland) Regulations 2013
- Carers Bill
- Criminal Justice Bill
- Audit Scotland - Health & Social Care Integration report, December 2015

This plan takes account of the Clackmannanshire and Stirling HSCI Partnership Strategic Plan and priorities. 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. Consideration has been given to specialist services out with Forth Valley that Falkirk residents may need.

In the development of our Strategic Plan we took into account the existing plans that relate to health and social care.

These include for example:

- Falkirk Single Outcome Agreement 2013 - 2023
- Falkirk Strategic Outcomes and Local Delivery Plan 2016 - 2020
- NHS Forth Valley Healthcare Strategic Plan 2016 - 2021 (draft)
- NHS Forth Valley Clinical Services Review 2015
- NHS Forth Valley Local Delivery Plan 2015 - 2016
- NHS Forth Valley Winter Plan 2015 - 2016
- Falkirk Council Corporate Plan 2012 - 2017
- Poverty Strategy: Towards a Fairer Falkirk 2011- 2021
- Falkirk Joint Commissioning Plan for Older People 2014 –2017
- Forth Valley Integrated Carers Strategy 2012 - 2015
- Drug and Alcohol Strategy 2015
- Integrated Children Services Plan 2010 – 2015
- Local Housing Strategy 2011 – 2016
- Falkirk Council's Community Learning & Development Action Plan 2013-2018.

There are a number of national strategies, including:

- Mental Health Strategy
- Keys to Life Strategy (Learning Disabilities)
- Dementia Strategy 2012
- Physical Activity Strategy 2007 – 2017

4. PEOPLE'S VIEWS

The Strategic Plan has been developed using information about the Falkirk area, population and their needs. The HSCI Partnership will produce a Consultation and Engagement report on the process to develop the Strategic Plan. In addition, the HSCI Partnership will produce a detailed Falkirk Participation and Engagement Plan. This will outline how we will continue to engage with people and partners to develop integrated models of service delivery.

4.1. Wider Engagement

The HSCI Partnership has listened to the views of people living in and providing services within the Falkirk area to shape the plan. We have also acknowledged the legislation and national and local policy and planning arrangements.

Locality planning will put people and partners at the centre of developing current and future services, which includes setting local priorities. The Falkirk Participation and Engagement Plan will describe how people can be involved.

In the development of the Strategic Plan, we have:

Informed	**Engaged**	**Consulted**
Staff Newsletter Local Media Social Media Website Banner Posters in public venues/GP surgeries	Staff engagement sessions *(7 in total April & May 2015)* Transitional Board priority setting workshop *(18 June 2015)* Stakeholder engagement event for staff across all sectors *(30 June 2015)* Strategic Planning Group meetings *(August and November 2015 & January 2016)*	Citizens Panel Survey *(November 2015, with 493 responses)* Online Survey *(November & December 2015, with 73 responses)* Targeted presentation and feedback sessions *(23 in total throughout November & December 2015)*

Table 4

The process to date has been sequenced, with information from each event helping to inform the next. The Strategic Planning Group then refined and agreed the priorities. Wider consultation has taken place through the Citizens Panel and online surveys, during November and December 2015. This was also supported by 23 targeted presentation and feedback sessions to a range of stakeholder groups within the Falkirk area. These included:

Target Audience	Group/Forum
Communities	Community Council Forum Carers Forum ALFY Public Education Events Patient Participation Forum Friends of Dundas
Staff	Occupational Health Forum GP Sub Committee NHS Forth Valley Corporate Management Team Community Care Service Managers Meeting Playing to your Strengths Event
Partners	NHS Forth Valley Board Falkirk Council Falkirk Community Planning Partnership ICF Project Leads Alcohol and Drugs Partnership Community Care and Health Forum Scottish Care Providers Make it Happen Forum Fife and Forth Valley Community Justice Authority Board

Table 5

4.2 What people said future services should be

Consultation and engagement events have informed the HSCI Partnership about what future services should look like, **to *enable people in Falkirk to live full and positive lives within supportive communities*.** The responses from engagement on the draft plan are summarised below.

Respondents said future services should be:

- **Person-centred** – Good services are outcomes focused, centred round the needs of people. People are able to make informed decision regarding their own care pathway and are supported to self-manage, where possible. The transition process will be seamless and well-co-ordinated. For example, young people transition from children's to adult health and social care services will begin at a point that allows sufficient time to plan for new arrangements to be in place. 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.

- **Improved Access** – People are able to access services quickly via a single point of contact, particularly those with multiple or long-term conditions. Transition between services is supported with a back office infrastructure that facilitates smooth transfer via effective communication and information sharing. In addition, services are responsive and available consistently throughout the year, on a 24/7 basis, if appropriate. People said transport to services should be available, when appropriate.

- **Focused on Early Intervention** – People are supported by responsive, proactive services before reaching crisis. Education and information is accessible and readily available to people, their carers and families, which allows them to make informed choices and manage their own health and wellbeing. The HSCI Partnership recognises the critical link between traditional health and social care provision and the contribution of wider partners, for example, the Community Planning Partnership, Criminal Justice & Housing.

- **Enhanced Information Sharing** – Information sharing is critical to good integrated care – and is extended across all sectors. Information sharing includes the ability to share single assessments and care plans, which are co-produced by services users and professionals, and can be used and updated across professional specialisms. 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 with data sharing procedures in place.

- **Skilled Workforce** – A shared vision is held across all partners. The workforce across all sectors is highly skilled. Joint working across agencies and sectors is the norm and frontline staff are empowered to take decisions, which allow them to tailor response and care to suit the needs of individuals. The HSCI Partnership is able to identify, manage and tolerate risk, and staff are supported in being able to work in different ways to help people achieve their personal outcomes.

4.3 Further information on the consultation and engagement process to develop the Strategic Plan are described in the Consultation and Engagement report on the process to develop the Strategic Plan. The information from the Joint Strategic Needs Assessment and the consultation has helped shape the priorities for the partnership. These are described in the following sections.

5 HOW WILL THIS PLAN BE DELIVERED?

5.1 The Falkirk HSCI Partnership is committed to continuing our engagement with individuals and communities to develop high quality, responsive and effective services that improve outcomes for people. This section sets out how we will deliver the Strategic Plan. We will do this by:

- Working with communities and our staff to develop locality plans for each of the three areas
- Continue to engage with our workforce to develop services and to provide appropriate training and support
- Working with Community Planning Partners and the Third and Independent sectors to develop local services and support.

The Strategic Plan sets a direction for the next 3 years and will continue to develop in response to the changing environment and emerging feedback from communities and partners. In order to work towards the outcome and priorities, the following section outlines the required actions.

5.2 Localities

The Strategic Plan will be realised within three different localities, namely

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

The Falkirk HSCI Partnership will work alongside Falkirk Community Planning Partnership, including NHS Forth Valley and Falkirk Council, to implement a locality planning framework that will mean that local communities are involved in the design and implementation of new services; provided by statutory agencies and by communities themselves. This will also support the Community Empowerment (Scotland) Act.

Although three health and social care localities have been identified, the Community Planning Partnership will work with a greater number of smaller localities across the Falkirk area, with a particular focus on areas with high levels of deprivation. Local action planning that has previously been undertaken, in line with the local Community Learning and Development Action Plan 2015-2018, have highlighted challenges and need within communities based on 'lived experience'. Information has been gathered relating to health and well-being and health inequality. The Partnership will use and build on this intelligence when considering future community based provision.

5.3 Community Engagement

The HSCI Partnership will implement our Participation and Engagement Strategy. This will be in line with the National Standards on the Principles of Community Participation and Engagement, the Council's Principles of Community Involvement and the NHS Participation Standard.

This will mean that engagement with communities and the providers working within the areas will generate information which will set the scene for holistic provision. It will link to the work of the Community Planning Partnership to target health improvement activity and actions to reduce health inequalities and support people to live more independently in supportive, safe communities.

5.4 Services

The HSCI Partnership has responsibility for the planning and operational delivery of health and social care for adults within the boundaries of the Falkirk Council area.

There is a range of social care, primary and secondary healthcare and public health improvement services. There are also several examples of integrated working arrangements in place, such as the Community Mental Health and Learning Disability Teams. These provide valuable resources to continue to develop integrated services and ways of working.

Many initiatives are currently being tested and are contributing to local outcomes. Some of these initiatives are specific to certain localities and could be rolled out across the Falkirk area. Initiatives and service redesign have been, and will continue to be, developed consistent with the outcomes and priority areas.

The adult health and social care services, including those provided by the Third and Independent sectors, which will be within the agreed scope for planning and delivery are:

Current Community Health Services	**Current Local Authority Services**
• District Nursing • Services related to substance addiction • Services provided by AHPs in outpatient clinics or out of hospital • Primary medical services/ Public dental service/General dental, Ophthalmic and Pharmaceutical services • Community Mental Health and Learning Disability services.	• 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

Current Hospital Services	
• Emergency Department • Inpatient hospital services (General Medicine/Geriatric Medicine/Rehab Medicine/Respiratory) • Hospital based Mental Health services • Psychiatry of Learning Disability.	• Day services • Local area co-ordination • Respite provision • Occupational therapy services • Re-ablement services, equipment and Technology Enabled Care.

Table 6:

5.5 Housing

Housing has an important role to play in the delivery of coordinated, joined up and person-centred health and social care services. Successful integration of health and social care services will require that more people will be cared for and supported in a homely setting.

Falkirk has an ageing population, it is estimated that people over 65 years will increase by 72% from 2012 to 2037 (National Records of Scotland 2012 population projections). Over the same time period there will be an increase of 32% in single person households. The majority of the population (65%) in Falkirk live in owner occupied housing (2011 Census) which is above the national average (62%). In relation to older people, they are more likely to own properties than younger people.

It is estimated that there is a need for disabled adaptations in 2% of dwellings locally, equating to around 1, 380 properties (Scottish House Condition Survey 2011-13). Applying local information to national research, it is estimated that there may be a need for 510 all tenure wheelchair properties locally (Watson et al 2012).

The Housing Contribution Statement (HCS) is informed by consultation with stakeholders and the analysis carried out for the Housing Need and Demand Assessment. This Assessment identifies the contribution that specialist provision plays in enabling people to live well, with dignity and independently for as long as possible. It is important to target funding to plan the delivery of need from specialist groups; further information is available in the Housing Contribution Statement which has highlighted a potential need for Extra Care Housing for older people, advice and information for specialist groups and the importance of streamlining procedures for disabled adaptations.

The Housing Contribution Statements is an integral part of the Strategic Plan and provides a link between the Strategic Plan and the Local Housing Strategy.

5.6 Workforce

Effective leadership is crucial in providing direction and delegation, enabling staff at all levels across the HSCI 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.

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.

This workforce plan sets out our commitment to ensure a workforce that is responsive and skilled and is able to provide care and support that is local and of a high quality consistent with the Partnership ambitions.

The workforce plan also sets out the commitment to working across the wider health and social care sector, not just those employed by the NHS or the Council. This will support the ongoing joint commissioning of services and the approach to delivering services integrated at local level.

This plan will be a 'live' document and will be supported by more detailed workforce and organisational development action plans for localities and will reflect the ongoing Integration Joint Board corporate and national priorities.

5.7 Strategic Plan and other plans

In section 2.2, we describe the range of partnership and service plans in place. Importantly, public views and evidence based approaches informed their development, and there was wide consultation and research on these. The partners have individually and/or collectively agreed to work towards these and are at different stages of completion.

These plans are a helpful starting point to focus future HSCI Partnership activity. This Strategic Plan takes account of the legislative strategic planning requirements and how future local plans must align with the integration agenda and a whole system approach.

The Strategic Plan is supported by key documents which are available as annexes.

These are:

- Joint Strategic Needs Assessment
- Financial Plan
- Performance Management Framework
- Participation and Engagement Strategy
- Housing Contribution Statement
- Market Facilitation Plan

5.8 Resources - Financial Statement

Financial statement to follow - including position for IJB and budget savings targets.

5.9 Risk Management

The Strategic Plan will be underpinned by a Risk Management Strategy. This will provide staff with the necessary structure to assess and manage risk. Such an approach will be adopted at all levels of the HSCI Partnership to include management decisions and front line services with consideration of service users' and carers' views.

5.10 Equality and Diversity

Taking equalities into account is important as the demographics and needs of individuals and communities can be different and can change. It is necessary to consider equalities and diversity so that the Strategic Plan can have a positive impact on people that take account of their personal protected characteristics.

The HSCI Partnership will publish a set of equality outcomes and prepare a mainstreaming report.

5.11 Market Facilitation Plan

The Strategic Plan will be underpinned by a Market Facilitation Plan. The plan will give the Partnership a good understanding of the current levels of need and demand for health and social care services. This will then help us to identify what the future demand for care and support might look like and help support and shape the market. This will ensure there is a diverse, appropriate and affordable provision available to deliver effective outcomes and to meet needs.

The plan will represent the dialogue with service providers, service users, carers and other stakeholders about the future shape of our local social care and support market. By implementing the plan, we can ensure that we are responsive to the changing needs and aspirations of Falkirk's residents.

5.12 Performance Management and Reporting

Performance management is necessary to ensure the efficiency, effectiveness and quality of services and that these are regularly evaluated and monitored. This will include evaluating collaborative working within and across all sectors.

The Integration Joint Board will be held accountable for all services within their responsibility and need to publish an annual performance report. This will set out how the partnership is improving the National Health and Wellbeing Outcomes.

The Scottish Government has set out a range of core integration indicators to guide us (see Appendix 1). These are 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, we will supplement performance reports with local information that is collected more often.

Additionally a local suite of performance indicators will monitor progress against outcomes and priorities. Regular performance reports will be submitted to the Integration Joint Board. These will be included in the annual performance report.

Appendix 2

Falkirk Health and Social Care Integration Partnership

Strategic Plan Consultation and Engagement Report

Summary Findings

In summary, engagement and consultation has highlighted:

People generally see the integration of health and social care as an opportunity to improve care and support provided, however some feel the cultural differences between agencies will present a challenge that must be addressed.

People feel that joined process and procedure will allow effective integration, but that the focus should be on service improvement, effective use of resources and avoiding bureaucracy.

Improved communication with people who receive services and between agencies was consistently highlighted as important, as were accessible services with well trained and engaged staff.

Introduction

The Health and Social Care Integration (HSCI) Partnership set out to involve key stakeholders during the production of the Strategic Plan. Service users, carers, health and social care staff, , the public and key partners have had various opportunities to tell us what they think and participate in the production of the Strategic Plan. This was done through a series of information and consultation methods.

The engagement plan set out:

- 7 Staff engagement sessions: April to May 2015
- Transitional Board priority setting workshop: 18 June 2015
- Stakeholder engagement event for staff across all sectors: 30 June 2015
- Strategic Planning Group meetings: August and November 2015 & January 2016
- Presentation and Feedback sessions targeted: November to December 2015
- Online and Citizen's Panel survey

Information was disseminated to the public through staff newsletters, local media, social media, the Council and NHS Forth Valley websites and posters in in key spaces (including GP surgeries). A mix of consultative methods were used: a module of HSCI questions were included in the Council's Citizens Panel in November 2015, an online survey was open through November and December 2015 (routed from the Council and NHS Forth Valley's websites), and targeted presentation/feedback sessions took place throughout November and December 2015.

Staff engagement sessions were used to inform staff and changes and allow them to provide feedback on how their approach to work could alter. These staff included nurses, Occupational Therapists, Social Workers and Care Workers and also staff from Third and Independent Sector providers. Staff in these sessions discussed the impact of the HSCI changes on the day-to-day delivery of health and social care services. What was discussed then informed the Strategic Planning Group as they further refined the Strategic Plan's priorities.

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, however the Integration Joint Board agreed to extend the minimum prescribed membership to include Board, GP and staff representation. The prescribed membership includes representatives from service users, carers the Independent and Third Sector and Housing.

The proposed priorities were then distributed for wider consultation via the Citizens Panel and online surveys in November 2015 and targeted presentation and feedback sessions. The results of the surveys and sessions with the public have been fed into the redrafting of the Strategic Plan.

This report now presents consultation findings followed by a brief discussion and conclusion.

Citizens Panel 15 Findings

The Citizens Panel is made up of around 1,500 residents from across the Council area, with questionnaires distributed electronically or by post three times a year. The questionnaires have covered a variety of topics, with questions on quality of life, housing, , community safety and public health. This was the 15th Citizens Panel survey and had four particular sections: Local Development Plan, Local Housing Strategy, Health and Social Care Integration and About You.

There were 493 responses to the survey, with 174 postal returns and 319 online completions. For postal surveys we cannot utilise mandatory fields and therefore the number of responses is variable across questions.

39% of respondents were male, 42% were female and 19% did not specify their gender. The age range of this Citizens Panel was weighted to people over 45, with 38% aged 65 years or over and 72% aged 45 years or older. 12% were aged 25 to 44 years old. 15% did not specify their age. Figure 1.1 shows a complete breakdown of the age categories.

15% of respondents self-identified as disabled, with 69% stating they were not disabled. 16% did not answer the question.

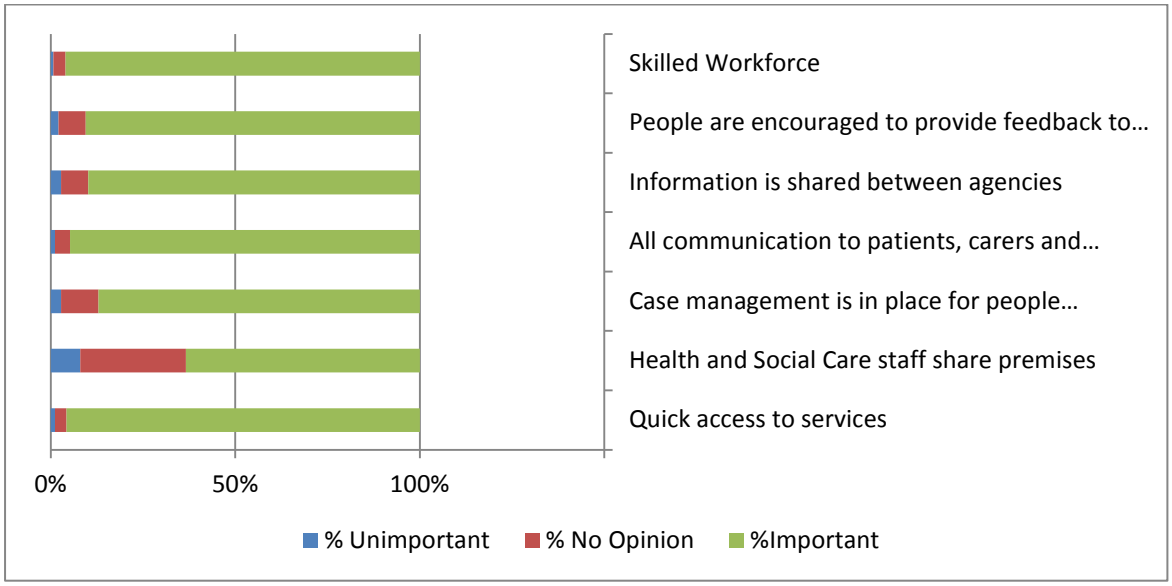
There were two questions within the HSCI section of the Citizens Panel questionnaire:

- *Q 34 - Here are a series of statements about Health and Social Care Integration. Please tell us how important these are to you.*
- *Q 35 - Based upon your experience, is there anything about Health and Social Care Services that you would like incorporated into the Strategic Plan?*

Q34: Here are a series of statements about Health and Social Care Integration. Please tell us how important these are to you.

423 people answered this question. Figure 1 below shows that most people think all themes are relatively important (i.e. noted important or very important on the Likert Scale), with the exception of co-location. Quick access to services and a skilled workforce could be identified as respondents' most important themes.

Figure 1: Importance of HSCI Themes



There were 33 comments in the 'other' field. Transport, confidentiality, operational capacity and communication were the most commonly recurring themes. (These themes were each identified by 4 people.) Table 1 provides illustrative quotes alongside key themes.

Table 1: Coded Responses to HSCI Themes

Theme	Responses	What People Said
Transport	**4**	*'Problems with transport to get to hospital for appointments.'* *'No shuttle transport from my area which goes near local health centre.'* *'dedicated transport enabling accessibility by elderly and infirm within the area of health care provision.'* *'Why do health centres have NO PARKING facilities for cycles?'*
Confidentiality	**4**	*'Assurance that confidentiality is maintained.'* *'more specific - and not all information should be shared around everyone unless it is on people who are in danger.'* *'Private and Confidential* [sic] *information should be as always.'* *'PRIVATE AND CONFIDENTCIAL* [sic]*!'* *'Information is only shared with other agencies where relevant.'*
Operational capacity	**4**	*'home carers* [sic] *are underpaid'* '*not enough care service today , too many hurdles , social services inadequate , only managers no Indians !! nobody willing to listen or act*.' *'Less PC….. more real people.'* *'Processes need to reflect support required for the ageing population.'*

3

Communication	**4**	*'Information must be relevant to those concerned.'* *'All communication should be in plain English with no jargon.'* *'Keep it simple.'* *'At the moment there is very little communication be the services.'*

Q35: Based upon your experience, is there anything about Health and Social Care Services that you would like incorporated into the Strategic Plan?

There were 117 responses to this question. The most commonly recurring themes were information sharing (20%); care-plan reviews (14%) and GPs (13%). Several aspects of GP care were raised, such as the number of GPs, the waiting times or length of GP appointments. Care-plan comments included the need for better dialogue between service providers and service users (co-production) and quicker assessment.

Box 1: People's Experiences of Health and Social Care Services

Information Sharing
'There needs to be more time spent with the elderly and more communication with health centres & families [sic]*.'*
'At the moment it seems that information is taking a long time to reach other departments, in this technology age that should not be a problem.'
'The different services need to work together to provide the best care. it is too disjointed & one department don't know what the other is doing.'

Care-plan Reviews
'Peoples [sic] *careplan should be reviewed ….., communication must be better between services.'*
'social care service that listens and then acts.'
'Timelines and all key contacts regularly reviewed.'
'Better understanding for people who require care.'

GPs
'More long-term doctor's at our clinic's easier appointment system week in advance not daily phone calls for appointments then being told to phone back next day etc, etc by receptionist.'
'Why are surgeries only open during office hours? Why not at weekends? I should have a blood checks at my local surgery. To do this I would need to take holidays. '
'Longer opening times at GP practices, including weekends.'
'Health centre is a joke at Bonnybridge + Banknock. Unable to see doctor for 4 weeks in between appointments. Bonnybridge drop in is ok if you are willing to wait between 2-3 hrs. With babies + children this is impossible.'

Online Survey

There were 73 responses in total to the HSCI online survey. The number of responses for each question was highly variable.

The online survey was promoted via:

- Front page banners on NHS Forth Valley and Falkirk Council Websites linking to the survey
- Partner agencies such as Third Sector Interface and Carers Centre promoting the consultation via their websites and newsletters
- Posters in community centres and GP surgeries, across the Falkirk area
- Information included within all Falkirk Council and NHS Forth Valley staff Pay slips
- Email via distribution lists?

There were targeted presentations to 23 groups across the Falkirk area (also giving opportunity for feedback).48 people told us whether they were staff, service users, carers and/or Third Sector workers. People could select more than one category, reflecting that someone can provide and use services. 58% (28 people) identifying themselves as service users., 42% (20 people) identified themselves as health and social care professionals, 40% (19 people) as carers and 31% (15 people) as Third Sector Organisations. 10 respondents identified themselves as representing an organisation, with 41 people answering as individuals and 22 non-responses.

There were 38 responses to the gender question, with 76% identifying themselves as female and 24% as male. All respondents had the same gender identity at birth. 83% (29) of 35 respondents identified themselves as heterosexual, with one person self-identifying as 'other' and 5 people selecting 'prefer not to answer'. 29 people stated their age on their last birthday, with 34% (10 people) aged 25 to 44, 34% aged 45 to 64 and 31% (9) aged 65 years or older.

All 38 respondents who gave their ethnicity identified themselves as white. Church of Scotland was the most prevalent religious affiliation, with 44% of 36 respondents followed by 31% identifying themselves as atheist.

11 people identified themselves as having a disability, 28% of the 39 people who answered that question. However, contradicting this data, 23 people specified a particular disability. 48% stated a physical disability, 48% a long term health condition and 35% a mental health condition.

There were seven questions in the HSCI online survey:

Q1: Based on your experience, is there anything that you would like to tell us about Health and Social Care Services that will help develop the plan?

There were 42 responses to this question. Table 2 provides a breakdown of the main issues people responded with and a selection of quotes for each. 42% of respondents emphasised a need for effective partnership working, whilst 29% underlined the importance of information sharing between key stakeholders. Improving patient care, smoothing access to services (such as a single point of contact), addressing the root cause of conditions and plain English communications were also put forward by 5 or 6 people each.

Table 2: Suggestions for Improving the Plan

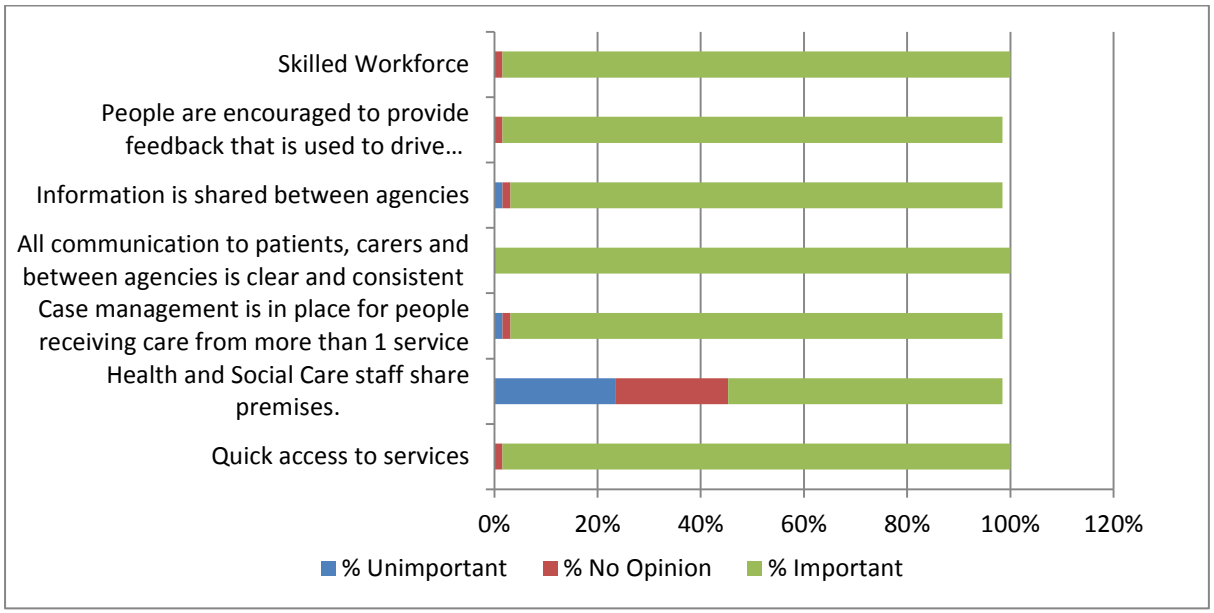
Theme	Responses	What People Said
Partnership Working	**17**	*'Reference to more explicit commitment to community planning (at strategic , tactical and operational levels) would strengthen the Plan and demonstrate a willingness to work in partnership with CPP partners to achieve improved outcomes.'* *'The partnership* [sic]*working across both services must continue and respect of each others roles acknowledged. Single shared assessment has never been evolved fully.'*[1]*'There is a need for a seamless transition between health and social services provision. More consideration is required for the transition from childrens* [sic] *services (health) to adult services (social work) where disabled are concerned.'*
Shared Information	**12**	*'IT communication should be improved to allow sharing of information easier.'* *'More communication between staff might make a difference.'* *'I think to have effective integrated teams there needs to be huge*

		consideration taken about having teams located together and everyone in those teams having access to each others information systems.'
Single Point of Contact/Ease of Access to Services	**6**	*'The near impossibility to contact a social worker to discuss possible future needs - this could result in the caring services being subject to unnecessary stress and expense.'* *'There are no easy answers to dealing with MS, but a single point of contact for me would really have helped me during the year since diagnosis.'*
Specific Condition	**6**	*'Right now management of long term conditions is lacking and within health there is not consistent treatment with locums and lack of services from GPs. The use of CBT for all mental health conditions and substance misuse is a short term plaster on the wound approach rather than a sustainable look at the root cause approach.'*
Improving Patient Care	**6**	*'Integration seems to be about bringing together two "organisational" bodies - what is needed is integral health and social care, integral medicine - all we are doing is producing more of the same whereas what is need is a change not only in how we do medicine and care but the kind of care and medicine we do. This is completely overlooked.'*

Q2: Here are a series of statements about Health and Social Care Integration. Please tell us how important these are to you.

64 people answered this question. Figure 2 below shows that most people think all themes are relatively important (i.e. noted important or very important on the Likert Scale), with the exception of co-location. This matches the results from CP15. Communications could be identified as the most important theme. There were 11 comments entered in the 'other' field. Four of these emphasised improving patient care, two suggested information sharing, whilst prevention, co-location and community-based support were mentioned once each.

Figure 2: Importance of HSCI Themes



Q3: Do you agree that by focusing on the priorities within the draft Plan, that health and social care will improve?

6

There were 73 responses to this question. 71% said yes and 29% said no. Three of these suggested insufficient capacity within health and social care to meet the objectives of the Strategic Plan, particularly in light of service reductions. Seven people specified the difference in organisational cultures as a barrier to improving health and social care services. Box 2 contains some of the things people said.

Box 2: Organisational Culture

'services may have shared budget and management[sic] *but still work within two different systems , practical day to day working needs to be a priority'*

'Social work and health are like oil and water. They speak different languages'

' I don't believe joint working is going to have good outcomes. I believe it will be health focused and not social work minded.'

'The plan has no real substance to it full of strategies and no doubt endless meetings to discuss how to do things meaning more bureaucracy and no real quality services at the front line'

'They are limited in scope and not aspirational enough'

'Has the field work staff been involved in the initial proposals and planning? Staff feel this has been proposed by politicians.'

Q5: Are there any other priorities that you think should be included?

65 people answered this question. 52% stated there were, whilst 48% said there were not. 28 people suggested additions to the existing priorities, with two most prominent suggestions being the engagement of service users and/or carers (36%/10 people) and improving some aspect of the health and social care user experience (29% /8 people). Partnership working, prevention, information sharing were each suggested by four people. More explicit focus on dementia, palliative care and drugs and alcohol were each suggested by one person. Table 3 contains more details on suggested additions to the Strategic Plan.

Table 3: Suggested Additions to the Plan

Theme	Responses	What People Said
Engaging service users/carers	**10**	*'Where to get information on how people can get more involved.'* *'More freedom to allow carers to dispense basic medication with agreement with family.'* *'Consultation with parents and carers did not happen before the decision to close the Rowans was taken.'* *'An embracing of a new medical / care paradigm, one which REALLY puts the patient at the centre, which treats causes not just signs and symptoms, which embraces the best of conventional and functional, integrative, complimentary approaches, and which truly LISTENS and communicates better. Patients are not all ill-informed nor ignorant.'* 'Use of project management approaches and customer feedback to help communicate changes to both staff and public.' 'Use of technology to support people to articulate their needs,

		provide feedback and influence services and plans and improve care, particularly at home…'
Improving Patient Care	**8**	*'To*[sic] *many people are being sent home from hospital to early meaning they end up back at hospital. Not everyone is seen by the appropriate professionals i.e physio, O.T. This could be avoided with better planning and a checklist should be made before someone can go home. Especially people who live on their own.'* 'Continue process to check post in-patient medicine reconciliation which has received attention in last few years. […] *Reduce medicine costs by not disposing of all unused medicines. Allow pharmacists* [sic] *to make the decision on which medicine can be sensibly re-used. Address wastage across the NHS. Doctors should tell the patients how much their medication costs so they might appreciate what they are getting free and* [sic] *finish the course.'* *'Achieving cultural* [sic] *shift to use of TEC in care planning as a first and not as a last resort.'*

Q7: Do you have any other comments you wish to make?

There were 24 responses to this question. The most common theme here was the practical impact that the organisational restructure could have. Box 3 contains some of the things people said

Box 3: Organisational Restructure

'A more joined up approach will benefit all stakeholders.'

'The plan should logically model the outcomes of the H and SC Board, the CPP and the ADP as they have similar priorities and outcomes.'

'Whilst core performance indicators are welcome, it would be beneficial if targets or quantitative measures of improved outcomes were included in the Plan.'

'More joined up services between GPs, DN and SW staff. Meet regularly, work together.'

'There needs to be a massive restructure of health and social care with less managers having ridiculously high salaries and massive pensions with more being spent on those actually delivering the services. More knowledge of what is actually behind poor health and less money wasted on meeting after meeting to discuss strategies and then implementation of strategies then changing strategies to justify management posts'

'Do not join up it will see a reduction in services and not person centred [sic] *outcomes which will benefit me or others.'*

5 people provided general comments on the engagement of service users and carers. There were two specific suggested amendments to the report:

> *'In the summary statement under local initiatives PDS should be under self management and instead the Alzheimer Scotland Community Connections programme should be under the community based support.'*

'The latter pages of the report where the 5 Outcomes are spelled out as against the nine areas in the 2020 vision makes for very confused reading for me as a professional and would be a severe challenge to most. The layout is the issue and improvements in this would be helpful in making sense of this as a summary.'

Presentation/Feedback Sessions

There were 23 different sessions with a range of participants. The following table provides a breakdown of who we spoke with.

Table 4: Presentation/Feedback Sessions

Participants	Group/Forum
Communities Carers Service Users Staff – health and social care	Community Council Forum Carers Forum ALFY Public Education Events Patient Participation Forum Friends of Dundas
Staff– health and social care	Occupational Therapists Forum GP Sub Committee NHS Forth Valley Corporate Management Team Community Care Service Managers Meeting Playing to your Strengths Event
Partners Communities Carers Service Users Staff – health and social care Third sector Independent Sector Housing sector	NHS Forth Valley Board Falkirk Council Falkirk Community Planning Partnership Integrated Care Fund Project Leads Alcohol and Drugs Partnership Community Care and Health Forum Independent Sector Providers Make it Happen Forum (for over-50s) Fife and Forth Valley Community Justice Authority Board Local Housing Strategy group - think this was the name of the group

Each session was made up of a presentation by a member of the Strategic Plan Co-ordinating Group followed by an opportunity for discussion and feedback. Similar themes emerged in the sessions as those raised in responses to the Citizens Panel and online survey. The most common theme was that people wanted integration to lead to improvement of health and social care services. All other themes discussed tie in with this, unsurprisingly. Information sharing and communications were discussed regularly. People also talked about the accessibility of services, how communities had been engaged and would be engaged in future, and they also asked how services would be resourced. Accountability was a common theme of the feedback exercises, with people asking who would be responsible for different parts of health and social care services at various points of time.

Table 5 below presents the main themes discussed and some of the things that people said.

Table 5: Key Themes from Information/Feedback Sessions

Theme	Occurrences	What People Said
Improved Services	**28**	*'There have been positive developments – Independent Sector Development Officer post has enabled better information sharing; learning opportunities in place – at local and national level'* *'Plan must recognise transition between child and adult services. Important to make strong links with Children Services in general'* *'How will the Board ensure that information is shared appropriately and securely?'* *'What is the role of the Board in regard to planning and service delivery?'* *'What difference will plan make?'*
Accountability	**20**	*'… clear implementation plan with delivery actions including the need to agree that these are the Partnership priorities and commit officer to proceed with these'* *'need to build an accountability to the delivery of the plan, challenge when this is not being done'*
Information Sharing	**17**	*'Need for improved information sharing was agreed as a priority area'* *'How will the Board ensure that information is shared appropriately and securely?'*
Accessing Services	**14**	*'Who can be key contact for people?'* *'It would be helpful if there was one person, one key contact who could contact everyone to inform them'*
Level of Resources	**13**	*'The ICF process needs reviewed for future allocations'* *'The independent sector is facing a lot of challenges – recruitment and retention; low pay; ability to offer contracts to staff* […] [these are] *impacting on ability to deliver these hours of care'*
Community Engagement	**13**	*'Community Council know their areas – what is needed and potential solutions – and should be more engaged in discussion about services'*
Communications	**13**	*'need to have a clear vision that is known by all and clarity how this will be communicated'* *'Community Councils have their own Facebook pages and can share information to the wider community'*

Going Forward

Staff engagement has been relatively strong, but engagement with the public has not been as strong as we would have liked. Only 73 people took part in the online survey and nearly half of those people work in health and social care. However, this is just the first stage in an ongoing engagement with service users, carers, staff, partners and local communities.

The key issues people raised throughout the HSCI engagement were effective information sharing; clear communications; accessible, accountable and improved services and meaningful community engagement. We have made sure that these issues are represented within the Strategic Plan. We have also, as and when required, provided information to the relevant people on suggested improvements to services. This is part of our concerted efforts to listen to the needs of people and make our services more responsive to people's needs.

This paper relates to
Agenda Item 7

Title/Subject: **Delayed Discharge**

Meeting: **Integration Joint Board**

Date: **5 th February 2016**

Submitted By: **CHP General Manager and Head of Adult Social Care Services**

Action: **For Noting**

1. INTRODUCTION

1.1 The purpose of this paper is to update Integration Joint 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.

2. RECOMMENDATION

2.1 The Integration Joint Board is asked to note current performance.

3. BACKGROUND

3.1 As of 15th January census date, there were 27 people delayed in their discharge, 20 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 a modest improvement in the overall position from November 2015 and in the number of people waiting over 2 weeks, compared with November and December census position.

Table 1 (excluding Code 9 & Code 100)

	Apr 15	May 15	Jun15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16
Total delays at census point	6	19	24	23	25	36	23	37	35	27
Total number of delays over 2 weeks	1	9	11	11	16	25	19	20	24	20

3.3 Table 2 shows the total picture of delays in Falkirk Partnership across all categories expressed as occupied bed days. These figures are for full months to the end of December.

Table 2 total occupied bed days

	September	October	November	December	Equivalent Beds (December)
Standard Delays	1097	802	1001	1085	35
Complex Delays/ Guardianships (Code 9)	268	248	231	248	8
Code 100 Delays	210	248	279	279	9

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

Ta**ble 3**

	Total Delays (excl. Code 9)	Delays Over 2 Weeks	Delays Under 2 Weeks	Longest Wait (days)	Code 9 (Only guardianship 51x)	Total (Standard + Code 9,51x)
23rd Dec	37	22	15	63	17	54
30th Dec	38	29	9	72	17	55
7th Jan	33	28	5	80	16	49
14th Jan	30	21	9	87	15	45

3.5 The availability of care homes in Falkirk to support patient's first choice remains very limited. In addition, there has been limited availability of interim places across Forth Valley in the last 2 months. The number and length of delays continue to be challenging with **5** patients delayed for more than **4** weeks and **12** delayed for more than 6 weeks.

3.6 The discharge of **5** patients is currently been taken forward under the policy on choice.

3.7 The availability of care at home services remains a challenge due to difficulties in recruitment. Services are working hard to recruit appropriate staff and will use short term and interim placements at Oakbank and Summerford should delays for this reason increase. Work on jointly agreeing the criteria for the use of short term placements is underway and should result in better use of these placements.

3.8 Some nursing homes are now refusing to take people on an interim basis. Work continues through the Development Worker from Scottish care to address this issue.

4. ACTION PLAN

4.1 The Delayed Discharge Sub Group of the Joint Management Group has been working on the development of an action plan covering the following 5 key areas:

- Re-model services to deliver a broader range of community based services available over 7 days. This would encompass Closer to Home and Alfy, Frailty, short stay assessment, and community rehabilitation services.

- Identify the population who have the biggest need for health and social care services and plan services which reduce that need and support them to live well at home.

- Analyse the discharge pathway, identify blockages, and improve the process of discharge with a focus on 72 hour discharge.

- Promote power of attorney both with staff and with the public through staff awareness and public awareness campaign.

- Embed a home first ethos across acute hospital and community services. Review model of intermediate care including short stay assessment and intermediate care beds.

A summary action plan is attached at Appendix 1.

5. CONCLUSIONS

5.1 The delayed discharge position has seen modest improvement last 2 months and the delayed discharge position continues to be a significant challenge for the Partnership.

5.2 Ongoing actions are required 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: 21/01/16
List of Background Paper

Key Issue 1: There are a number of services which are currently being delivered which are having an impact on small numbers in the population but are not having the impact required across the area to reduce ED attendances or acute admissions.

Measures of Success/Impact

- **Process measures** : Evidence of coordination across services e.g. single points of access/awareness of services and how they work.
- **System Impact measures** : Linked data showing impact on admission/discharge/length of stay and readmission.
  : Positive impact on high cost care.
- **Person centred measures** : Evidence of person experience/story/audits of individual case studies linked to strategic plan person centred outcomes.

Action	Lead Officer	Timescales	Key Milestones	Reporting
Systematic review of current service provision. Re-model and implement changes where necessary to meet the needs of the total population in a planned and sustained way. Services will include closer to home/Alfy/Frailty/Short Stay Assessment provision/OOH 24/7 services.	• Kathy O'Neill	• 6 month interim evaluation of closer to home model June 2016	By the end of 2016:- • Closer to home will be fully implemented across all 3 pathways. • All services will be better connected with single points of contact/access where appropriate. • There will be linked data showing the impact on individuals and the wider health and social system of more coordinated and intensive interventions.	Integration Joint Board
Linked Actions:				
• Implement closer to home.	• Marlyn Gardner	• December 2015		Joint Management Team
• Recruitment of community physicians/development of closer to home acute pathway.	• Leslie Cruickshank	• During 2016		Joint Management Group
• Recruitment to ARBD Team and evaluation of impact on high resource patient group.	• Kathy O'Neill	• 6 month interim evaluation of ARBD Team – July 2016		Integration Joint Board
• Use of LIST data analysts to identify population who require most intensive input across health and social care.	• Patricia Cassidy	• February 2016		Joint Management Team

Key Issue 2: There are patients in hospital whose pathway is delayed for a variety of reasons and, while not formally delayed in their discharge, their length of stay in hospital could have been shorter.

Measures of Success/Impact

- **Process measures** : Increase in proportion of discharges within 72 hours. Staff awareness of admission/transfer/discharge policy.
- **System Impact measures** : Improved length of stay measured through day of care audits.
- **Person centred measures** : Patient stories/audit of individual pathways.

Action	Lead Officer	Timescales	Key Milestones	Reporting
Analyse current patient pathways from home to home. Analyse key points in pathway through hospital, indentify blockages and streamline pathway. **Linked Actions:**	• Chris Beech	• March 2016	During 2016:- • Key points in the process of admission and discharge will be measured. • Blockages affecting timely discharge will be proactively identified and addressed. • Potential to discharge to assess at home or in short stay assessment will be proactively pursued.	Joint Management Group
• Develop patient tracking system and measure key points in admission and discharge pathway	• Chris Beech	February 2016		
• Review model of intermediate care in Falkirk including pathway for use of short stay assessment beds.	• Susan Nixon	• March 2016		Joint Management Group
• Implement agreed changes to skill mix and utilisation of the Integrated Discharge Team to support timely discharge from acute hospital.	• Lorna Henry	• January 2015		Joint Management Group
• Use planned dates of discharge on admission proactively.	• Ian Aitken	• December 2015 (linked to Winter Plan)		Delayed Discharge Sub Group

Key Issue 3: There are a number of patients whose discharge becomes delayed as they fall within the scope of the Adult with Incapacity Act.

Measures of Success/Impact

- **Process measures** : All ACPs have evidence of discussion regarding power of attorney.
  : Close measurement of AWI pathway and evidence of review at key points in guardianship process.
- **System Impact measures** : Reducing trend in overall number of people delayed for AWI reasons.
  : Reducing trend in occupied bed days.
- **Person centred measures** : More patients and carers aware of benefits of power of attorney.

Action	Lead Officer	Timescales	Key Milestones	Reporting
Promote power of attorney through proactive awareness with GPs, Acute hospital and health & social care staff. Educate general public that this is positive step for future. **Establish Project Team to undertake this work.** **Linked Actions:**	• Kathy O'Neill & Project Team	• Spring 2016	By summer 2016:- • There will be a step change in the awareness and understanding of staff of the importance of power of attorney. • A public campaign raising awareness of the benefits of power of attorney will have happened.	Joint Management Group & IJB.
• Identify patients early in hospital stay who are likely to fall within remit of AWI Act. Take steps to have early conversations with families.	• Ian Aitken	• Immediate	• Where guardianship applications are necessary, the process will be proactively managed.	
• Involve MHO staff early in the inpatient journey.	• Susan Nixon	• Immediate		
• Meet with Sheriff Principals and local Solicitors to streamline legal process.	• Project Team	• Spring 2016		
• Plan and undertake local public campaign (radio/press/leaflets/TSI).	• Project Team	• Spring 2016		
• Ensure every ACP has evidence of discussion of power of attorney.	• Marlyn Gardner	• Immediate		

Key Issue 4: The right balance and range of care options is now available in Falkirk to support early discharge and avoid admission.

Measures of Success/Impact

- **Process measures** : Improved information on need and required capacity for range of care options.
- **System Impact measures** : Proportion of Falkirk population going into long term care.
  : Increase in numbers of patients discharged home from FVRH.
- **Person centred measures** : Patient stories/individual case audits.

Action	Lead Officer	Timescales	Key Milestones	Reporting
Embed ethos of "home first", 72 hours discharge to assess. Following admission, ongoing care needs should be considered in a non acute environment. **Linked Actions:**	• Ian Aitken	• Immediate and ongoing	By the end of 2016:- • There will be a greater understanding of the utilisation of long term care options in Falkirk to inform future planning and commissioning.	
• Identify care home admission rate per head of population. Use this to identify required capacity in short and medium term.	• Susan Nixon	• February 2016	• The benefits of and need for short stay assessment care options will be better understood and more embedded as a clear pathway from hospital.	
• Review use and availability of short stay assessment beds as an alternative to admission to care home.	• Susan Nixon	• March 2016		
• Consider options for "step up" to short stay assessment as part of a pathway including closer to home/frailty unit etc.	• Chris Beech/Marlyn Gardner	• March 2016		

This paper relates to

Agenda Item 8

Title/Subject:	**Health and Social Care Integration Programme Plan Update**
Meeting:	**Integration Joint Board**
Date:	**5 February 2016**
Submitted By:	**Chief Officer**
Action:	**For Decision**

1. INTRODUCTION

1.1. The purpose of the report is to provide a progress report to the Integration Joint Board on the programme of work to implement health and social care integration.

2. RECOMMENDATION

The Integration Joint Board members are asked to:

2.1. Note the content of the report and progress to date

2.2. Consider the IJB meeting timetable to enable the necessary consideration and approval of reports being brought forward by the workstream groups as at section 4.5.

3. BACKGROUND

3.1. The Public Bodies (Joint Working) (Scotland) Act 2014 sets out a number of statutory requirements for Health and Social Care Partnerships to meet in order to implement health and social care integration.

3.2. The Integration Joint Board has received regular reports noting the programme of work to ensure the Board is satisfying itself that all relevant matters are being progressed in a timely manner.

4. INTEGRATION PROGRAMME PLAN

4.1. The Integration Programme Plan and associated workstreams should ensure the delivery and implementation of a range of tasks that are required to support new integration arrangements and to ensure the Partnership meets their statutory obligations from April 2016.

4.2. The workstream groups established to support integration arrangements are as follows:

- Strategic Planning group
- Strategic Planning co-ordinating group
- FV Governance group
- FV wide Finance group, with two supporting sub groups
- FV wide HR workforce group
- FV wide Performance and Measurement group
- FV wide Data Sharing Partnership group
- FV wide Clinical and Care Governance group
- FV Risk Management group
- Falkirk Participation and Engagement group
- Falkirk Partnership OD and Workforce Development group.

4.3. The key achievements updates since the report in September 2015 and future actions for these workstream groups are attached in Appendix 1. The Strategic Planning Group and Strategic Planning Co-ordinating group updates are separately reported to the Integration Joint Board in the standing agenda item on the Strategic Plan.

4.4. There has been work undertaken with the workstreams to revise their action plans to ensure these reflect the required tasks, leads and timescales. The Programme Board has highlighted that a number of the actions are interdependent across the workstreams and can be completed when the financial position and delegated functions are finalised.

4.5. The workstreams are taking forward a range of work that will ensure the Board meets its obligations from 1 April 2016. These are identified in Appendix 1. The Board is asked to consider its meeting timetable to enable the workstreams to bring forward reports for the necessary consideration and approval.

5. CONCLUSION

5.1. Work is progressing within challenging deadlines, which will require a strong commitment from all partners to ensure the Partnership meets its statutory obligations under the Public Bodies (Joint Working) (Scotland) Act 2014 by 1 April 2016.

5.2. A number of the workstreams have significant areas of work and will continue beyond March 2016 as part of the longer terms change programme.

5.3. **Resource Implications**
The Integration Joint Board should note that the respective partners are contributing significant resources to supporting integration as reflected in the membership and areas of work being taken forward in the respective workstreams. It should be noted that this is, at this point in time, considerable commitment for all parties.

5.4. **Impact On IJB Outcomes, Priorities And Outcomes**
By completing the work associated with the work streams the Partnership will meet its statutory obligations under the Public Bodies (Joint Working) (Scotland) Act 2014 by 1 April 2016. The primary focus for the workstreams is on meeting the core legal requirements and those provisions within the Integration Scheme by this deadline.

5.5. **Consultation**
Workstream outputs, where required, will be subject to consultation.

5.6. **Legal & Risk Implications**
There is a risk if work as outlined is not completed we will fail to meet our statutory obligations under the Public Bodies (Joint Working) (Scotland) Act 2014 by 1 April 2016.

5.7. **Equalities And Human Rights Assessment**
Equalities and Human Rights Impact Assessments will be carried out as required for each workstream. The recommendations in this report do not require an Equalities and Human Rights Assessment.

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Approved for Submission by: Patricia Cassidy, Chief Officer

Author: Suzanne Thomson, Programme Manager – Integration
Date: 25 January 2016

List of Background Papers:
Transitional Board: 4 September 2015 - Health and Social Care Integration Programme Plan and Workstream Updates
Integration Joint Board: 4 December 2015 – Health and Social Care Integration Programme Plan Update

Work Stream	Chair	Key Milestones to Date	Key Priorities / Actions	Outline Timescales
Governance	Patricia Cassidy	Agreed the scope of the workstream which will ensure compliance with the Act, the roles and responsibilities guidance and other relevant non-financial guidance. Standing Orders agreed by the IJB on 6 November 2015.	Complaints policy and procedures in place for IJB complaints FOI policy and procedures and Publications Scheme in place in line with FOISA Equalities duties completed (in line with IJB requirements under the Equalities Act 2010)(Specific Duties)(Scotland) Regulations 2012 Agree template for EQIA to be used Creation of Records Management Policy, retention schedules and when invited submission to the Keeper of the Plan in line with PRSA Parties to agree the provision of support services for the IJB - on incorporation - integration function are carried out IJB to put in place its own code – Ethical Standards in Public Life etc (Scotland) Act 2000.	March 2016 March 2016 30 April 2016 31 March 2016 31 March 2018 March 2016 November 2016
Finance	Fiona Ramsay	Three years spend and budget information shared for in scope health and social care. Due diligence undertaken with four issues identified for further consideration.	2016/17 Budget Setting from respective authorities	End February 2016

Work Stream	Chair	Key Milestones to Date	Key Priorities / Actions	Outline Timescales
		Paper outlining 2015/16 Budget information and 2016/17 outlook scheduled for consideration at February meeting Governance work concluded for Internal Audit and Reserves		
HR Workforce	Helen Kelly	High level management data has been collated to allow an understanding of the workforce in scope for HSCI within their partnership. Integrated Workforce Plan drafted and submitted for consideration at January IJBs. Held learning event with colleagues in the Ayrshire and Arran partnership, shared experiences and lessons learned. Second formal Joint Staff Forum took place on 9 December, constitution agreed.	Development of Operational Plan Further analysis of workforce data information.	April 2016 March 2016
Performance & Measurement	Elaine Vanhegan	Draft Performance Management Framework developed and reviewed by Programme Board in January Workstream meets regularly with main focus on requirements to 31 March 2016 and then review ongoing support in terms of performance to the IJBs and partnerships Three key areas of focus reported previously continue: • Creation of initial Performance Management Framework acknowledging legislative	Further update required once agreement reached on operational arrangements and scope. For IJB approval in March Agreement on relevant and priority indicators for Year 1 based on national outcomes and needs of Strategic Plan – finalise on approval of Plan Preparation of Integration function performance target list and Non integration functions performance target list. Finalise on	March 2016 March 2016 March 2016

Work Stream	Chair	Key Milestones to Date	Key Priorities / Actions	Outline Timescales
		requirements and needs of both routine reporting and production of an Annual Report - Framework focuses on the Why and How • Metrics and Indicator mapping based on National Outcomes Integration Indicators cross linked to relevant local SOA/HEAT targets = the What • As per the Integration Schemes prepare: o Integration functions performance target list. o Non integration functions performance target list. Close liaison with other work streams to prevent duplication i.e. data sharing IM&T	agreement on operational functions - For IJB approval in march	
Data Sharing Partnership	Jonathan Procter Paul Woolman (Interim)	Information Sharing Board (ISB) bid for funding received in December, only half the funding needed for Data Sharing Portal Pilot. Network IT and security principles agreed with Councils. Detailed level requirements are needed from IJBs and business managers.	Alternatives to Orion Portal pilot discussed and several options being progressed Delayed discharges replacement system requirements analysis progressing Delayed discharges social work process data still awaited from Councils Outline requirements for IT network access being requested from managers in various departments Pursuing infrastructure options with Cisco	ISB funding to be spent this financial year End January Awaiting council SW developments Awaiting requirements This financial year

Work Stream	Chair	Key Milestones to Date	Key Priorities / Actions	Outline Timescales
			Joint inspection requirements analysis is progressing	March 2016
Clinical & Care Governance	Tracey Gillies	Draft Clinical and Care governance framework for consultation with Programme Board for comment	Approve Clinical and Care governance framework	March 2016
Risk	Hugh Coyle	Draft Risk Management Strategy and Guidance developed by workstream and circulated for comments	Revised draft Risk Management Strategy and Guidance discussed at Programme Board Develop Risk Register	March 2016 March 2016
Participation & Engagement	TBC	Consultation and engagement completed on the draft Strategic Plan during November and December 2015. Meeting held with communications leads to agree process to develop strategy and identify lead. A further meeting is convened to progress this.	Finalise Consultation Plan on the development of the Strategic Plan Develop Participation and Engagement Plan Staff newsletter has been drafted for circulation Web-based information updated.	February 2016 March 2016 February 2016 Ongoing
Organisational Development & Workforce Development	Morag McLaren	<u>Falkirk Partnership</u> Approval for an Appreciative Inquiry engagement process with staff and stakeholders has not progressed as planned. Delivered short intervention leadership programme – 'Playing to Your Strengths' (Nov 15 – Jan 16)	Identify alternative focus for Appreciative Inquiry process, if appropriate (Feb 16) Continue to support existing work as well as work which may be commissioned by the Partnership. It is expected that this will include (specific to Falkirk and in relation to	

Work Stream	Chair	Key Milestones to Date	Key Priorities / Actions	Outline Timescales
		OD & Workforce Development Group continues to meet with members from key stakeholder organisations <u>Both Partnerships</u> IJB OD Sessions delivered (Oct/Nov/Dec 15) Draft Joint Workforce Training & Development Frameworks for both Partnerships produced (Dec 2015) Draft medium-long term Workforce Strategy produced (Dec 15) Meeting held to discuss development needs for Joint Staff Forum Members	both Partnerships): • Identify further short-term development requirements for Partnership leaders and structures based on outputs of 'Playing to Your Strengths' programme (Feb 16) • OD support to Community Planning Partnership Strategic Priorities Workshop – Improving Mental Health & Wellbeing (Feb 16). Seek IJB approval of draft medium-long term Workforce Plans (Jan/Feb 16) and engage with key stakeholders to develop resulting detailed OD & WFD Plans for 2016/17 and beyond (Mar 16). Seek approval of draft Joint Workforce Training & Development Framework (Jan/Feb 16) and develop an initial resulting Plan which identifies workforce development and training priorities to be taken forward during 2016/17 in support of delivery of the Strategic Plan and aligned with the wider Workforce Plan (Mar 16). Publish phase 1 staff engagement outputs report (ASAP), and develop and implement plans for phase 2 (Jan/Feb 16)	

Work Stream	Chair	Key Milestones to Date	Key Priorities / Actions	Outline Timescales
			Support the Chief Officer to review and develop Joint Management & Governance Structures to meet the needs of the new Partnership. Support the Chief Officer and senior leaders to identify future leadership development needs. Continue to support development of newly established Partnership structures (e.g. IJB, Strategic Planning Group, Joint Staff Forum), including identifying and implementing interventions to support individual member development needs. OD support to Community Nursing leadership cohort (Jan 16) Personal Development needs of IJB members to be identified and supported (Mar 16)	

This paper relates to Agenda Item 9

Report to: **Integration Joint Board**

Title/Subject: **Partnership Fund Update**

Date: **5 February 2016**

Submitted By: **Chief Officer**

Action: **For Decision**

1. INTRODUCTION

1.1 The purpose of the report is to provide an update to the Integration Joint Board (IJB) on the Partnership funding.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1 note the updated summary of partnership funding and the projected uncommitted resources as detailed in the Partnership Funding Summary at section 4

2.2 authorise the Chief Officer, in discussion with the IJB Chair and Vice-chair and Chief Executives, to agree interim funding of up to 6 months beyond 31 March 2016 where funding ends at that date within the existing available resources

2.3 remit the Chief Officer to complete a full evaluation and review of each project and to report back in detail with recommendations to the IJB meeting on 3 June 2016

2.4 remit the Chief Officer, in conjunction with the Falkirk Joint Management Group (JMG), to review local governance arrangements for the administration of the partnership funding

2.5 remit the Chief Officer, in conjunction with the Falkirk JMG, to bring forward to the June 2016 Board meeting a detailed Partnership Spending Plan for 2016/17 that will support the implementation of the Strategic Plan priorities

2.6 remit the Chief Executives, in conjunction with the Chief Officer, to consider support arrangements for the IJB and bring forward proposals as part of the Financial Plan at the next meeting of the IJB.

3. BACKGROUND

3.1 The Transitional Board and Integration Joint Board have previously received reports on the partnership funding made available from the Scottish Government to support the delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen our approach to tackling inequalities. There have also been specific reports on the Integrated Care Fund which builds on the Reshaping Care of Older People (RCOP) Change Fund Plan and the Delayed Discharge fund.

3.2 The Integration Joint Board received a report in December 2015 outlining the partnership funding position. This noted that the Transitional Funding has been committed in 2015/16 and there will be a balance of funding in the Bridging Resource.

3.3 The partnership funding that will therefore be available in 2016/17 and 2017/18 and referred to in this report are the:

- Integrated Care Fund (ICF)
- Delayed Discharge fund
- Bridging Resource.

4. PARTNERSHIP FUNDING SUMMARY

4.1. The following table provides an update of projected spend in 2015/16 identifying slippage of £1.739m which will be carried forward into 2016/17. Slippage has increased since the previous report.

Table 1 : Funding and Projected Partnership Spend 2015/16

	2015/16 Funds Available £'000	2015/16 Proj. Spend £'000	2015/16 Proj. Variance £'000
Bridging Resource	1,639	1,492	(147)
Delayed Discharge	897	897	0
Integrated Care Fund	2,880	1,288	(1,592)
Transitional Funding	126	126	0
Total	**5,542**	**3,803**	**(1,739)**

4.2 Funding for 2016/17 would be £ 5.483m (inclusive of carry forwards) as follows in Table 2 :-

Table 2 : Estimated Funding Availability 2016/17

	2016/17 £'000
Bridging Resource c/fwd	147
Delayed Discharge	864
Integrated Care Fund	2,880
Integrated Care Fund c/fwd	1,592
Total	**5,483**

Given the level of carry forward into 2016/17 this confirms interim funding availability to support the proposal outlined in 5.4 below.

5. PARTNERSHIP SPENDING PLAN FOR 2016/17 INVESTMENT

5.1 The Board has received a report on the development of the Strategic Plan as a separate agenda item, and is aware that further information regarding the IJB budget has to be concluded as part of the Council and NHS Forth Valley budget setting processes.

5.2 Taking into account that the available partnership funding is the dedicated resource available over the next 2 years to support the integration process, it is critical that consideration is given to how this can be used in its entirety to best effect.

5.3 Further work is required to ensure that existing projects and proposals for new projects are clearly aligned to the Strategic Plan. Given the timing of the production of the plan, there has been initial work completed to evaluate projects, however this needs further refinement before presenting to the Board for consideration.

5.4 There are a number of projects where funding is due to end on 31 March 2016. To minimise service disruption, it is proposed that the Board consider remitting the Chief Officer, in discussion with the IJB Chair and Vice-chair and Chief Executives, to agree interim funding of up to 6 months to current projects within the existing available resources. This will allow time to complete a full evaluation of each project to assess if it can contribute to improve local outcomes. A full report will be submitted to the IJB meeting in June 2016 with recommendations to continue, mainstream or stop.

5.5 The additional funding will provide project leads time to complete the evaluation and to enable them to manage any change as a result of the board decisions taken in June.

5.6 The Board will be aware of the proposal to appoint a Co-ordinator on a 6-month basis, to oversee the projects supported by the partnership. The recruitment process is ongoing for this post, which has had an impact on the evaluation and administration of the funding. It is therefore proposed that the Board remit the Chief Officer, in conjunction with the Falkirk Joint Management Group (JMG), to review local governance arrangements for the administration of the partnership funding.

5.7 The JMG as part of this process will consider short-term initiatives and priorities which can support change in current care models or may require more sustained funding. These will be focussed on the priorities identified in the draft Strategic Plan.

5.8 It is further proposed that the Board remit the Chief Officer, in conjunction with the Falkirk JMG, to bring forward to the June 2016 Board meeting a detailed Partnership Spending Plan for 2016/17 that will support the implementation of the Strategic Plan priorities.

5.9 There will also be a need to consider the necessary infrastructure requirements to support the Integration Joint Board and the implementation of the Strategic Plan. There are a number of posts, including the Chief Finance Officer, where funding is due to end in March 2016. Given the legislative requirements associated with these posts, it is proposed that the Chief Executives, in conjunction with the Chief Officer, consider these arrangements and bring forward proposals as part of the Financial Plan.

6. CONCLUSION

6.1 There has been initial work completed within the available resources and capacity to review existing projects and funding. This now needs to be concluded in line with the Strategic Plan priorities that have been identified through an analysis of local needs and priorities and consultation and engagement work.

6.2 In the meantime, there are a number of projects where funding arrangements need to be considered, and the report proposes arrangements to do this.

Approved for Submission by: Patricia Cassidy, Chief Officer

Author: Patricia Cassidy, Chief Officer and Fiona Ramsay, Director of Finance

Date: 27 January 2016

List of Background Papers:
Integration Joint Board – 4 December 2015: Partnership Funding Summary

This paper relates to Agenda Item 10

Title/Subject:	**Budget Position**
Meeting:	**Integration Joint Board**
Date:	**5 February 2016**
Submitted By:	**Chief Finance Officer & Director of Finance**
Action:	**For Noting**

1. INTRODUCTION

1.1 A report was previously provided to the Board in September which outlined the process underway by both partners to determine the budget resources which would be made available to the Integration Joint Board. The purpose of this report is to provide an update on where this exercise sits and give more detailed content on the elements making up the Budget. This will also give the Board a realistic sense of the overall resources likely to be made available to it, subject to the Budget processes of the Partners which will be concluded by March.

2. RECOMMENDATION

2.1 The Integration Joint Board is invited to consider the content of the report.

3. SCOTTISH GOVERNMENT BUDGET AND FINANCIAL SETTLEMENT

3.1 Following the Chancellor's Spending Review on 25 November, the Scottish Government Budget was presented on 16 December including the Financial Settlement for Local Government and Health. The Budget remains to be approved by the Scottish Parliament in February.

3.2 Budget proposals were restricted to one financial year (2016/17). The expectation is that the Scottish Government's next Budget in the Autumn of 2016 will provide content for two and possibly three years forward. This will materially facilitate forward medium term planning, notably to inform the Board's Strategic Plan.

3.3 The block grant from Westminster for resource spending will fall by 5% in real terms over the period to 2019/20. At the national level, Health received a 3.3% increase from 2015/16 whilst Local Government faces a -3.5% (£350m) reduction in revenue support. A large part of the £400m increase in Health is accounted for by the £250m directed, via Health, to the Integrated Joint Boards. The treatment of this large sum is fundamental to the Budget setting processes of the two Partners and the Board and clarification is urgently awaited from the Scottish Government. The implications of this funding Settlement for the two Partners is set out below.

3.4 **Falkirk Council**

3.4.1 The Council had projected a Budget Gap of £18.4m and this reflected an assumed grant loss of £3m. In the event, a further £7m grant was lost resulting in an extremely challenging Budget Gap in 2016/17 both in terms of quantum (circa £25m) and the compressed timeframe within which a statutory balanced Budget is to be achieved.

3.4.2 The circa £10m loss of grant equates to more than the combined assumptions across both financial years 2016/17 and 2017/18. It is noteworthy that the Council's extra loss of grant i.e. £7m, exactly matches the Integration Board's expected population based share of the £250m.

3.4.3 The Council is vigorously working to achieve a balanced Budget in time for the scheduled Budget setting meeting on 17 February. In large measure, this will be achieved by bringing forward savings options already identified for 2017/18. As noted at para 3.3, the conditions applicable to the £250m channelled to the Integration Boards via Health will feature in these deliberations.

3.4.4 Given the overall frame of the Spending Review and the indications within the Scottish Government 2016/17 Budget, notably the protection afforded to Health in particular and Police, against a real terms cut in the Westminster grant, suggests that the financial prognosis for Local Government looking forward is indeed grim. The Council will need to revisit its projections of the scale of future years' Budget Gaps.

3.4.5 In addition to revenue grant support, the Council also receives Capital grant to support its General Services Capital Programme (i.e. all Services other than council housing). This Programme averages circa £30m p.a. Due to reprofiling of this grant, the Council will receive £10.6m grant in 2016/17, a 15% reduction. The Scottish Government has advised that this will be balanced in future years.

3.5 **Forth Valley Health Board**

3.5.1 The key messages and planning parameters for Health and specifically NHS Forth Valley for 2016/17 are as follows :-
Indicative Budget Uplift on Baseline of 1.7%
Indicative Social Care Allocation 2.9%
Indicative Baseline Change 4.6%

As indicated earlier in the paper national dialogue regarding the £ 250m investment (the 2.9% identified above) is ongoing.

3.5.2 There are a range of other factors which are contained within the draft Spending review and others which are outwith which impact on financial planning for Health. One example is funding for Alcohol and Drug Partnerships which will now solely be managed via Health (currently Health and criminal Justice). In 2015/16 resources totalled £ 69.2m across health and justice – for 2016/17 £ 53.8m has been indicated as funding to be distributed – a reduction of £ 15.4m. Another includes ring-fenced allocations which the NHS currently receives some of which are within services within scope of IJBs – these funds will in total be reduced by 7.5% although details have not yet been received including the outcomes which are expected to be delivered in future from these resources.

3.5.3 Based on estimated costs for workforce costs (pays, pensions changes etc), prices, prescribing and demographic impacts and on the estimates of funding availability NHS Forth Valley is planning for real cash savings of approximately 6% (£27m) in 2016/17.

3.5.4 As outlined the draft Spending Review covers a single year however indications are that savings of a similar level will continue to be required in future years.

4. FIRST YEAR PAYMENT TO THE INTEGRATION JOINT BOARD

4.1 The September report outlined the due diligence process being applied by both partners. The framework guidance was also provided at that time. As noted in that report, once the due diligence exercise has been completed, the content will require to be reviewed through the corporate governance process of the partners and then brought before the Integration Joint Board.

4.2 The major undertaking of Due Diligence has been successfully completed, with four areas as highlighted in Section 5 where further discussion was required.

4.3 Previous reports to the Board have highlighted that allocating the Forth Valley Health Board's in-scope budget to the two partnerships would be challenging, particularly in relation to the allocation of budgets for strategic planning including relevant elements of hospital services.

4.4 The process for determining the 2016/17 payments by the partners to the Board is set out in section 8 of the Integration Scheme. Paragraph 8.2.6 of the Scheme is particularly relevant:-

"The Parties shall determine and agree their respective Payment to the Integration Joint Board for the delivery of the Integration Functions in advance of the start of each financial year and shall formally advise the Integration Joint Board by no later than 28 February each year, subject to Scottish Government confirmation of NHS funding for the forthcoming year".

4.5 The table below provides an update on the provisional figures currently agreed based on 15/16 Budget. As noted in section 3, they will be subject to the 16/17 Budget processes of the Partners, adjustment for inflation and assessment of 15/16 Budget versus projected outcome. Further update will be required to reflect agreements reached in respect of Section 5 components.

	£'m
Forth Valley Health Board	133
Falkirk Council	62
	£195

The Health Board contribution is broken up into 3 parts as shown below:

	£'m
Set Aside (Large Hospital Services)	31
Operational (excluding Family Health Services)	35
Family Health Services (mainly contracted)	67
	£133

It should be noted that services included within Family Health Services are for the total population and not solely for adults.

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Details of the Budget components making up these indicative figures are appended.

5. DUE DILIGENCE AREAS TO BE AGREED

5.1 There are four areas where further discussion was required between the partners. The key issues are listed below:

a) Mental Health Officer (MHO) posts have been treated as out of scope by Falkirk Council, but in scope by both Stirling and Clackmannanshire Council. There had been a general principle of retaining similarity between both Partnerships from an NHS perspective however a different approach has been agreed in this area.

b) Medical staffing budgets have been excluded from costings to date. There are two components to Medical Staffing costs

- Junior Medical Staffing : training posts where funding is provided from National Education Scotland (NES) as part of training agreement on a posts by post basis. This is not appropriate for inclusion as funding control of this resource rests with NES
- Senior Medical Staffing : medical staffing budgets have been excluded where staff work across more than one service, rota or geographical locality. They have been included where they are fully embedded into the services in a particular locality

c) Inpatient services delivered in Community Hospitals have been subsumed under Large Hospital services and associated budgets therefore treated as set aside.

Discussions have concluded that the direct budgets for these services for Bo'ness Hospital and Falkirk Community Hospital will be moved from the 'set aside' to 'operational oversight' subject to a number of clear principles being agreed across the Board area. 2015/16 Budget information will be updated to reflect this change.

d) Alcohol & Drug Partnership –Given the reduction in funding to the Alcohol and Drug partnerships highlighted earlier in the report financial issues arising from due diligence have been overtaken and the funding reduction will require to be taken into account. It should be stressed that 2016/17 will be a 'settling in ' year and periodic reviews/monitoring will be undertaken during the year including a clear focus on any issues arising from the four areas highlighted above

5.2 A further issue has been raised as part of the Stirling/Clacks Partnership due diligence, regarding equity of resources between partnerships. The national finance guidance recognises that using historic data inevitably builds in any existing inequity of resource use indicating that it is difficult to avoid without causing immediate destabilisation. The Guidance also indicates that over time issues of equity can be considered and may, where appropriate, be addressed through allocation process in subsequent years.

6. CONCLUSIONS

6.1 The finances available to the Partnership will be of central and strategic interest to the Integration Joint Board. This report sets out where matters currently lie in this process and the work that is in progress to ultimately determine what the Board's 16/17 budget will be. A definitive position will not be available until March.

Approved for Submission by: Chief Finance Officer, Bryan Smail

Author: Director of Finance and Chief Finance Officer
Date: 8 January 2016

List of Background Papers: None.

Budget in Scope

	In-Scope Function	2015/16 Net Revenue Budget. Excludes Central Support and Capital Charges
	Core Scope	
	FUNCTIONS CURRENTLY PROVIDED BY LOCAL AUTHORITY	**£'000**
1	Older People	**2,738**
2	Mental Health	**583**
3	Learning Disability	**270**
4	Physical Disability	**578**
5	Sensory Impairment	
6	Adult Support & Protection	**208**
8	Carers	**206**
9	Reablement	
10	Care & Support at Home	**19,095**
11	Residential Care	**19,052**
12	Respite Care	**1,242**
13	Day Care/Services: PD, LD, OP, MH	**4,001**
14	MECS/Telecare/Telehealth	**150**
15	Housing with Care/Sheltered Accom.	**8,933**
16	Shopping Service	**71**
17	Equipment & Adaptations	**411**
18	Advocacy	**96**
21	Substance Misuse	**0**
22	Sensory Team	**373**
23	Mental Health Team	**267**
24	Learning Disability Team	**547**
25	JLES	**83**
26	Day Care/Centre: MH	**249**
27	Sensory Resource Centre	**87**
28	Voluntary Organisations	**395**
29	Garden Aid	**550**
30	Housing Aids and Adaptations	**1,164**
31	Improvement Grants	**286**
32	Care & Repair Scheme	**87**
		61,722

NHS Forth Valley - Budget in Scope

Appendix 2

Scheme Ref		Falkirk IJB 15/16 Budget £m
	Set Aside (LargeHospital Services)	
2	Accident and Emergency Services	6.205
3	In patient Hospital Services Relating to :	
3a	General Medicine	3.001
3b	Geriatric Medicine	10.280
3c	Rehabiltation Medicine	1.380
3d	Respiratory Medicine	1.143
3e	Psychiatry of learning disability	1.474
4	Palliative Care (Hospital Based)	0.915
5	In patient Hospital Services Provided by General Medical Practitioners	
6	Addiction Inpatient Services	
7	Mental Health Inpatient Services	6.163
	Subtotal - Strategic Planning	**30.560**
	Operational (excluding Family Health Services (FHS))	
8	District Nursing Services	3.779
9	Community Addiction Services	2.996
10	Community Based AHP Services	5.856
11	Public Dental Service	1.111
17	Services provided outwith a hospital in relation to geriatric medicine	1.161
18	Palliative Care (delivered in Community)	0.054
19	Community Learning Disability Services	0.650
20	Community Mental Health Services	4.480
21	Continence Services	0.232
22	Home based Kidney Dialysis	
23	Services Provided by health professionals that aim to promote public health	1.518
	Resource Transfer	11.142
	Joint Partnership Agreements	2.567
	Sub-Total - Operational (excluding FHS)	**35.547**
	Family Health Services incl FHS Prescribing & GP Out of Hours Services	
12	Primary Medical Services (GMS Contract)	20.566
13	Primary Dental Services (GDS Contract)	8.236
14	Community Ophthalmic Services	2.821
15	Community Pharmaceutical Services	34.266
16	GP Out of Hours Services	1.429
	Sub-Total - FHS	**67.319**
	TOTAL	**133.426**

This paper relates to Agenda Item 11

Title/Subject: **Financial Governance**

Meeting: **Integration Joint Board**

Date: **5 February 2016**

Submitted By: **Chief Finance Office & Director of Finance**

Action: **For Decision**

1. INTRODUCTION

1.1 The purpose of this report is to provide the Board with an update on progress on establishing a framework of Financial Governance for the Integrated Joint Board.

1.2 This report also details the various strands of work which will be coming to the Board over the course of the next few months for information and approval.

2. RECOMMENDATIONS

2.1 The IJB are asked to note the progress on establishing a framework for Financial Governance.

2.2 The IJB are asked to approve the arrangements proposed for the provision of Internal Audit services.

2.3 The IJB are invited to approve the reserves policy and strategy (Appendix 1).

3. BACKGROUND

3.1 The development of a Financial Governance framework is being carried out by the Finance Workstream which includes representatives from all Forth Valley partners. This report draws on the following documents:

- Integrated Resources Advisory Group (IRAG) Finance Guidance
- Scottish Government document Integration Financial Assurance
- Integration Scheme as agreed by the partners.

4. FINANCIAL GOVERNANCE

4.1 Financial Governance covers a broad range of areas, most notably:

- Annual Financial Statement/Strategic Plan Element
- Financial & Management Reporting
- Financial Regulations
- Internal Audit
- Audit Committee
- Final Accounts
- Reserves Policy & Strategy
- Staff Resources

4.2 An update on each of these areas is provided below.

4.3 The Integration Scheme recognises that the appointment of a Chief Officer and Chief Finance Officer will impact on Financial Governance arrangements. However, at this time, an appointment to the Chief Finance Officer role for the Falkirk partnership has not been made. It is recognised that proposals developed to date may change once this appointment is made.

5. ANNUAL FINANCIAL STATEMENT/STRATEGIC PLAN ELEMENT

5.1 The IRAG guidance and the Scottish Governments' Strategic Planning Guidance stipulate that an annual financial statement must be prepared which sets out the total resources that the Integration Authority intend to allocate under the provisions of the strategic commissioning plan. Further guidance on the format and content of this statement is anticipated. In addition the IJB is expected to produce an annual performance plan which will link financial resources to performance against the National Health and Wellbeing Outcomes. It is acknowledged by Scottish Government that this approach will take time to develop.

5.2 The resources available for 2016/17 will flow from both partners budget deliberations and are discussed in a separate report to this meeting of the IJB. As highlighted in that report, the Scottish Government settlement covered 2016/17 only and therefore any estimates within the Strategic Plan for future year resources are very tentative.

5.3 The budget report on the agenda for this meeting also highlights the impact of the financial settlement on the partners and the increasingly constrained resources available to partners in 2016/17 and forecast for future years. This will undoubtedly impact on the resources available to the IJB. Ultimately it is for the partners to determine what they can afford to contribute.

5.4 For financial years following 2016/17, the Integration Scheme sets out a process where the IJB will request funding based on the Strategic Plan and associated business cases. This will then be considered as part of each partners budget setting process. In order to align this with partners budget setting processes, the business case would have to be made available to partners by October/November of each year at the latest.

5.5 In order to allow the IJB to prepare future business cases, partners should inform the IJB Chief Officer and Chief Finance Officer of likely changes in funding levels as early as possible.

5.6 The IJB may also submit capital business cases to respective partners for consideration as part of their capital programme development processes.

6. FINANCIAL & MANAGEMENT REPORTING

6.1 The IRAG guidance recommends that:

- A process of regular in-year reporting and forecasting is agreed between the partners and the IJB Chief Finance Officer;

- Partners agree a consistent basis for the preparation of management accounts.

The guidance notes that these are matters for local decision making.

6.2 The Integration Scheme includes arrangements for quarterly reports to both the IJB and the Chief Officer.

6.3 Work is underway to look at how the financial information from the Health Board and the Local Authority can be consolidated to prepare a single meaningful report. The Integration Scheme requires consolidation protocols to be developed which will covers issues such as:

- Reporting on a cash (used by Local Authority) or accruals (used by Health Board) basis;
- Structure of the reports, i.e. presentation of the operational arm, the full IJB etc.
- Structure of the financial ledger, including who is going to host the financial ledger for the IJB.

6.4 Proposals are currently being developed and the aim is to report these to IJB before the start of the new financial year.

7. FINANCIAL REGULATIONS & SCHEME OF DELEGATION

7.1 Financial Regulations and the Scheme of Delegation form a key part of any organisation's Corporate Governance arrangements. They represent a framework of control that allows an organisation to demonstrate that it is doing the right things, in the right way, for the right people, in a timely, inclusive, open, honest and accountable manner.

7.2 The IRAG guidance confirms that the IJB should have its own Financial Regulations, approved by the IJB. However, once funds are delegated to the partners, the Financial Regulations of the partners will become relevant. The Financial Regulations of the partners will need to be updated to reflect the interaction with the IJB.

7.3 The Financial Regulations and the Scheme of Delegation of the IJB will need to cover a minimum set of controls, including:

- Financial stewardship
- Budgetary control
- Budget transfers (virements)
- Information management and security
- Segregation of duties
- Internal audit
- Risk management

7.4 Financial Regulations are in the process of being drafted, in line with the financial framework set out in the Integration Scheme. A critical element of the Scheme of Delegation will include the arrangements for budget transfers and this will have to be approved by the IJB.

7.5 It is anticipated that the Financial Regulations and Scheme of Delegation will be presented to the IJB in April 2016 for approval.

8. INTERNAL AUDIT

8.1 The IRAG guidance is clear that is the responsibility of the Integration Joint Board to establish adequate and proportionate internal audit arrangements. This will include determining who will provide the internal audit service for the IJB and nominating a Chief Internal Auditor.

8.2 There are two approaches to the provision on the internal audit service:

- A joint service whereby both partners' Chief Internal Auditor split the role of Chief Internal Auditor for the IJB; and
- A rotation based system where one partners Chief Internal Auditor carries out the role of Chief Internal Auditor for the IJB for a specified period of time, before handing over to the other partner.

Whilst the IRAG guidance suggests that one partner should provide the service, the Scottish Government have confirmed that the service can be delivered jointly.

8.3 The Chief Internal Auditors for all partners have been meeting to discuss the most appropriate way forward. All partners have agreed that a three year rotation based approach would be most appropriate. This will be organised to ensure that the Health Board do not have to undertake this service for both partnerships in the same three year period. At this point it is anticipated that Health will lead on the audit for the Falkirk IJB in the first rotation but will draw on resources from both partners.

8.4 Once a Chief Internal Auditor is nominated, they will have to submit a risk based internal audit plan to the IJB for approval. This should be presented to the next meeting of this IJB. The IRAG guidance notes that the operational delivery of services within the Health Board and Local Authority on behalf of the IJB will be covered by their respective internal audit arrangements.

8.5 Given the IJB will have responsibility for commissioning and performance management, the Internal Audit service of the IJB is likely to focus on those areas, along with arrangements for governance, including Financial Regulations etc.

8.6 The Chief Internal Auditor of the IJB will be required to submit an annual audit report on Internal Audit activity to the Chief Officer and the IJB which will include a statement on the overall level of assurance to be provided.

9. AUDIT COMMITTEE

9.1 The IRAG guidance states that the IJB must have appropriate and proportionate arrangements in place for consideration of the audit provision and annual financial statements. The guidance notes that this could be done through the establishment of an Audit Committee which meets before the main IJB two or three times a year.

9.2 Proposals on arrangements will be brought to the IJB in due course. It should be noted that arrangements will have to be in place for consideration of audit reports and the annual accounts.

10. FINAL ACCOUNTS

10.1 The IJB is subject to the audit and accounts provisions of a body under Section 106 of the Local Government (Scotland) Act 1973. One of the implications of this is that the accounts of the IJB must be prepared along the same lines as those of a Local Authority and are therefore subject to a similar approval and audit process.

10.2 The financial statements of the IJB should be prepared by the CFO of the IJB and will contain the following:

- Management commentary
- Statement of responsibilities
- Annual governance statement
- Remuneration report
- Balance sheet
- Statement of income and expenditure account
- Statement of accounting policies and notes to the accounts; and
- Audit report

10.3 It is still to be determined who will produce these statements for the Falkirk IJB for the period ended 31 March 2016, recognising no IJB Chief Finance Officer is in place. These statements must be submitted for approval to Audit by 30 June 2016.

10.4 The IRAG guidance makes suggestions on the approval and signature of the statements. Recommendations on the process will be made to the IJB in due course.

10.5 The IJB will be subject to external audit and for the Falkirk partnership, Audit Scotland have been appointed to provide this service. At this stage, Audit Scotland have indicated a fee of c£5,000 for the 2015/16 audit work. However, at a recent Finance Leads Network meeting some questions were asked around this area and the Scottish Government is going to discuss these with Audit Scotland.

11. RESERVES POLICY & STRATEGY

11.1 The IJB has the power to hold reserves and the IRAG guidance recommends that a reserves policy and reserves strategy are agreed as part of the annual budget setting process and reflected in the Strategic Plan.

11.2 There are three main types of reserves:

- Earmarked reserves to plan for major expenditure or one-off significant payments;
- General reserves for use as the IJB sees fit; and
- Capital reserves – unlikely to be applicable to the IJB at this point.

11.3 Given the financial constraints that the partners are facing, it is not anticipated that the IJB will have general reserves available to it for some time. Once the IJB is in a position to build it reserves, it is recommended that a maximum level of general reserves is established. A maximum level of £0.5m is proposed.

11.4 A reserves policy and strategy is appended to this report for approval (appendix 1).

12. STAFF RESOURCES

12.1 This report highlights a number of Financial Governance strands which will be influenced by the appointment of a Chief Finance Officer. Following this appointment, and agreement of reporting frameworks etc, an estimate of the accounting staff resource which the Chief Finance Officer would need access to will be determined. Work will then have to be carried out to identify how best to provide this resource, taking into account the capacity of the partners to provide resource.

13. CONCLUSIONS

13.1 This report provides an overview on the arrangements for the financial governance of the IJB. A significant amount of progress has been made towards the establishment of a framework for financial governance albeit there is evidently still work to be progressed. Work will continue over the next two months to ensure that the necessary controls are developed. A further report will be presented to the IJB in April 2016.

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Approved for Submission by: Chief Finance Officer, Bryan Smail

Author – Bryan Smail, Chief Finance Officer
Date: 28 January 2016

List of Background Papers: None.

Falkirk Integration Joint Board
Reserves Policy and Strategy

1 Introduction

1.1 This document outlines the Falkirk Integration Joint Board's strategy for developing and holding financial reserves.

1.2 The strategy is linked to the Integration Joint Board's Strategic Plan objectives and medium term financial strategy which highlights the financial risks and challenges facing the Integration Joint Board and its constituent partners beyond the current financial year.

1.3 The strategy will be reviewed annually to ensure all financial changes and challenges facing the Integration Joint Board and its constituent partners are taken into account in determining the appropriate level of reserves to hold for the future.

2 Legislative/Regulatory Framework

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the framework for the integration of health and social care in Scotland. The Act empowers an Integration Joint Board to hold reserves subject to an agreed reserves strategy.

2.2 As the Integrated Joint Board is considered a Local Authority body under section 106 of the Local Government (Scotland) Act 1973, all relevant legislative and regulatory principles as applied to local authorities have been deemed equally applicable to the Integration Joint Board.

2.3 In Scotland, explicit statutory powers under Schedule 3 of the Local Government (Scotland) Act 1975 permit local authorities to establish a Capital Fund, alongside a requirement to maintain a General Fund Reserve. Within the General Fund Reserve, local authorities are allowed to earmark elements for specific intended purposes.

2.4 Local Authority Accounting Practice Bulletin 99 published in July 2014 provides advice from the Chartered Institute of Public Finance and Accountancy in respect of local authority reserves and balances. The principles and good practice examples contained within the Local Authority Accounting Practice bulletin have been applied in developing the proposed reserves strategy for the Integrated Joint Board.

2.5 Legislation also places a range of safeguards that help to prevent local authorities over-committing themselves financially as follows:

- The balanced budget requirement, for Scotland this is derived from Section 93 of the Local Government Finance Act 1992;
- The Chief Finance Officer's duty to report on robustness of estimates and adequacy of reserves when considering the annual budget requirement;
- The Chief Finance Officer's duty to make arrangements for, in addition to having responsibility for, the proper administration of the Integration Joint Board's financial affairs; and
- In line with the "Prudential Code" published by the Chartered Institute of Public Finance and Accountancy, the Chief Finance Officer's duty to have full regard to affordability when making recommendations about future capital programs, including giving due consideration to the level of long term revenue commitments.

3 Reserve Policies

3.1 Pressures on public finances now and over the medium term are intense with the result that the constituent partners do not currently have the capacity to provide extra resources to provide reserves. Therefore, the ability to build up and retain reserves for unforeseen events and circumstances becomes not only difficult, but something that requires careful consideration.

3.2 Having the right level of reserves is important. If reserves are very low, there may be little resilience to financial shocks and sustained financial challenges.

3.3 Reserves should not be used to fund material levels of ongoing operational costs as they are not a permanent funding solution for this type of expenditure. They may, however, be used for small-scale initiatives which do not impact on the overall reserves strategy.

3.4 Reserves should act as a "buffer" to absorb one-off pressures or to enable a short-term bridge to fill a gap until a sustainable funding solution is identified.

3.5 Contributions from reserves should only be used to set a balanced budget where reserves have been specifically earmarked for future projects as agreed by the Integration Joint Board.

3.6 The level of reserves to be held should be based on an assessment of the likelihood and impact of financial and operational risks.

3.7 In addition to maintaining an adequate reserves balance to protect against risks, it may also be necessary to plan for an increase in reserves as a means of meeting Strategic Plan objectives.

3.8 Reserves in excess of prudent estimated levels should not be held. This will ensure unnecessary cash balances do not build up which may impact on resources available for operational activities.

4 Types of Reserve

Earmarked Reserves

4.1 The purpose of an Earmarked Reserve is to set aside amounts for initiatives that extend beyond one year or as a contingency against a specific situation occurring. Earmarked Reserves will increase through decisions of the Integration Joint Board and will decrease as they are spent on their specific intended purposes.

4.2 Once an Earmarked Reserve has been established by the Integration Joint Board, it is the responsibility of the Chief Finance Officer of the Integration Joint Board to ensure funds are spent in line with their purpose. The purpose of each Earmarked Reserve should be reviewed annually to ensure that it is still relevant.

General Reserves

4.3 General Reserves represent non-earmarked elements of Integration Joint Board funds. The main purposes of General Reserves are to operate as a working balance to help manage the impact of uneven cash flows, and to provide a contingency to cushion the impact of emerging or unforeseen events or genuine emergencies.

4.4 Given the pressures on public finances now and over the medium term, constituent partners do not currently have the capacity to provide extra resources to provide for General Reserves. As such, the expectation for the foreseeable future is that General Reserves will not be available to the Integration Joint Board. However, ideally, the build-up of a robust level of General Reserves should still be considered as a target within the Integrated Joint Board's medium term financial strategy.

Capital Reserves

4.5 Capital reserves represent monies set aside to meet expenditure of a capital nature, as opposed to day to day expenditure on operational activities.

5 Principles of a Risk Based Approach to Reserves

5.1 In order to assess the level of reserves, the Chief Finance Officer of the Integration Joint Board should take account of the financial and operational risks facing the Integration Joint Board over the life of the medium term financial strategy. The estimate of these risks should include (but are not limited to):

- The reasonableness of underlying budget assumptions.
- Inflationary pressures.
- Realisation of income targets.
- Trends and current spending patterns.
- Known future legislative or other regulatory changes.
- Ability to achieve Strategic Plan objectives.
- Estimates of likely demand for demand-led budgets.
- A review of any major risks associated with future years' budgets.
- The availability of any revenue contingency budget.
- Discussions and contributions from constituent partners.

5.2 The Chief Finance Officer should develop and implement proper arrangements to manage these risks, including adequate and effective systems of internal control.

5.3 The Chief Finance Officer's advice on the level of reserves should be set in the context of the Integration Joint Board's risk register and medium term plans, and should not focus exclusively on short-term considerations. Advice should be given on the level of reserves over the lifetime of the medium term financial plan, and should also take account of the expected need for reserves in the longer term.

5.4 Part of the risk management process involves taking appropriate action to mitigate or remove risks where this is possible, which in turn may lead to a lower level of reserves being required. A balance will need to be found between maintaining adequate levels of reserves and investing in risk reduction measures.

5.5 Whilst it will primarily be the responsibility of the Integration Joint Board and its Chief Finance Officer to maintain a sound financial position, external auditors will regularly express their views on the adequacy of the reserves of the Integration Joint Board for which they carry out the audit function. However, it will not be the responsibility of external auditors to prescribe the optimum or minimum level of reserves to be held.

6 Management of Reserves

Overview

6.1 The required levels of Earmarked and General Reserves and their purpose will be agreed as part of the annual budget setting process and reflected in the Strategic Plan agreed by the Integration Joint Board. The constituent partners will be able to review the levels of reserves held by the Integration Joint Board as part of this process.

6.2 The level of Earmarked and General Reserves to be maintained may change from year to year depending on any changes to the financial risks facing the Integration Joint Board, and/or resources needed for investment to meet Strategic Plan objectives and budgetary control.

6.3 Any in-year call on General Reserves will generally only be approved to meet the cost of unexpected and unforeseen expenditure, or where an opportunity has arisen which is time limited and/or meets an objective within the Strategic Plan.

6.4 The Integration Joint Board will allocate resources it receives from the constituent partners in line with the Strategic Plan. In doing this it will be able to use its power to hold Earmarked and General Reserves, so that in some years it may plan for an underspend to build up reserves, and in others to breakeven, or to use a contribution from reserves in line with the Reserve Policy and Strategy.

Use of Reserves

6.5 Decisions on the use of General Reserves should take account of the financial and operational risks that could impact on the Integration Joint Board's position, and should be made in a coordinated and planned way to ensure that best use is made of these resources.

6.6 For this reason it is important that any approval to use General Reserves complies with the Integration Joint Board's Reserves Policy and Strategy and a formal procedure facilitates this process.

6.7 The application to use General Reserves should be submitted to the Integrated Joint Board for approval and should include as a minimum:

- How the application meets the requirements of the Reserves Policy and Strategy.
- Why the use of reserves is considered to be the most appropriate form of funding.
- Whether the use of reserves is required to meet an objective of the Strategic Plan, or is outside of this.
- Whether the constituent partners been consulted on the proposal to use reserves.
- A statement from the Integration Joint Board's Chief Finance Officer detailing the current level of reserves and projected year end position.

6.8 With reference to section 8 of the Falkirk Integration Scheme, the following in-year scenarios could impact on any General Reserves held by the Integration Joint Board:

- **In-Year Overspend on the Operational Integrated Budget** - Where there is a projected overspend against an element of the operational budget, the Integration Joint Board may decide to increase the payment to the affected body by utilising the balance of the General Reserve of the Integration Joint Board (if available) in line with the Reserves Policy and Strategy.

- **In-Year Underspend on the Operational Integrated Budget** - Underspends on either arm of the operational integrated budget should be returned from the relevant constituent partner to the Integration Joint Board and carried forward through General Reserves (with the exception of underspends that arise due to material differences between assumptions used in setting the payments to the Integration Joint Board and actual events).

Reporting Arrangements for Reserves

6.9 In terms of reporting on Earmarked and General Reserves, all budget reports to the Integration Joint Board should include from the Chief Finance Officer of the Integration Joint Board (where applicable):

- A statement reporting on the annual review of Earmarked Reserves. The statement should list the various Earmarked Reserves, the purposes for which they are held and provide advice on the appropriate levels. It should also show the estimated opening balances for the year, planned additions/withdrawals and the estimated closing balances.
- A statement showing the estimated opening General Reserve balance for the year ahead, the addition to/withdrawal from the reserve, and the estimated end of year balance.
- A statement on the adequacy of Earmarked and General Reserves in respect of the forthcoming financial year and the Integration Joint Board's medium term financial strategy.

7 Level of Reserves

Earmarked Reserves

7.1 As mentioned previously, Earmarked reserves provide a means of accumulating funds for use in a later financial year to meet known or planned initiatives. As such, the level of any required Earmarked Reserve is likely to be known with reasonable certainty. The purpose of each Earmarked Reserve should be reviewed annually to ensure that it is still relevant.

General Reserves

7.2 There is generally no prescriptive basis for the level of General Reserves that should be held. The level of General Reserves will depend on the financial risks and challenges facing the Integration Joint Board and its constituent partners, but ideally as a minimum, should be capable of covering all estimated financial risks including contingent liabilities.

7.3 However, as mentioned previously, the pressures on public finances now and over the medium term are intense with the result that the constituent partners do not currently have the capacity to provide extra resources to provide for General Reserves. Therefore, the ability to build up and retain General Reserves for unforeseen events and circumstances will be extremely difficult.

7.4 Although there is no requirement or expectation placed on the Integration Joint Board to build up General Reserves, it is still appropriate to at least consider a prudent "target" level of reserves that may be achievable in the future when financial capacity of the constituent partners allows.

7.5 Setting a suitable target level of General Reserves provides its own difficulties. Many of the financial risks impacting on the Integration Joint Board will be difficult to estimate, and the ability to benchmark other Integration Joint Board reserve policies and strategies is currently not yet available.

7.6 It is recommended that a maximum target level of General Reserves for the Integration Joint Board be initially set at a cash value of £0.5million. This target will be subject to review as part of future annual budget setting processes.

Capital Reserves

7.7 It is currently not anticipated that the Integration Joint Board will require to hold a Capital Reserve.

7.8 The Integration Joint Board will identify the specific asset requirements to support the Strategic Plan. Where the Chief Officer of the Integration Joint Board identifies as part of the Strategic Plan new capital investment requirements, a business case should be developed and submitted to all constituent partners to consider.

7.9 Options may include one or more of the constituent partners approving the project from its own capital budget or where appropriate, using the hub initiative. The existing procedures in the constituent partners should be used to consider capital bids and business cases.

8 Conclusion

8.1 Robust financial management and control requires the Integration Joint Board to give consideration to the holding of General Reserves to provide protection against unforeseen and/or unavoidable costs arising.

8.2 Given the pressures however on the finances of the constituent partners currently and over the medium term, the expectation is that General Reserves will not be available to the Integration Joint Board.

8.3 Although there is no requirement or expectation placed on the Integration Joint Board to build up General Reserves, it is still appropriate to at least consider a prudent “target” level of reserves that may be achievable in the future when financial capacity of the constituent partners allows.

8.4 It is recommended that a maximum target level of General Reserves for the Integration Joint Board be initially set at a cash value of £0.5million. This target will be subject to review as part of future annual budget setting processes.

8.5 Where appropriate, Earmarked Reserves should also be considered to plan for major expenditure or one-off significant payments.

8.6 It is currently not anticipated that the Integration Joint Board will require to hold a Capital Reserve.

This report relates to Agenda Item 12

Title/Subject:	**Joint Staff Forum**
Meeting:	**Falkirk Integration Joint Board**
Date:	**5 February 2016**
Submitted by:	**Chief Officer**
Action:	**For Decision**

1. Introduction

1.1 The purpose of this paper is to brief the Integration Joint Board members on the establishment of the Joint Staff Forum. This paper relates to a previous paper considered in March 2015 on the subject of non voting IJB members from the Joint Staff Forum.

2. Recommendations

The Integration Joint Board is asked to:

2.1 Note the establishment of the Joint Staff Forum.

3. Background

31 The Joint Staff Forum will provide a mechanism to ensure effective communication, involvement and consultation with employee representatives at appropriate stages, recognising that formal consultation mechanisms within partner organisations will still be required and implemented as appropriate.

The Joint Staff Forum will discuss relevant employee related matters relating to Health & Social Care Integration. The Forum will cover both the Falkirk Partnership and the Clackmannanshire & Stirling Partnership; where such matters are shared across both partnerships. Where employee related issues are unique to only one partnership, a Sub-Forum may deal with such matters.

There are 12 places for employers. Each employer as follows has 3 places:

- Clackmannanshire Council
- Falkirk Council
- NHS Forth Valley
- Stirling Council

There are twelve places available for employee representatives. These places include those employee representatives who are the named non-voting representatives on the Integration Joint Boards.

The first formal Joint Staff Forum meeting took place on 15th September 2015. The Joint Staff Forum will now meet bi-monthly. The next meeting is scheduled for 29 January 2016. The role of chair will be shared between the Chief Officers and the nominated Chair of the Employee Representatives.

The Joint Staff Forum constitution was agreed on 29 December 2015 by all members. A copy is attached as appendix A.

There has been a successful delivery of a development session with Joint Staff forum members to agree shared vision and develop partnership working and engagement. The agreed vision will form part of the constitution.

4. Main Body Of The Report

Please see attached at Appendix 1 the Joint Staff Forum Constitution

5. Conclusions

In conclusion, the Integration Joint Board is asked to note the establishment of the Joint Staff Forum.

Resource Implications

It is intended that the Joint Staff Forum will continue utilising the HR team as well as Chief Officers and Service Managers across the three employers.

Impact on Integration Joint Board Outcomes, Priorities and Outcomes

The work of the Forum will be to assist those involved in responding to employee issues arising from Health & Social Care Integration, and recommend good practice methods of working, and solutions to issues, as they arise.

Legal & Risk Implications

N/A

Consultation

The Joint Staff Forum will provide a mechanism to ensure effective communication, involvement and consultation with employee representatives at appropriate stages.

Equalities Assessment

Equalities considerations have, and will continue to be given.

6. Recommendations

The Falkirk Integration Joint Board is asked to:-

6.1 To note the establishment of the Joint Staff Forum

Approved for Submission by: Chief Officer, Health and Social Care Integration

Author: Helen Kelly, Director of Human Resources, NHS Forth Valley
Date: 21 January 2016

List of Joint Staff Forum Constitution

APPENDIX 1

HEALTH & SOCIAL CARE INTEGRATION

JOINT STAFF FORUM

INTRODUCTION

a. The Joint Staff Forum is intended to provide a forum to enable effective joint discussions between employer and employee representatives, on employment issues, relating to the effective implementation of Health and Social Care Integration.

b. The Joint Staff Forum will provide a mechanism to ensure effective communication, involvement and consultation with employee representatives at appropriate stages, recognising that formal consultation mechanisms within partner organisations will still be required and implemented as appropriate.

REMIT OF FORUM

2.1 The Joint Staff Forum will discuss relevant employee related matters relating to Health & Social Care Integration. The Forum will cover both the Falkirk Partnership and the Clackmannanshire & Stirling Partnership; where such matters are shared across both partnerships. Where employee related issues are unique to only one partnership, a Sub-Forum may deal with such matters (as detailed below).

2.2 The work of the Forum will be to assist those involved in responding to employee issues arising from Health & Social Care Integration, and recommend good practice methods of working, and solutions to issues, as they arise.

2.3 The Forum will take account of relevant legislation including employment legislation and other Acts or guidance documents as relevant to Health & Social Care Integration such as:

- Public Bodies (Joint Working) (Scotland) (Act) 2014;
- The Joint Appointment Guide 2014;
- Local Integration Plans (now agreed)
- Local Strategic Plans (once developed).

PARTNER ORGANISATIONS

3.1 For the purposes of the Forum, the partner organisations include:

Falkirk Partnership
- Falkirk Council
- NHS Forth Valley

Clackmannanshire & Stirling Partnership
- Clackmannanshire Council
- Stirling Council
- NHS Forth Valley

SCOPE OF THE FORUM

4.1 The Forum will have the scope to consider employment issues as they relate to employees of the partner organisations, working in the functions included within the remit of the Health & Social Care Integration Joint Boards.

MEMBERSHIP OF THE FORUM

5.1 The membership and numbers of places for each partner organisation and relevant employee representatives is as follows:

5.2 For partner organisations:

Three places for each of:
- Clackmannanshire Council
- Falkirk Council
- NHS Forth Valley
- Stirling Council

5.3 For employee representatives:

There are twelve places available for employee representatives. These places to include those employee representatives who are the named non-voting representatives on the Integration Joint Boards. Please see appendix 1 for details of named members and substitutes.

Full time officers may attend on an ex-officio basis, noting their attendance in advance.

5.4 All members should notify the Forum Administrator of their intention to attend meetings.

5.5 Membership will be reviewed in April 2016.

MEETING ARRANGEMENTS

6.1 The Joint Staff Forum will meet on a bi-monthly or more frequently as required.

6.2 The meetings will be chaired on a rotational basis with each of the following identifying a chairperson for this purpose:
- Falkirk Partnership
- Clackmannanshire & Stirling Partnership
- Employee Representatives

6.3 There may be occasions on which an issue is raised at the Forum which does not relate to all partner organisations. In such circumstances, the Forum can:

- Refer the matter to a Falkirk Partnership Sub-Forum/ a Clackmannanshire & Stirling Sub-Forum; OR
- Refer the matter to the relevant partner organisation for it to be addressed through that partner's normal employee relations mechanisms.

6.4 Where a Sub-Forum for one of the partnerships requires to consider an issue unique to that Partnership, the Sub-Group will involve relevant employer and employee representatives from the respective partner organisations.

6.5 Members of the Joint Staff Forum will adhere to the values listed in Appendix 2.

GOVERNANCE

7.1 The meetings of the Joint Staff Forum will be minuted by a representative from one of the partner organisations.

7.2 Minutes from each meeting will be issued to attendees for comment, and then submitted to the next meeting of the Joint Staff Forum for homologation.

7.3 A copy of the agreed minutes will also be made available to both the Falkirk, and Clackmannanshire & Stirling, Integration Joint Boards, as well as to the relevant JTUC of each partner organisation.

REVIEW OF JOINT STAFF FORUM

8.1 The role, remit and membership of the Forum, and sub forums as appropriate, will be reviewed in April 2016 when full Integration commences; OR as requested by one of the partner organisations/the employee representatives. The aim of any review will be to ensure the Forum/Sub-Forums continue to meet the needs of both Partnerships.

APPENDIX 1 – Employee Representatives

Employee Representatives – December 2015

Name	Organisation	Substitute
Pam Robertson	Clackmannanshire Council	Kevin McIntyre
Abigail Robertson	Stirling Council	Lorraine Thompson
Sandra Burt	Falkirk Council	Kevin Robertson
Tom Hart	NHS Forth Valley (Stirling & Clackmannanshire)	Robert Clark
Tom Hart	NHS Forth Valley (Falkirk)	Lindsey Orr

APPENDIX 2 – VALUES

A development session was held on 15 September 2015, at this session the Joint Staff Forum agreed the following values and agreed to embrace and embed these values to ensure that the forum is effective in fulfilling its remit.

Values
Adaptable
Ambitious (Realistic)
Collaboration
Confidentiality
Constructive challenge
Trust
Direct – honest - Sensitivity
Fairness
Inclusion
Person focussed
Respectful
Shared purpose – staff /service users

This paper relates to
Agenda Item 13

Title/Subject: **Integrated Workforce Plan**

Meeting: **Falkirk Integration Joint Board**

Date: **5 February 2016**

Submitted By: **Chief Officer**

Action: **For Decision**

1. Introduction

1.1 The purpose of this paper is to provide the Integration Joint Board with an Integrated Workforce Plan for consideration and approval.

This Plan has been developed consistent with the commitment described in the Integration Scheme. It also provides the workforce response to the draft Strategic Plan

2. Recommendations

The Integration Joint Board is asked to:

2.1 Consider and approve the proposed Workforce Plan.

2.2 To note that progress reports on implementation will be provided to the Board during 2016.

3. Background

3.1 This Workforce Plan has been developed through an inclusive process involving the Chief Officer, Service Managers, Human Resources and Organisational Development colleagues and members of the Joint Staff Forum. It provides clear strategic statements and details priorities for the integrated workforce in order to deliver the ambitions of the Integration Joint Board.

Within the paper, the priorities are described over the three year period of the Strategic Plan.

4. Main Body Of The Report

The Integrated Workforce Plan is attached.

5. Conclusion

In conclusion, the Integration Joint Board are asked to approve the proposed workforce plan.

Resource Implications

It is anticipated that this Workforce Plan will be implemented utilising the HR and OD resource from across the two employers.

Impact on Integration Joint Board Outcomes, Priorities and Outcomes

The strategic aim of this Workforce Plan is to support the delivery of the Strategic Plan through the development of the joint workforce.

Legal & Risk Implications

It remains the position that employees are contracted to the two individual employers. This Workforce Plan will be taken forward within this context.

Consultation

This Workforce Plan has been developed with the involvement of the Joint Staff Forum and implementation will be progressed in collaboration with the Joint Staff Forum.

Equalities Assessment

Equalities considerations have, and will continue to be given, in the processes to implement the integrated workforce plan.

Approved for Submission by: Chief Officer, Health and Social Care Integration

Author: Helen Kelly, Director of Human Resources, NHS Forth Valley
Date: 21 January 2016

List of Background Papers:
Integration Scheme
Strategic Plan

Falkirk Health and Social Care Partnership

Integrated Workforce Plan

1. Introduction and Context

1.1 The integration of Health and Social Care will see the establishment of a Partnership with its own Integration Joint Board, developed by Falkirk Council and NHS Forth Valley, allowing a unique opportunity to work in a truly integrated way.

1.2 The main purpose of the Partnership is to ensure that we provide joined up and seamless support and care to those members of our community who rely on us. This will ensure our live full, independent and positive lives within supportive communities

1.3 The partnership has now produced a 3-year (draft) Strategic Plan which outlines how it will work together to achieve this vision. This will see local outcomes focusing on:

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.

1.4 At a local level, Falkirk Council and NHS Forth Valley are building on existing common working practices to put in place robust arrangements with the aim of providing better, more integrated adult health and social care services. The Partnership knows that the workforce is the single most important resource in delivering high quality services and the transformation required to ensure the delivery of the Scottish Government 2020 Vision for Health and Social Care.

1.5 The ever changing nature of these services is complex and challenging. Falkirk Council and NHS Forth Valley, in collaboration with partners and stakeholders seeks to ensure that the health and social care workforce of tomorrow, both third sector and independent sectors, are knowledgeable and skilled and able to respond to changes that the sector demands.

1.6 This Workforce Plan is specifically targeted at the services in scope for Integration and will provide priorities which compliment Falkirk Council and NHS Forth Valley employer commitments made to their staff within their respective Workforce Plans and Strategies: *Falkirk Council Social Work Adult Services, Service Performance Plan 2015 – 2018 (incorporating*

Workforce Development plans) and NHS Forth Valley Workforce Strategy 2014 – 2016.

2. Strategic Intention

2.1 The following statements reflect the strategic intention for the development of the workforce across the Falkirk Partnership.

- Through an approach of caring together we will ensure a workforce that is fit for the future of Health and Social Care.

- We will create workforce development plans that ensure the availability of a flexible responsive workforce with the right skills, in the right place and at the right time to help ensure that our service users get the right level of support early enough to deliver on our strategic outcomes.

- We will ensure our workforce feels engaged with the work they do and are supported and empowered to continuously improve the information, support, care and treatment they provide.

- At the heart of the care and support provided will be a culture of collaboration putting the service user at the centre and creating connections between partner organisations to share skills, knowledge and resources to deliver improved services and outcomes.

- We will ensure that our workforce delivers best value, making the best use of available resources within an environment that strives for quality, efficiency, safety and integration at every opportunity.

3. Strategic Aims

3.1 The overall aims of the strategic approach to engaging with and developing our workforce and our partnership are:

- To develop workforce plans which describe the current workforce profile, the roles, skills and abilities needed to deliver the strategic objectives and outcomes for the partnership.

- To support role development which focuses on the needs of the service users and the available skills whether specialist or general.

- To develop a multi-skilled workforce, who are engaged and involved, and have the professional skills, the ability and drive to take a team approach to service delivery and improvement.

- To develop leadership capability and capacity at every level of the partnership.

- To develop and sustain organisational structures and processes which enable the right balance of accountability and assurance, and also encourage our workforce to deliver services which can adapt and evolve and innovate to meet the challenges ahead.

4. Strategic Priorities

The following areas would be seen as the priorities for workforce and organisational development to support the 3 year period of the Strategic Plan. These strategic priorities will be progressed in collaboration with the Joint Staff Forum.

4.1 Workforce Information, Demographics and Role Development

Priorities for Year 1 (2016 – 2017)

- Develop an understanding of staff in scope (and their demographic) by the completion of a workforce scoping exercise where workforce data is developed and agreed for the partnership.
- Review the workforce profile to identify areas of opportunity and address areas of challenge.
- Map the current workforce plans against the Strategic Plan.
- Provide a gap analysis process to identify and explore the profile of the future workforce needed to deliver the Strategic Plan.
- Review and as appropriate establish clear processes which support and facilitate agreed change to deliver the strategic vision

Priorities for Year 2 and 3 (2017 – 2019)

- Confirm the range and scope of the redesign of roles for the future, incorporating the roles the voluntary and private sector play in delivering services and support.
- Agree clear descriptions for any changes of roles and new roles to support the integration context.
- Map the current workforce performance reporting practices and gain agreement on common information and language set to describe the workforce required for the partnership.
- Agree joint workforce performance management standards.
- Commence the development of new roles, supporting managers and staff to meet the demands of new service developments and service user needs.
- Identify those areas where recruitment and retention is challenging across the Partnership and develop approaches to attract staff to caring roles which may be redesigned to support new models of care with clear career prospects.

4.2 Workforce Training and Development

Priorities for Year 1 (2016 – 2017)

- The Strategic Plan describes an ambition to change the future provision of care and support, describing a shift from predominantly crisis intervention to a model focusing on prevention, well being, and reablement recovery and rehabilitation. To realise this ambition we will need to move the workforce of today which has been embedded in a culture of time and task to this new culture, of values and attitude that supports independence, self directed support, self management and prevents or delays people from becoming dependent.
- *Complete* the *Workforce Training and Development Framework*, setting out the way in which joint priorities for staff development are identified and agreed (supporting delivery of the Strategic Plan).
- Training and Development priorities for the Partnership are agreed and supported in the context of the Joint Management Group and the Integration Joint Board.

- Identify and agree programmes for skills and behavioural competency development are agreed to support the desired culture of collaborative working and detailed training and development plans.
- Commence (and continue) joint delivery of agree priority training and development programmes.

Priorities for Year 2 and 3 (2017 – 2019)

- Staff development, supervision and appraisal processes are mapped to agree a joint approach to individual and personal development to support cultural change and any role development identified.
- Current available resources for staff development and training are mapped to identify where any joint working can produce a desired culture change and efficiency in delivery.
- Managers and staff are working to achieve agreed, joint personal objectives and/or personal development plans, targeted at achieving the Partnership Strategic Plan and outcomes.

4.3 Leadership and Management Development

Priorities for Year 1 (2016 – 2017)

- Commence a series of interventions which will ensure all leaders and managers are skilled in approaches to managing change processes, demonstrating the skills required for collaborative working and developing the culture of partnership.
- Continue the leadership development process for the Integration Joint Board as a group and for individual members.
- Agree processes and Programmes for the Senior Leadership group and development for individuals.
- Deliver a range of 'Masterclasses' for senior leaders, Board members and Middle Managers, bringing external knowledge, experience and innovation to the Partnership.
- Establish clear accountabilities and responsibilities for leaders and managers, testing these through scenario planning situations.
- Establish and engage leaders in joint development and networking opportunities at an early stage), focusing on localities and their development.

Priorities for Year 2 and 3 (2017 – 2019)

- Review current leadership and management competency frameworks, mapping a joint framework for Falkirk Partnership.
- Develop Locality Leadership Teams engaging with General Practice, all partners and stakeholders.
- Develop opportunities for cross-sector mentoring / shadowing and leadership exchanges.
- Review existing coaching arrangements and develop a Partnership Coaching Alliance, enabling all managers and leaders to have access to accredited, high quality coaching as an approach to developing people and culture.
- Explore approaches to talent management and succession planning on a Partnership basis, focussing on opportunities for career development and to improve integration, where possible

4.4 Workforce Engagement and Support

Priorities for Year 1 (2016 – 2017)

- Share current practice in change management and agree a Partnership standard process for change programmes, to include a focus on culture.

- Agree shared Partnership Values and behaviours which will support a culture of collaboration and Person-Centeredness.
- Ensure respective organisational support staff are fully briefed, engaged and aligned to supporting the Partnership Workforce Plan.
- Ensure full and proactive staff engagement and involvement through the establishment of consultation meetings and Joint Forums; ensuring Staff Side/Trade Unions are engaged, with mechanisms for full engagement with the Partnership leadership group and staff.
- Take forward a range of 'engagement events with groups of staff to develop a shared understanding of what this will mean for service users and a personal commitment to the partnership/integration culture and the shape of the workforce.
- Managers and leaders establish and embed staff engagement systems and process as the norm in their working practices to ensure that staff are able to engage with managers on any issues.
- Maintain a range of communication and feedback channels with staff, providing clear, consistent information through a range of different media.

Priorities for Year 2 and 3 (2017 – 2019)

- Achieve agreement on a joint approach to measuring Staff Experience based on the Workforce Vision and Workforce Plans, taking forward the national measure: *'**Percentage of staff who say they would recommend their workplace as a good place to work'**.*
- Take forward a review of workforce policies and procedures, harmonising these, where possible to support team working for integration.
- Re-develop the Joint Staffing Framework to support the creation of joint posts and new/changed roles.

4.5 Organisational Design and Processes

Priorities for Year 1 (2016 – 2017)

- Review local governance groups and management teams to enable levels of permission to act, where managers are confident and skilled to work collaboratively in delivering the partnership outcomes.
- Agree groups and structures to support effective delivery of services, based on the principles of effective Organisational Design.
- Establish clear and unambiguous governance structures, leadership structures and workforce structures which empower managers and staff in their roles and support the collaborative desired culture.
- Perform a structural gap analysis using Organisational Development tools to support effective structures and effective use of resources

Priorities for Year 2 and 3 (2017 – 2019)

- Identify Teams and services which are required to move to an Integrated Model and/or work in an integrated way to deliver new Models of Care.
- Ensure those Teams and Services priorities are provided with OD support and intervention to ensure early success.
- Provide co-location (to further support an integrated way of working) for these teams wherever possible.

5 Summary

This workforce plan sets out our commitment to ensure a workforce that is responsive and skilled and is able to provide care and support that is local and of a high quality consistent with the Partnerships ambitions.

The Plan also sets out the commitment to working across the wider health and social care sector, not just those employed by the NHS or the Council. This will support the ongoing joint commissioning of services and the approach to delivering services integrated at local level.

This plan will be a 'live' document and will be supported by more detailed workforce and organisational development action plans for localities and will reflect the ongoing Integration Joint Board corporate and national priorities.