Falkirk
Health and Social Care
Partnership

Falkirk Health and Social Care Partnership

Annual Performance Report 2016 – 2017

Introduction

Welcome from the Integration Joint Board (IJB) Chair

I am delighted to take up the role of Chair of the Falkirk Integration Joint Board (IJB), following Councillor Allyson Black, who oversaw the establishment of the Board and its first year of "going live". This was a challenging time, and I wish to continue making sure that our focus is always on people and their carers, and improving the outcomes that make a difference to them.

I know that there will be many challenges facing the Board. Our first year working together has ensured a strong foundation to face these challenges and to move forward. There have been some changes to Board membership, and I would like to thank those Board members who had an important role in the initial shaping of the Falkirk Health and Social Care Partnership. Their commitment, knowledge, enthusiasm and contributions were invaluable and ensured we jointly set the direction for our partnership.

I welcome our new Board members and look forward to what we can achieve over the coming years through positive and supportive relationships. The IJB has an ambitious and innovative strategic plan and a clear change programme which will help us maintain our focus. We want to ensure that health and social care developments in our plan are delivered by the Chief Officer, the Leadership Team, and staff across the Partnership without delay and with our support. Integration of health and social care provides real and tangible opportunities for services to work differently. We will encourage innovation and creativity, the ambition to be the best we can, and transform the way we will work with our communities, workforce and partners.

Julia Swan
Falkirk IJB Chair

Welcome from the IJB Chief Officer

Since 1 April 2016 - our first year of integration – the Falkirk Health and Social Care Partnership has made good progress, often in challenging circumstances. This ability to respond to these situations has demonstrated the commitment, resilience and professionalism of our workforce across the partnership area, including carers and volunteers, to work together and make a positive difference to people who use our services. One of my ambitions is to the make Falkirk Health and Social Care Partnership the employer of choice, with leadership champions across all of our services, supporting the transformational change required. We will do this by continuing to invest in workforce development over the coming years.

In our work together, we must continue to recognise the experiences of people who use our services and their carers. We often get this right, and we must reflect on what worked well and replicate this where we can. However through listening to service user and carer experiences, we recognise there are times when services are disjointed or there is a delay in receiving services. We are building on our understanding of the complexity of our health and social care system – how this works, our capacity, the demand and how well these services perform. This work will help us decide areas for service improvement and redesign and where to invest, and in some cases to reinvest in other services. We know the current status quo is not sustainable, or working for many, and change is required. This can be unsettling to patients, service users, their carers and our employees, and we will work together to explain this and hear views on what matters and how better to deliver services.

The financial position remains of concern, yet over the financial year 2016 – 2017, we achieved a balanced budget and implemented the Scottish Living Wage with our external providers.

There is more that we can achieve and I look forward to working with the Integration Joint Board and the Leadership Team to achieve this with you.

Patricia Cassidy
Chief Officer

Our Partnership

IJB, Governance and Decision Making

Falkirk Integration Joint Board (IJB) was legally constituted on 3 October 2015 and held its first Board meeting on 6 November 2015.

The Public Bodies (Joint Working) (Scotland) Act 2014 established the framework for the integration of health and adult social care in Scotland, to be governed by IJB's. These Boards have responsibility for the strategic planning of the functions delegated to it. They are also responsible for ensuring the delivery of its functions, through the locally agreed operational arrangements.

On 1 April 2016, health and social care functions were formally delegated to the Falkirk Integration Joint Board. This means the IJB takes responsibility for the strategic planning and commissioning of:

- Social Work Adult Services
- Community and Family Health Services relating to in-scope functions
- Large hospital services planning, with partners who will continue to manage and deliver the services as part of the pan Forth Valley structures.

NHS Forth Valley and Falkirk Council delegate budgets to the IJB, which decides how resources are used to achieve the objectives of their Strategic Plan. The IJB then directs the partners, through the Health and Social Care Partnership, to deliver services in line with this plan. The Integration Joint Board controls an annual budget of approximately £200m, and is responsible for providing health and social services for the Falkirk area population.

A governance framework is in place which covers areas including the Integration Scheme, IJB Standing Orders, Risk Management and Clinical and Care Governance. This framework covers the rules and practices by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The IJB has legal responsibilities and obligations to its stakeholders, staff and residents of the Falkirk Council area.

Membership of the Integration Joint Board is set out in legislation and is made up of 19 members. The Board has 6 voting members – 3 Falkirk Council Elected Members and 3 NHS Forth Valley non-executive Board members. The membership must also include senior officer representation from health, social work and wider stakeholders including service users, carers, Third Sector and staff representatives.

The range of members on the Board has enabled insightful contributions from different perspectives, and informed our decisions. The voice of service users and carers in particular, has been of importance and value to the Board.

The diagram below (figure 1) provides an overview of the key activities of Falkirk Integration Joint Board during 2016/2017.

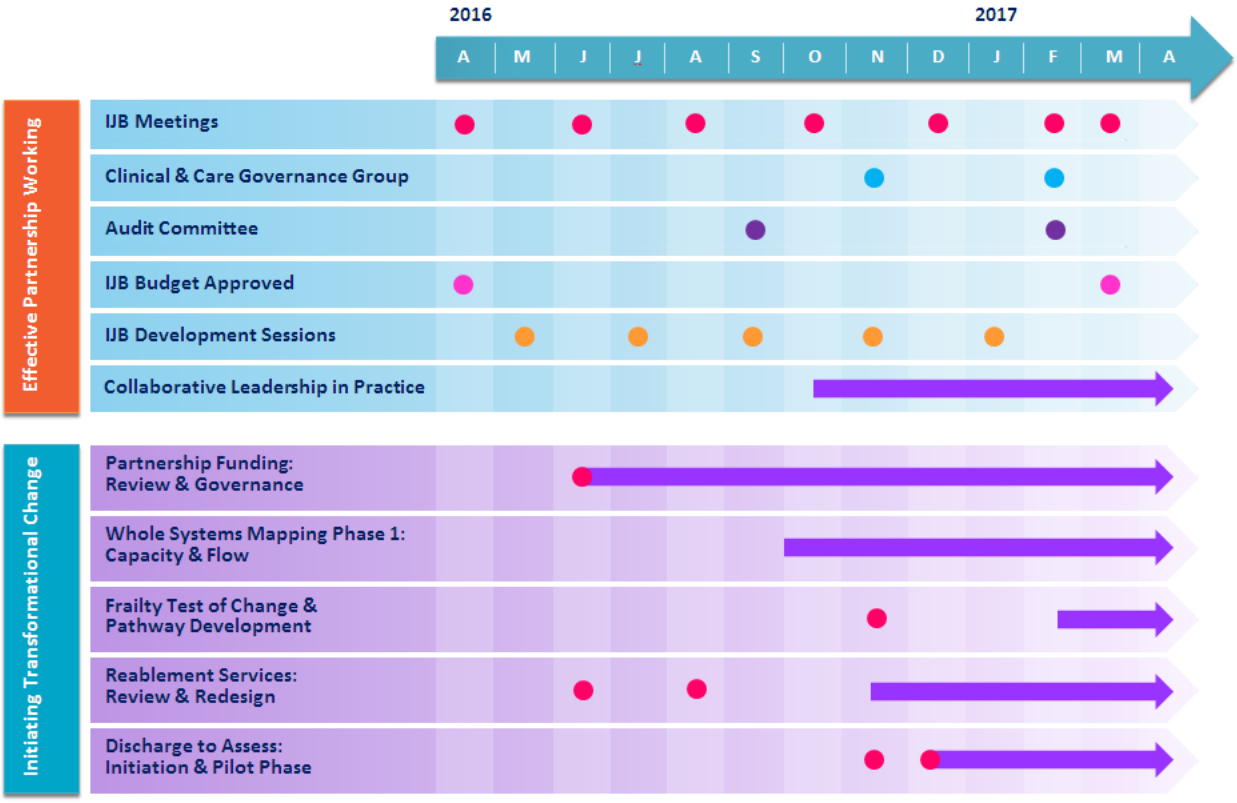


Figure 1

Strategic Plan

The Falkirk Integrated Strategic Plan 2016 – 2019 describes how the Falkirk Health and Social Care Partnership will continue to make changes and improvements to health and social care services for all adults. The plan details how the partnership will prioritise services in response to the key issues for the Falkirk area and is supported by a Joint Strategic Needs Assessment (JSNA). Integration will focus on health and social care services with third and independent sectors providing a valuable contribution.

The IJB approved its Strategic Plan to deliver the vision for Falkirk:

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

The Scottish Government has set out nine national health and wellbeing outcomes to improve the quality and consistency of services for individuals, carers and their families, and those who work within health and social care. Figure 2 highlights these national outcomes.

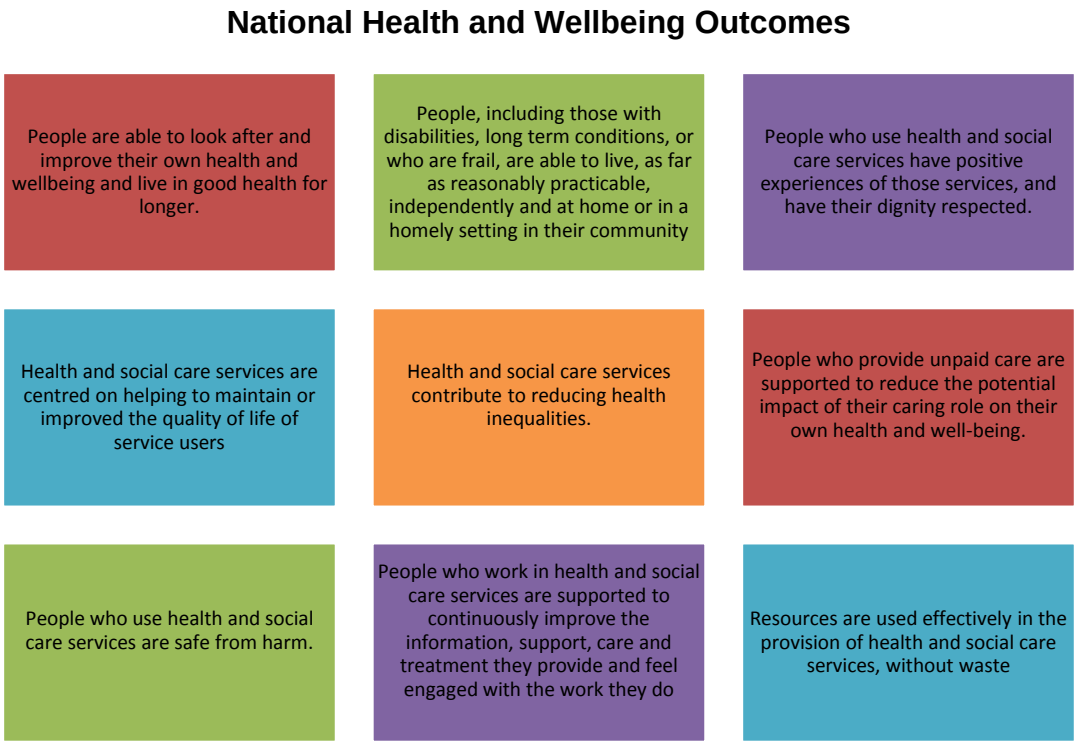


Figure 2: National health and wellbeing outcomes

The Strategic Plan identifies five specific local outcomes which align with the Scottish Government's national health and wellbeing outcomes, the National Health and Social Care Delivery Plan and the Falkirk Community Planning Partnership Strategic Outcomes and Local Delivery (SOLD) Plan.

The five local outcomes are:

1. **Self-Management**: Individuals, carers and families are enabled to manage their own health, care and wellbeing
2. **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
3. **Safe**: Health and social care support systems are in place, to help keep people safe and live well for longer
4. **Service User Experience:** People have a fair and positive experience of health and social care
5. **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.

The following section of this Annual Report will explain in more detail what these outcomes mean for people and communities and what we are doing to help achieve these outcomes.

The Local Outcomes were created to address the key challenges highlighted in the Joint Strategic Needs Assessment with the outcomes consistent with the views of service users, carers and local communities. To complement these outcomes, under-pinning principles for the Falkirk Health and Social Care Partnership were also agreed:

- putting individuals, their carers and families at the centre of their own care by prioritising the provision of support which meets the personal outcomes they have identified as most important to them
- recognising the importance of encouraging independence by focusing on reablement, rehabilitation and recovery
- providing timely access to services, based on assessed need and best use of available resources
- providing joined up services to improve quality of lives
- reducing avoidable admissions to hospital by ensuring that priority is given to strengthening community based supports
- sharing information appropriately to ensure a safe transition between all services
- encouraging continuous improvement by supporting and developing our workforce
- identifying and addressing inequalities
- building on the strengths of our communities

- planning and delivering health and social care in partnership with community planning partners
- working in partnership with organisations across all sectors e.g. Third sector and independent sector
- communicating in a way which is clear, accessible and understandable and ensures a two way conversation.

In December 2016 correspondence received from the Scottish Government identified 9 key national priorities areas for all IJB's to address. These are to:

- reduce occupied hospital bed days associated with avoidable admissions and delayed discharges
- increase provision of good quality, appropriate palliative and end of life care
- enhance primary care provision
- reflect delivery of the new Mental Health Strategy
- where children's services are integrated, continue to invest in prevention and early intervention
- support delivery of agreed service levels for Alcohol and Drugs Partnerships' work
- ensure provision of the living wage to adult care workers and plan for sustainability of social care provision
- continue implementation of Self Directed Support
- prepare for commencement of the Carers (Scotland) Act 2016 on 1 April 2018.

Using a logic modelling approach, three models have been developed. These identify the activity required to achieve the five local outcomes. There are some overlaps with these outcomes and the logic models incorporate these. The process aligned the FHSCP local outcomes to the existing national health and wellbeing outcomes and identified the strategic activities required to deliver these outcomes.

The Partnership has undertaken further work to align the strategic activities in the logic models to the more recent nine Scottish Government priorities.

Locality Planning Arrangements

The Partnership has identified its locality areas for service planning purposes. There will be three localities within the Falkirk Council area, which are illustrated in Figure 3 and are:

- West – Denny, Bonnybridge, Larbert and Stenhousemuir
- Central – Falkirk central
- East – Braes, Grangemouth and Bo'ness

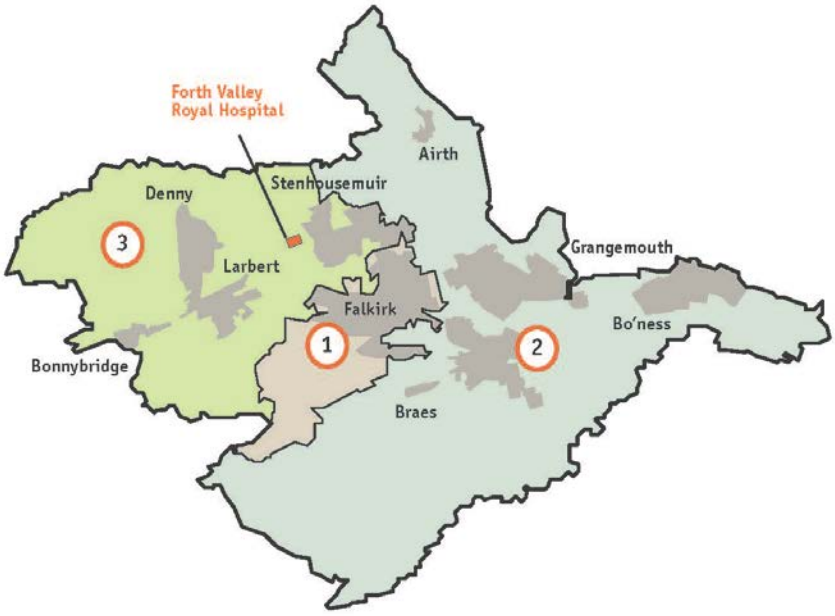


Figure 3

We are working closely with the Falkirk Community Planning Partnership to develop a joined up approach to locality planning that will improve outcomes for people and communities.

How we are making a difference

Our Strategic Plan sets out the Partnership's vision, outcomes and priorities for people who live in the Falkirk area. In this section of the report we set out what our 5 local outcomes will mean for people and communities and what we have achieved over the first year of the Falkirk HSCP.

Local Outcome 1: Self-Management

Individuals, carers and families are enabled to manage their own health, care and wellbeing	
What will 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 will 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.

Examples of work progressed during 2016/2017

1. Discharge to Assess Pilot
2. Support for Carers
3. Development of Reablement Services

1. Discharge to Assess

The Discharge to Assess pilot was set up to work with people to identify their immediate care and support needs when they present at the hospital. The pilot aims to prevent admissions and to reduce length of hospital stay and delays in discharge through supported early discharge of people over 65 years for assessment and reablement care at home.

This means people are supported to recover at home rather than in hospital and support is tailored to meet individual needs. People are assessed within the hospital by a multi-disciplinary team (MDT) and visited within the first few hours of getting home. There are weekly reviews with the care provider to ensure any emerging care related issues are appropriately addressed. The team work with the person on their reablement needs for up to 6 weeks and if ongoing support is required this is arranged. An evaluation of the impact of the implementation of the Discharge to Assess model will take place following the pilot period in late 2017. The following diagram (figure 4) shows the Discharge to Assess process.

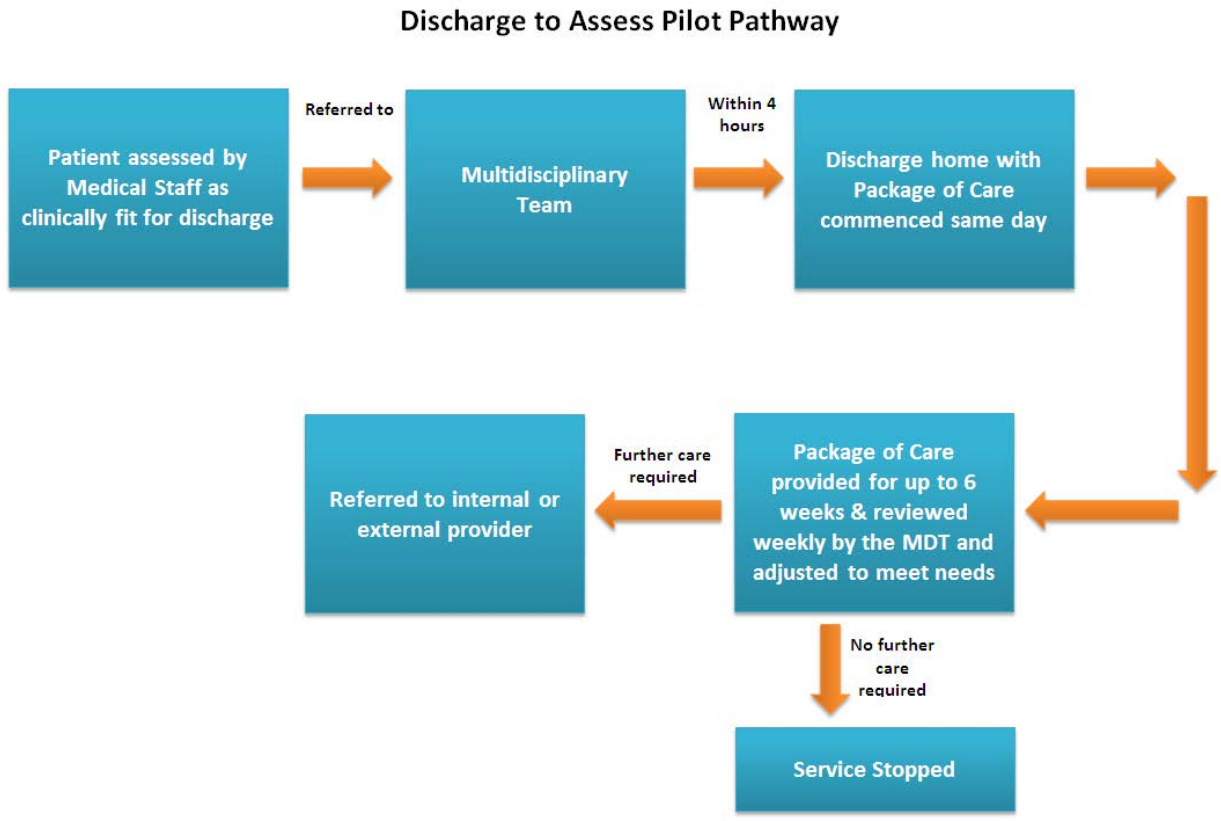


Figure 4

The following case study describes the service provided and the difference this can make to people.

Hospital Journey: Mrs B was transferred from Forth Valley Royal Hospital to Falkirk Community Hospital (FCH) for a 2 month period of rehabilitation following a fall. She had a history of stroke and was supported by her partner.

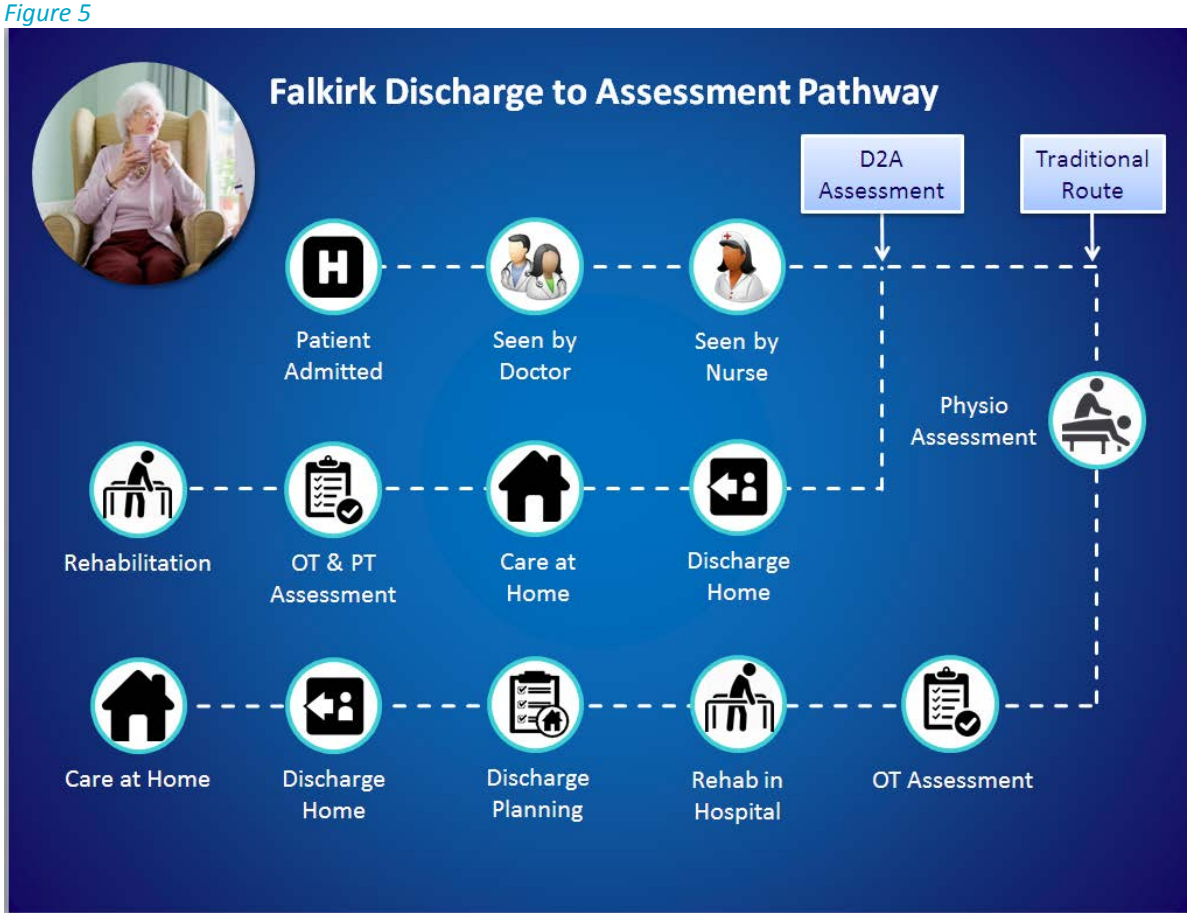
Discharge plan: Following assessment by FCH staff, during the 2 month period, a referral was made to Social Work, to provide 6 daily calls from home care. The referral was discussed by the multi-disciplinary team and referred to the discharge to assess care provider.

Review on discharge:

- Week 1 - 6 x daily calls were initially provided. In consultation with Mrs B and her family this was reduced to 1 x daily call. Further review was completed and it was clear that Mrs B had good insight into her situation and the support she wished and what goals she would like to achieve.
- Week 2 – MDT review to identify Mrs B's rehabilitation goals. In returning home Mrs B started carrying out household tasks. All of which have helped her rehabilitation, elevated her mood and supported her with working toward her long term goals.
- On-going - reablement of Mrs B continues at home with 1 x daily call.

Figure 5, below illustrates what the alternative pathway from hospital to home can be through our Discharge to Assess (D2A) pilot.

Figure 5



2. Support for Carers

There are a range of services in place to support carers. These are delivered in partnership with a number of providers including Falkirk and Clackmannanshire Carers Centre, FDAMH and Alzheimer's Scotland. Partnership funding has been used to provide services, including:

- **Carers Support Planning:** 3 Carer Support Workers support the development of Carer Support Plans. Carers have access to locality based support and have an increased ability to manage their caring responsibility whilst maintaining their own health and wellbeing. Asset based approaches are used to develop support plans. GPs, pharmacies, Community Care Teams have information and links to Carers Centre. Partnerships are established with local organisations to support carers through referral and signposting.

- **Enhanced Support for carers at point of hospital discharge:** 1 Carer Support Worker, based within ReACH team of Falkirk Community Hospital, provides early support to carers at the point of hospital discharge. An outcomes focused approach is adopted to identify individual needs, signposting and provision of relevant information and support.

- **Training for carers in their own community:** A Care with Confidence programme has been delivered which enables carers to feel more confident in their caring role. The programme is co-produced and delivered by a range of professionals including health, social work, Police Scotland, Fire and Rescue Service, and covers a range of topics - illness specific and carer focused.

- **Carers engagement:** a Carer Engagement Manager supports carers consultation and participation in local and national forums which have an impact on carers. Carers have been able to actively participate in the Carers Forum and one-off events, carers views have been gathered to provide input to a range of topics e.g. housing, Carers Act, integration. The Carer Engagement Manager represents carers on the Integration Joint Board.

- **Health and Wellbeing activities:** provision of health and wellbeing activities for carers which helps sustain their caring relationship by improving their own health and wellbeing. Carers are involved in the development of the programme by using solution focused, asset based approaches to support them to build their own skills and knowledge to plan the type of support that they need to help them continue with their caring role.

- **Short Breaks for carers:** this adds value to existing short breaks provision by providing 80 carers with short breaks (includes young carers). Carers are more confident and able to cope with their caring responsibility, have improved emotional and physical wellbeing, are able to combine their caring responsibility with work, social, leisure and learning opportunities, and are able to maintain good relationships with those cared for.

During 2016/2017, work has been initiated to review the Forth Valley Carers Strategy, in preparation for the implementation of the Carers (Scotland) Act 2018. A collaborative approach has been adopted and includes participation from NHS Forth Valley, Falkirk Council and Third sector partners.

3. Reablement Services

Reablement is at the core of the work that we do to support people to regain their independence. A key strand of work is to renew current reablement services and approaches to help identify areas of improvement and redesign. This development work will ensure that support is in place to help people regain independence following a stay in hospital or deterioration in their health.

The Reablement Leadership Group, which has been set up with support from Health Improvement Scotland, is considering the range of services that can be accessed through a streamlined assessment and referral process, based on individual outcomes. This will include support to self-manage as well as provision for people with high level, complex need.

The group is making progress to:

- define reablement
- develop consistent assessment and referral pathways
- initiate a training programme for staff across all partners on reablement
- embed reablement into every care settings.

There are a number of services that contribute to reablement and this is described in figure 6 below:

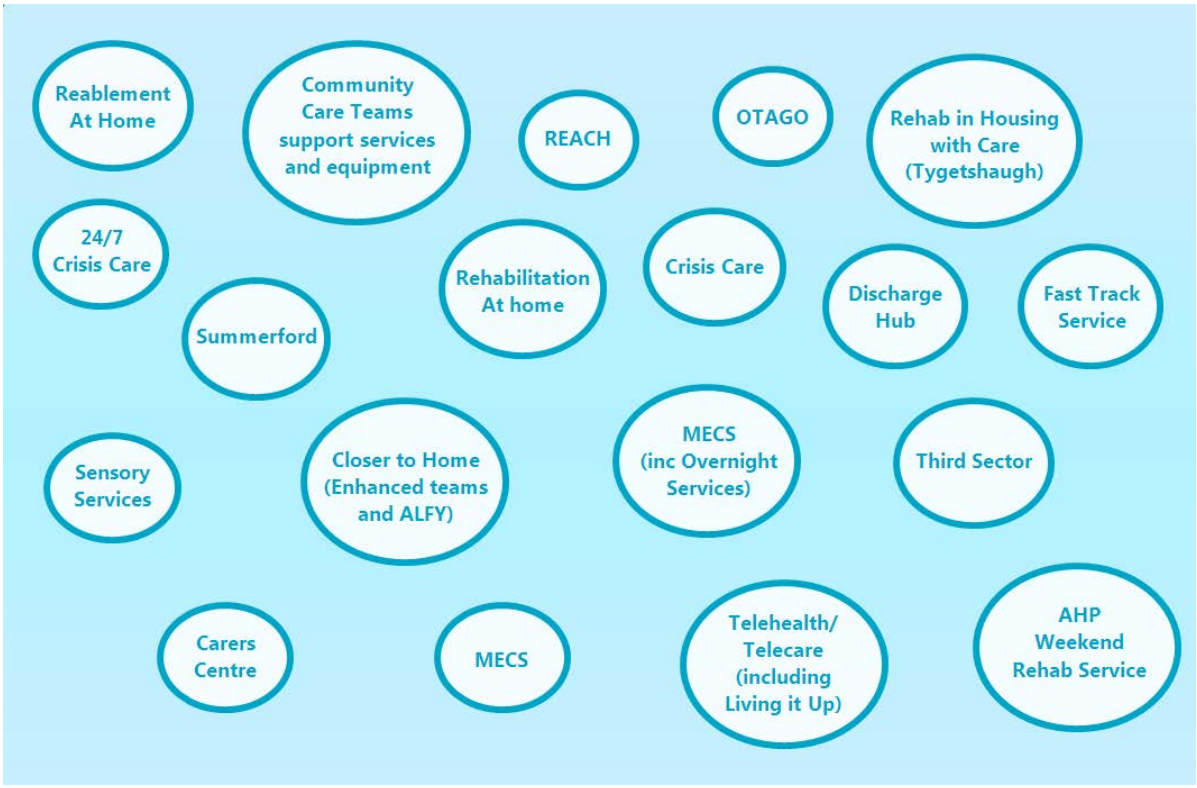


Figure 6

Local Outcome 2: 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	
What will 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 will 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.
Examples of work progressed during 2016/2017 1. Improving Access to Palliative and End of Life Care 2. GP Fellows & Enhanced Community Team 3. Moving Assistance Project 4. Adapting for Change 5. Public Awareness Campaign: Adults with Incapacity	

1. Improving access to palliative and end of life care

With an increase in the number of older people and people living with complex and multiple health needs, the Partnership works closely with service users, their carers, providers and communities to ensure that timely, appropriate and accessible services are available at end of life.

Palliative and end of life care is provided with a wide range of partners across the Falkirk area, including NHS Forth Valley, Strathcarron Hospice, Marie Curie and Macmillan. Specialist teams are in place and where possible, care and support is provided at home or within a community setting.

During 2016/2017, Strathcarron have worked with community groups and individuals to identify what is important to them at the end of life and what support would help them to live well and die well. Findings include, people:

- find it difficult to find or use information that might help them to plan ahead.
- find it difficult to communicate their wishes and fears with those close to them.
- would prefer where possible to use lay support from their own communities than work with professionals

- want to focus on living rather than dying and want to contribute to and participate in their own communities.

Key findings from this engagement will inform further community based work during 2017/2018.

2. GP Fellows and Enhanced Community Team

Over the last 12 months the partnership has been working across the Forth Valley area to develop a new model of care involving GP Fellows. This will contribute to supporting people to remain well at home.

The GP Fellows work as an integral part of the Enhanced Community Team (ECT) providing medical input and intervention. This will mean the team can deliver improved care in the community and support a more coordinated health and social care response to a patient's needs, particularly during times of crisis. Their key focus is to improve outcomes and where possible avoid hospital admission.

The project started in the Bo'ness, Grangemouth, Braes locality for frail older people and those with complex multi-morbidities. The ECT are now able to respond to more complex referrals, strengthening community based services and contributing to the aim of avoiding unnecessary hospital admissions.

The following housing projects have been taken forward with housing services and the voluntary sector.

3. Moving Assistance project

The Moving Assistance Project involved a partnership between Falkirk Council and Outside the Box. The project initially aimed to collect evidence about older people whose homes were unsuitable and to explore how practical assistance could be provided to help people move home. However, it quickly became apparent that there were difficulties around delivering practical assistance and after joint discussions it was agreed the project would focus on how to help people learn more about their housing choices. This enabled Falkirk Council and Outside the Box to gain a better understanding of what older people need and what would help them achieve this.

The project consulted with older people, asking what would help them with their housing choices. The consultation revealed that people take a long time to make a decision about moving house, although after having finally made the move people said "that they wished they had done it sooner". The project developed a series of hints and tips booklets to help people with their choices which are called:

- Do you want to move or stay
- Choosing the house that is right for you
- Recycling and de-cluttering
- Making the move

- Hints and tips for family and friends

A second project was then established called Home from Hospital. This project worked with older people to develop two booklets; one for hospital staff and a second for people returning home after a stay in hospital.

A Directory of Services was also written highlighting the large variety of services available for older people living in the area.

The feedback from older people and carers on both the content and style is positive.

> *"Good to see how older people can help each other in practical ways and by showing kindness."*
>
> *(older person)*

> *"Very readable and practical"*
>
> *(older person)*

People also like the way it shows how older people and families can find more choices and have some control in situations where they feel they have no choice, such as when someone is waiting in hospital until alterations are completed and they are well enough to return home.

This project won the Age Concern Jess Barrow Award.

4. Adapting for Change

Falkirk is one of the five pilots on-going nationally to streamline processes for housing adaptations and reduce timescales. This is progressed locally through the Adapting for Change (AfC) steering and working groups which involves ihub, HSCP, Falkirk Council Housing services and RSLs. To date the pilot has completed the following:

- Mapped the pathways to adaptations
- Agreed definitions for minor, moderate and major/ complex adaptations
- Developed procedures for a complex cases panel to make decisions on major/complex adaptations
- A specification tool has been developed to streamline the assessment process for adaptations which is currently being tested.
- Training has been developed and rolled out to front line staff involved in disabled adaptations.

The AfC Steering Group has also been working on performance indicators for disabled adaptations and linking them to monitoring for the Strategic Plan.

5. Public Awareness Campaign: Adults with Incapacity

The partnership has been working to increase public awareness of Adults with Incapacity (AWI) issues and to increase the numbers of people with a Power of Attorney (POA). This has been supported by CVS Falkirk and other community organisations in Falkirk such as the Making it Happen Group and Solicitors for Older People.

The campaign focuses on some key messages:

- it can be very difficult for families coping with situations where there is no POA
- many older people can access legal aid
- family members cannot make decisions for another family member without POA
- Power of Attorney is not just relevant for people with dementia.

Work carried out to date:

- Partnership working with Solicitors for Older People - stall and materials at Third Sector Conference, presentation to CVS Falkirk staff, attendance at CREATE session with information provided to professionals including GPs, Pharmacy Technicians, support staff
- Publicity
  - Leaflets in the Falkirk Community Hospital and medical centres
  - CVS - Dedicated e-bulletin articles and referenced in other articles. The e-bulletin distribution list has 1100 recipients
  - Tweets, including one promoting an information session for carers at the Falkirk and Clackmannanshire Carers Centre
  - Stall at Older People's Day and advert in Falkirk Herald to promote the event
  - Article in Central Scotland Regional Equality Council
  - Special e-bulletin promoting Power of Attorney
- Carers Training programmes organised by Falkirk and Clackmannanshire Carers Centre.

Local Outcome 3: Safe

Health and social care support systems are in place, to help keep people safe and live well for longer	
What will 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 quality of lives and be joined up to make best use of available resources.	**What will this mean for our communities?** Communities are confident that systems are in place for the identification, reporting, and prevention of harm.

Examples of work progressed during 2016/2017

1. Mobile Emergency Care Service
2. Advocacy Services
3. Social Inclusion Project: Community Justice
4. Falkirk Alcohol and Drugs Partnership

1. Mobile Emergency Service (MECS)

MECS aim to provide a prompt and appropriate response to alarm calls from service users through either pull-cord systems, dispersed alarms or telecare equipment in people's homes.

In 2016/17

- 4500 service users
- 193,051 calls received
- 26,166 calls requiring a mobile warden response
- 652 alarms were installed

2. Advocacy Services

Independent advocacy plays a vital role in enabling people to be involved in the decisions that affect their lives by safeguarding their rights and helping them to speak out about what matters to them. Advocacy services help people to access information and appropriate services and supports, promote their rights and responsibilities, explore choices and options and to speak out about what matters to them.

Falkirk HSCP provides independent advocacy services through a joint contract with the three Forth Valley local authorities and NHS Forth Valley. Over 2016 there has been work to

develop a new contract to tender for these services. As part of the process, there has been a range of activity to hear people's views. These include:

- Three open consultation meetings were advertised and held in Stirling, Alloa and Falkirk. Service users, third sector organisations, independent advocacy providers and Council officers attended these sessions. These events were attended by approximately 75 people.

- A survey was circulated to a wide range of stakeholders, who were encouraged to distribute this throughout their network of contacts to ensure as comprehensive coverage as possible. 109 electronic and 14 paper responses were received (123 responses in total).

- Further face-to-face meetings were carried out with service user forums and across the Partnership area. Many of the individuals consulted in these groups had direct experience of the advocacy provision in Forth Valley and were able to relate their experiences and preferences for future provision.

3. Social Inclusion Project: Community Justice

Falkirk HSCP provide Partnership Funding towards the Social Inclusion Project. The project supports individuals whose issues and behaviours have caused them difficulties with and exclusion from universal services. The project has been formed through a partnership approach between Police Scotland, the Criminal Justice Service, NHS Forth Valley, the Alcohol and Drugs Partnership, the Richmond Fellowship and substance misuse services. During the initial 12 months of the project, there has been a 78% engagement rate, providing a case management approach for individuals to help them navigate and consolidate a holistic recovery plan.

'I have seen four individuals recently who no longer have a position in the top ten A&E attendee's monthly data report, having been there for years. This is solely down to the Social Inclusion Project and the work that they have done with individuals.'

Hospital Addictions Team

4. Falkirk Alcohol and Drugs Partnership (ADP)

The Care Inspectorate worked with all ADPs across Scotland to undertake a supportive self-evaluation process. This took place in June 2016 and the purpose was to assess compliance with the National Quality Principles for Substance Misuse Services. Some of the identified local strengths were:

- There was strong collaboration, transparent and robust governance in place. The ADP was consistently meeting and exceeding on key performance targets indicating that

they were successfully delivering accessible services and that service users were offered high quality, evidence informed treatment, care and support interventions. The ADP had established robust partnership relationships within the context of the overarching Forth Valley Alcohol and Drug Partnership.

- A very high level of innovation, commitment to self-evaluation and on-going improvement was evident and this culture was extremely well supported and encouraged by local leaders. Person-centred approaches were evidenced and there was a very strong emphasis on peer support, volunteers and early interventions.

- There were strong working relationships with all the other appropriate thematic groups such as the Child Protection Committee (CPC), Adult Protection Committee (APC), children and families and other public protection agendas. In addition the Recovery Oriented System of Care, mutual aid and whole population work were also firmly rooted in strong partnership arrangements.

Local Outcome 4: Service User Experience

People have a fair and positive experience of health and social care	
What will 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 will 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.
Examples of work progressed during 2016/2017 1. Frailty Model: Test of Change 2. Equalities and Mainstreaming Report	

1. Frailty Model: Test of Change

We are working towards developing a frailty pathway which means that people will receive consistent and appropriate assessment and rapid access to the appropriate health and social care services.

A test of change took place involving the lead clinicians and multi-disciplinary team members. This identified areas where an integrated pathway will have positive benefits to enable more appropriate destinations for those people presenting at the front door of the hospital.

Discussions are on-going regarding the implementation of the Frailty Pathway to enable this to be a sustainable approach to assessment and planning appropriate care for patients. This work will incorporate the comprehensive geriatric assessment process and appropriate links with Discharge to Access, the Rapid Access Frailty Clinic and community services including the Enhanced Community Team (Closer to Home) and GP Fellows.

2. Equality Outcomes and Mainstreaming Report

The Partnership has produced an Equality Outcomes and Mainstreaming report. Mainstreaming means that equality is built into the way the Partnership works; the way decisions are made; the way people who work for and on behalf of the Board behave; our

performance and how we can improve. In other words, equality should be a component of everything the IJB does. Mainstreaming the equality duty has a number of benefits including:

- equality becomes part of the structures, behaviours and culture of an authority
- an authority knows and can demonstrate how, in carrying out its functions, it is promoting equality
- mainstreaming equality contributes to continuous improvement and better performance.

Local Outcome 5: 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	
What will 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 will this mean for our communities?** Communities are informed, involved and supported to work cohesively to develop and manage community based supports**.**

Examples of work progressed during 2016/2017

1. Hope House Low Secure Unit
2. Redesigning services: shifting from hospital to community provision at Lochview
3. Information

1. Hope House Low Secure Female Unit, Trystview

The Partnership will open a six bedded unit, Hope House, in summer 2017. This will provide a dedicated low secure female unit within mental health services in NHS Forth Valley. Currently there is no local service, and as a result, some patients have had to transfer to out-of-area units for treatment, and have been moved from their families and local communities. A low secure unit is now being developed, on the Bellsdyke site, to provide a specialist facility nearer to home.

Patients referred to the unit have already been assessed and outreach work is ongoing, to prepare them for transition and to develop a therapeutic relationship. Patients will be located and treated nearer their own homes and will be able to establish links with local community services and teams as part of their rehabilitation plan, and risk testing, pre discharge from hospital.

This change in service provision supports the Partnership's strategic vision and local outcomes.

2. Redesigning services: shifting from hospital to community provision at Lochview

Service users, their carers and staff across all partner agencies are involved in developing a wider and more responsive range of community based services for people with a learning disability. The focus is enabling people to lead more independent lives. The approach involves an incremental reduction in the number of available NHS in-patient learning disability beds. A proportion of bed based savings will be used to provide more appropriate and sustainable community services.

Over the year patients have been discharged from hospital, enabling them to establish links with their local community, optimising recovery and promoting rehabilitation and independence within a homely environment. This change also contributes to national policy agenda, in particular, ensuring that no individual should live out their life within hospital accommodation, irrespective of their age or disability.

The partnership's progress has seen the closure of six beds in House Four at Lochview on 4 April 2017. The next stage is to develop a proactive day assessment and treatment service model which will provide an alternative to in-patient beds. Such provision could also potentially facilitate timely discharge for those individuals delayed in their discharge.

This change in service provision is in line with the Partnership's vision and local outcomes.

3. Information

For Older People's Day in 2016 a drop-in event was held. This event brought together a broad range of support organisations to support older people and their carers and families. Along with information stands from various organisations who offer services, support and information to older people, there were:

- blood pressure checks
- sessions for Otago, a gentle exercise programme designed to prevent falls by improving balance and strength
- Solicitors for Older People Scotland (SOPS) with information on Power of Attorney and the services they offer.

How we are enabling change

We are taking a systematic approach to change, to ensure that improvement and re-design is taken forward directly in line with evidence based need. The process is on-going and includes:

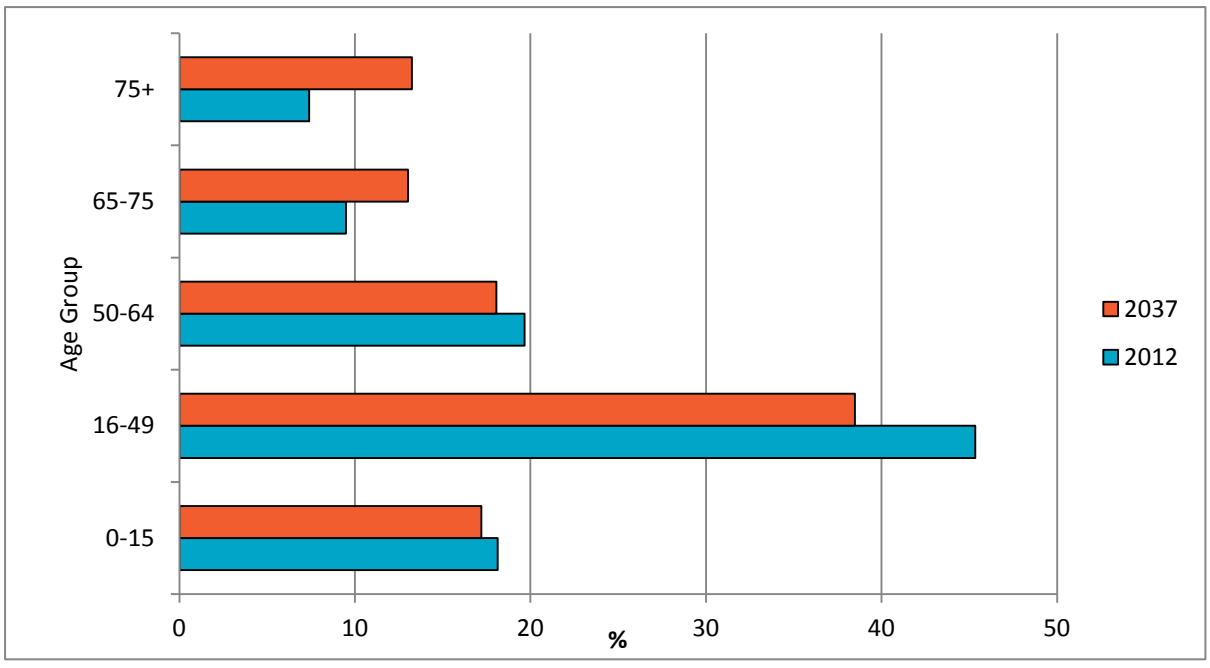
Our understanding of local needs

The Partnership's Joint Strategic Need Assessment (JSNA) has helped us to understand and demonstrate the needs which exist and to inform the development of the Strategic Plan.

The JSNA brings together the available data to describe the current pattern and level of supply of services and, where possible, identify the extent of the gap between need and supply. Understanding the differing levels of need and service provision across the Partnership will be key to future success. The emerging key issues are:

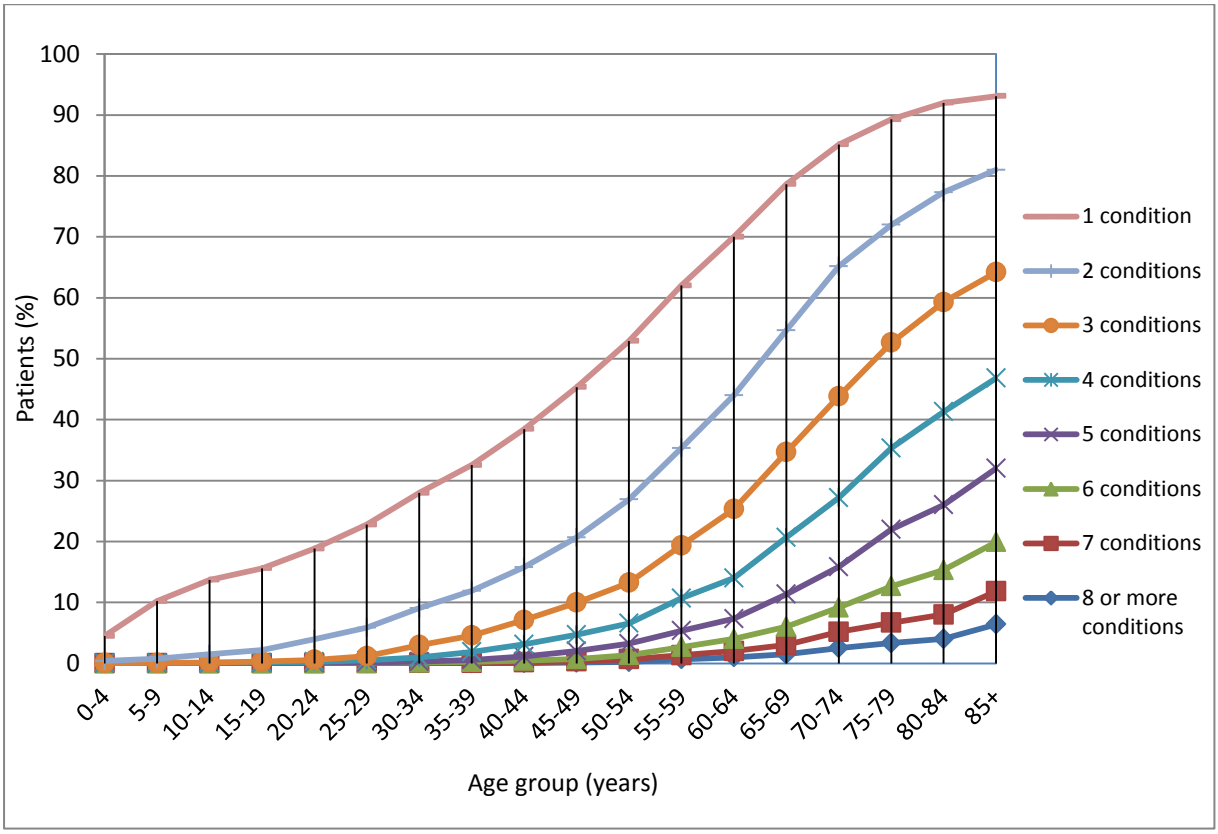
- **an ageing population** - the projected population age distribution is noted in figure 7 below

Figure 7 – Projected Population Age distribution in Falkirk, 2012 to 2037 (Source: NRS Population Projections (2012 based))



- **growing numbers of people living with long term conditions, multiple conditions and complex needs** - Falkirk will have more people with multiple long term conditions (also referred to as multi-morbidities). Figure 8 demonstrates that patients have more conditions as they age. The estimated number of patients within Falkirk with various numbers of long term conditions is forecasted to increase between 2015 and 2037.

Figure 8 – Estimated number of conditions by age group (Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer)



- **Carers** – According to Carers UK, there are an estimated 759,000 people who provide unpaid care in Scotland, which is 17% of the adult population. Utilising data from the 2011 Scotland Census, an overview of carers in the Falkirk area is presented below:

  - over 15,000 people were found to be providing unpaid care in Falkirk, 9.7% of the local population.
  - the carer population was 59.5% female and 40.5% male
  - approximately two thirds (65.4%) of those providing unpaid care are in the age band 35-64 years with those 65 years and over accounting for nearly a fifth (18.2%) of the carer population
  - over a third (35.7%) of carers in Falkirk provide in excess of 35 hours unpaid care each week with 27.2% (of that 35.7%) providing over 50 hours unpaid care
  - 29% of those providing in excess of 35 hours care are aged 65 years and over.

- **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.

The Partnership has also produced Locality Profiles and is working closely with the Falkirk Community Planning Partnership to develop and share local intelligence. This will to better inform service planning and delivery. Further work is ongoing to complete a mental health needs assessment, and profiles on carers and high health gain individuals.

Understanding our health and social care system

The Partnership has been working with the improvement hub (ihub), part of Healthcare Improvement Scotland, to develop our joint understanding of the integrated system across health, social care, Third and independent sectors. This has involved a range of activity, informed by available data on the demand, capacity and flow across the system. Figure 9 below is an example of a mapping process undertaken with staff.

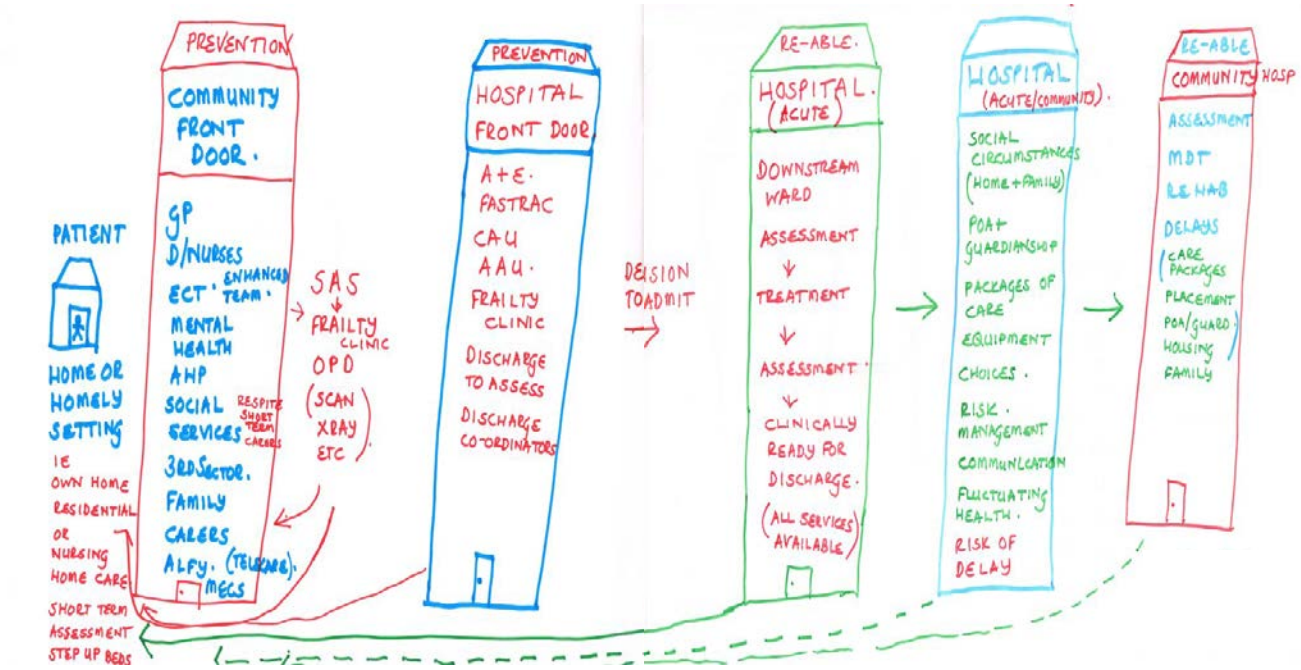


Figure 9

Since December 2016 approximately 90 people have participated in this work. This included employees across all partners, including the Third and independent sectors. Work also took place to include the lived experiences of service users and carers. People from a range of backgrounds, who currently experience health care, social care and/or support services were asked to describe their experiences and to identify improvements that matter most to them. Figure 10 provides an anonymised example of a service user pathway.

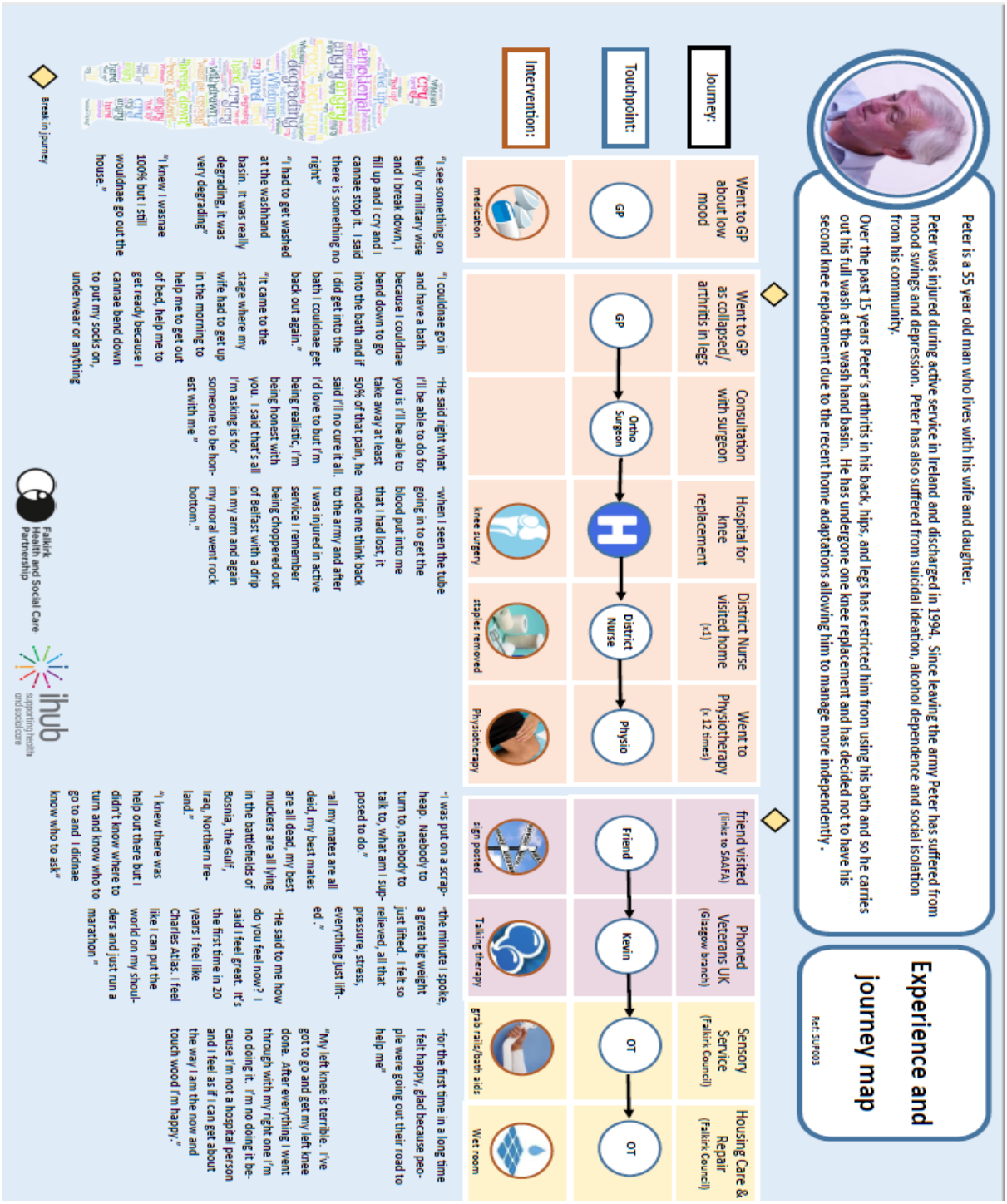


Figure 10

Through this process we have identified there is a range of data available that describes episodes of contact. However this does not necessarily describe the patient's journey through the health and care system and their experiences. The lived experiences work will be used to inform the improvement journey, highlighting the need to collect the right data at the right point.

During the second phase, we will work with the ihub and engage with people around improvements in health, social care and support services, to inform and shape the commissioning of services.

How we involve people

Falkirk HSCP Participation and Engagement Strategy sets out our commitment to effective and meaningful engagement with communities, staff and partners. Importantly, it also provides information about how people can participate and why participation is important.

The Strategy builds on existing good practice established within NHS Forth Valley's Person Centred Health and Care Strategy 2015-2017 'What matters to you, matters to us' and Falkirk Council's Participation and Engagement Strategy 2015-2018 'Have your say'.
It was produced in line with the National Standards on the Principles of Community Participation and Engagement, the Council's Principles of Community Involvement and the Scottish Health Council's Participation Standards. The table (figure 11) below shows some of the activity undertaken by the Partnership during 2016 – 17.

	Who was involved?			
Activity	**Service Users**	**Carers**	**Community**	**Staff**
Gather information about people's journey and experience of health and social care services to help identify areas for change and improvement	✓	✓		
Work commissioned in organisations to work within local communities to co-produce information and services	✓	✓	✓	
Work with In-Control Scotland to engage people in the modernisation of Day Care services	✓	✓	✓	✓
Engaged with people as part of the review of Eligibility Criteria	✓	✓	✓	✓
Worked with people as part of the development of the Advocacy contract	✓	✓		✓
Local networks in place e.g. Carers Forum, Making it Happen Forum and Public Patient Forum	✓	✓	✓	
Facilitated workshops on Delayed Discharge, Reablement and developing Logic Models for the Strategic Plan	✓	✓		✓
Published articles in the local press, Falkirk Council newsletter, and delivered presentations to local groups.	✓	✓	✓	✓
Strategic Plan developed	✓	✓	✓	✓
Public and carers representation on Strategic Planning Group	✓	✓		
IJB visual identity developed	✓	✓	✓	✓

Figure 11

How we support our workforce

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 health and social care integration. The Falkirk HSCP Integrated 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 our ambitions.

This will 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. 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.

The Integration 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. Through this approach our intention is 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.

Over 2016 – 17, the partnership undertook a range of activity including:

- issued newsletters across the two Health and Social Care Partnerships in Forth Valley to support information sharing
- completed an initial analysis of our work force with further work ongoing. This will help us to better understand our total staff group and identify where our resources are currently deployed, where we have pressures and skill gaps.
- engaged with the Collaborative Leadership in Practice [CLiP] national programme to support three levels of collaborate leadership training:
  - Strategic Leadership Team
  - Reablement Leadership Group
  - Leadership development for the integrated team pilot
- established a Joint Staff Forum for the two Health and Social Care Partnerships which brings together the staff side and trade union representatives from NHS Forth Valley and the three Councils – Clackmannanshire, Falkirk and Stirling
- Staff engagement sessions held.

How we are working with Falkirk Community Planning Partnership

We work with a wide range of partners across the Falkirk area and Forth Valley. We understand that good health and wellbeing is not just about health and social care services, but is also impacted upon by a range of other factors such as health inequalities, housing and employment. We also recognise that although the scope of Falkirk HSCP covers all adult services, our links with Children's Services are critical in terms of recognising children and young people within families and communities.

The Partnership is a strategic partner within the Falkirk Community Planning Partnership and makes a significant contribution to the CPP's Strategic Outcomes and Local Delivery (SOLD) Plan in a leading capacity, as follows:

- People live full, independent and positive lives within supportive communities
- Improving mental health and wellbeing.

The Health and Social Care Partnership also makes a distinct contribution to a number of other priorities and outcomes within the SOLD plan.

In relation to mental health and wellbeing, the Chief Officer chairs a multi-agency Mental Health and Wellbeing group, who have developed an area wide action plan, which all partners are accountable for delivering. Initial outputs include a service mapping exercise and the development of a service directory.

Community based mental health services are provided through an Integrated Mental Health Team and also through a range of third sector providers. Partnership Funding adds value to provision, with a range of initiatives currently in place within communities, two of which have a specific focus on dementia, supporting the Dementia Strategy.

How we are working with housing

The Falkirk Housing Contribution Statement provides an essential link between the Falkirk HSCP Strategic Plan and the Local Housing Strategy (LHS). A new LHS has been developed for the period 2017-2022, with the key priority linking to the HSCP Strategic Plan being "providing housing and support to vulnerable groups". The most relevant outcomes under this priority are:

- the supply of accessible properties is increased
- specialist housing advice is provided in partnership with the Housing Contribution Statement group
- older peoples' housing is reviewed by the Housing Contribution Statement Group
- further analysis on the housing needs of vulnerable groups is carried out.

The draft LHS has been reviewed by Scottish Government who highlighted that it was "very strong".

A HSCP Housing Contribution Group has been established with representation from Falkirk Council Housing Services, Falkirk HSCP and Registered Social Landlords. This group will oversee progress towards these outcomes.

How we are working with Falkirk Alcohol and Drugs Partnership

The issues of poverty, loneliness, unemployment, isolation and poor mental health are prevalent in those with substance misuse problems. Children affected by parental substance misuse are affected by all of the above within the family environment. This is an increasing trend, especially amongst looked after and accommodated children. If we are to break this cycle we must consider improving the lives of adults by reducing substance misuse within the family.

We know that alcohol is having a greater impact in our communities in that it is affecting older people with more evidence of alcohol related brain injury. More children are presenting with complex and challenging behaviors as a potential result of Foetal Alcohol Syndrome. We know our communities are concerned about the impact of alcohol and drug misuse within their area and we must address these concerns.

Partnership Funding is currently allocated to an initiative regarding case management of Alcohol Related Brain Disorder (ARBD). The purpose of the project is detect and treat individuals at risk, or with, ARBD timeously and to prevent the need for admission to residential care.

How we are working with Community Justice

During the past year, links have been developed between FHSCP and Falkirk Community Justice Partnership. The Scottish Government's Community Justice Strategy highlights that 'there are cyclical links between inequalities, offending, becoming a victim, fear of crime and poor health. Improving people's physical and mental health outcomes is not just a worthwhile end in itself, but can also help to reduce and prevent further offending'.

The Falkirk Community Justice Partnership have recently published a plan which sets out their pledge over the next 3 years to secure the best possible outcomes for people from the point of arrest, through prosecution, community disposal or custody and alternatives to these, until they are reintegrated back into the community. The work of the Community Justice Partnership includes making sure that every contact in the community justice pathway is considered a health improvement opportunity and there is evidence in the Falkirk area of collaborative working between community justice partners to ensure that individuals have access to the essential health services, substance use, and specialist mental health services they need from point of arrest onwards.

Reoffending is a complex issue and people who have committed offences may present complex and multiple needs. Alongside improving health and wellbeing the work of the Partnership is also focused on making sure people have access to support for other needs such as housing, financial inclusion and employability.

How we are working with providers

The partnership currently procures approximately £60m each year of adult health and social care services.

The HSCP Market Facilitation Plan signals the Partnerships intention to engage, listen and support the market, providing opportunities for improvement and solutions to improving outcomes for service users and their carers. The plan aims to provide a platform upon which commissioners and providers can work together to strengthen relationships and ensure the availability of high quality services.

The plan identifies a continuing increase in demand for care and support, against a back-drop of constrained financial resources. As such the key messages to the market are:

- the need to develop support that provides early intervention and prevention, to enable a move away from long term dependent care provision
- a focus towards shorter term intensive social care and support packages aimed at enablement and returning home
- the emphasis on personalisation, the delivery of individual outcomes and Self Directed Support mean that we need to consider new delivery models of social care and support;
- an increase in self-care initiatives to support long term health and wellbeing
- the role of information and advice in the market is expected to grow to support people in taking choice and control over how their needs are met
- the use of assistive technology needs to be further embedded into mainstream support provision
- there needs to be capacity building within the unpaid carers sector
- services for people with learning disabilities will need to offer a broader range of stimulating experiences for the service user and carer.

The Partnership has established provider meetings with Care at Home and Care Home providers, supported by Falkirk Council and the Integration Lead (independent sector). These meetings ensure ongoing dialogue to make the most efficient and effective use of existing budgets, to not only deliver efficiencies but also create capacity for investment to meet the increasing demand for care services.

Over 2016 – 2017 we have held:

- quarterly meetings with all homecare providers
- 2 development workshops with providers about the development of the new Care at Home contract/tender. Events were well attended with about 48 providers attending both events.
- 1-2-1 meetings with providers covering matters such as implementation and payment of Living Wage as well as day to day contract compliance
- 5 Care Home Managers meetings
- individual contract reviews with care homes on an annual basis.

How we are working with the Third sector

The third sector within the Falkirk Council area is very diverse and contributes greatly to the local economy and social welfare of our communities. The Third Sector Impact Measurement Report 2016, provides a context and details of the breadth of services offered, and the financial contribution made in the Falkirk Council area.

The Impact Report draws on information gathered from 381 organisations operating within the Falkirk Council areas. It is acknowledged that this equates to less than half of all Third sector organisations within the area. The report highlights that similar to Scotland as a whole, social care was the largest sub-sector, with 27% of organisations. Over 132,000 people benefitted from the activities of organisations and 60% had an income of less than £25,000. The report concludes that the Falkirk Third sector is healthy, growing, and contributes in many varied ways to our community.

HSCP Change Programme Board

The HSCP Change Programme Board was established during 2016 to strengthen governance arrangements and oversee the IJB's significant change programme. This is chaired by the IJB Chief Officer with senior representation from health and social care services. Over the past year there is evidence of transformational change taking place at strategic and operational levels.

How Partnership Funding is supporting transformational change and redesign

Over 2015 – 2018, the Scottish Government has provided funding in the form of Integrated Care Funding and Delayed Discharge Funds. These two sources support the delivery of Health and Social Care Partnership outcomes, and within the Falkirk Partnership are collectively referred to as Partnership Funding. The Scottish Government have set directions on the use of these funds to support the achievement of local Partnership outcomes and priorities.

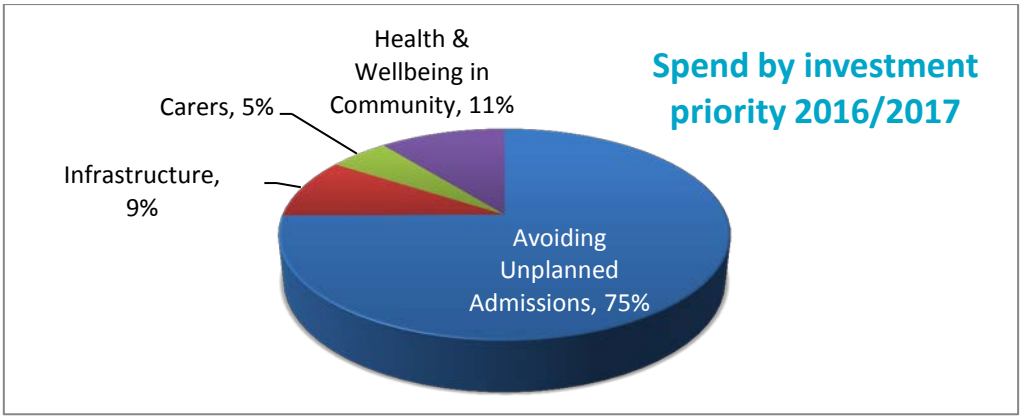
Although the ICF and Delayed Discharge (DD) fund have defined parameters of use, the collective resource has the potential to enable transformational change and improvement to service provision across the whole system. Therefore, to allow the impact of the total resource contribution to be evaluated, a consistent approach to governance, monitoring and reporting has been applied across all strands.

The Partnership's Integrated Care Plan sets out four local investment priorities, which are:

- Avoiding unplanned admissions
- Health and wellbeing in communities
- Support for unpaid carers
- Infrastructure.

Figure 12 shows the proportion of spend against each priority investment area. Over 2016 targeted investment has taken place to develop an effective system of support within communities, particularly in relation to prevention and self-management. The majority of these new community based initiatives have either commenced during the final quarter of 2016/2017 or from 1 April 2017. It is worth noting that most of the funding allocated within communities is small in value.

Figure 12



Activity and Progress during 2016/2017

During the course of 2016/2017, activities have been progressed to develop and implement the revised governance and performance framework and the on-going development of investment plans. A summary of strategic activity is provided in figure 13, below.

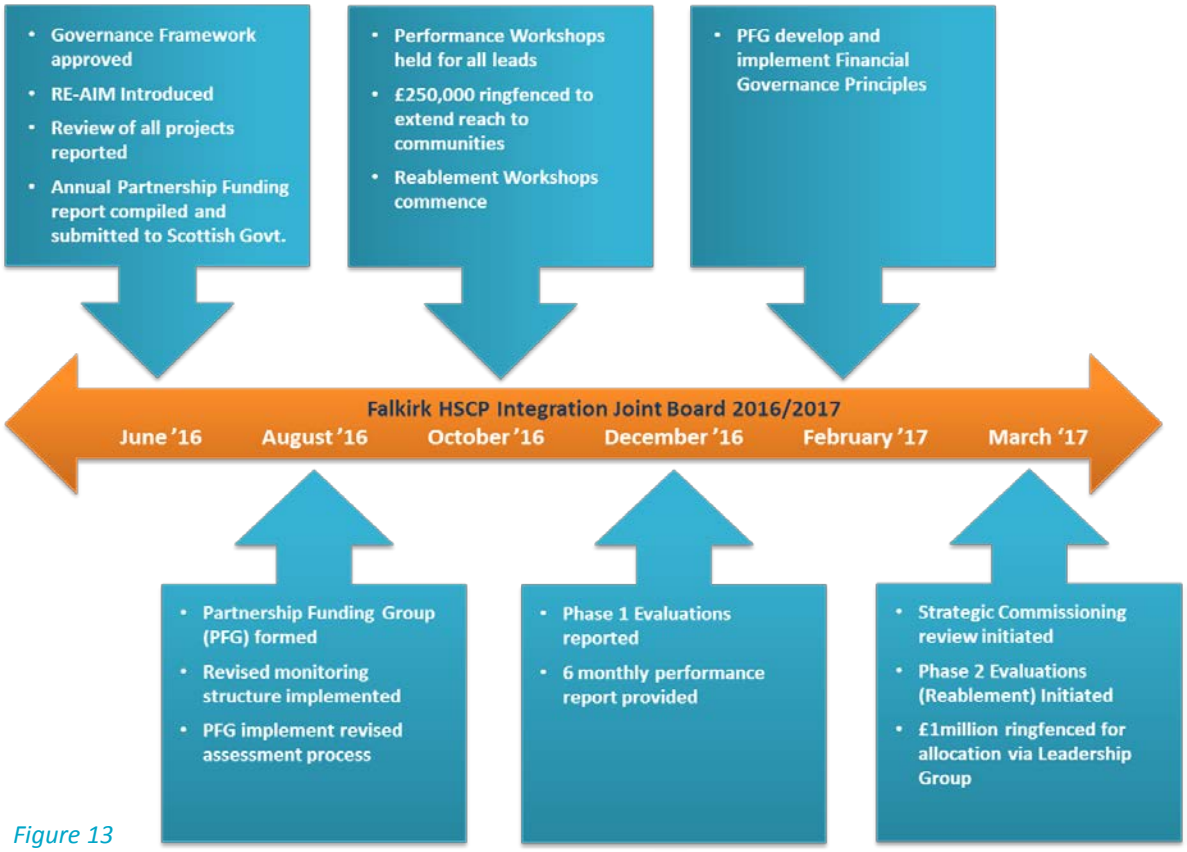


Figure 13

The development work undertaken during 2016/2017 has ensured that a robust governance and monitoring framework is in place, to enable Partnership Funding to be strategically commissioned in line with the priorities of the HSCP Strategic Plan. In addition, to ensure a continual drive towards transformational change and improvement, on-going development work aligns with the whole system approach and strategic programmes of work being led by the Partnership's Leadership Group, for example Frailty, Unscheduled Care and the implementation of the Discharge to Assess model.

Programme Learning, Challenges and Changes

During 2016/2017, programme level learning points have been identified. Some of the learning has been considered and has now been developed into improvement actions, which will continue to be progressed during 2017/2018, as highlighted in the below table.

Learning Point	Area of Improvement and Action
Initiative Sustainability	Initiative sustainability is a key issue encountered by all partners. The ability to mainstream service through redistribution of cost efficiencies achieved elsewhere within the system has not been realised. Furthermore, the requirement to consider sustainability from the outset has acted as a deterrent to new initiatives and to testing innovative approaches, particularly in the third sector. **Action:** Moving forward a proactive approach to commissioning will be adopted with the Partnership working with partners to clearly define what services are required, based on evidence of local need and linkage with the whole system e.g. referral pathways identified and agreed during service design and prior to investment. Strategic commissioning work currently underway in relation to services commissioned within the third sector, is intended to consider sustainability and future funding, aligned with local priorities and need. Evaluation process will also continue, with consideration being given to sustainability and service redesign. This work should sit within the context of longer-term local strategies and planning processes across the Partnership.
Performance Management	The standard of performance information gathered by initiatives has been inconsistent and challenging. This has specifically related to the ability of services to record meaningful outcomes data in addition to output data and the capacity to record information as standard practice. Workshops and one to one sessions have been facilitated to support leads to develop performance indicators. Improvement in performance information is now evident in quarterly returns.

	Action: Continue to work with project leads to embed performance frameworks and encourage the use of this information to drive service development and improvement. Ensure that performance information is established at the point of initiative design.
Commissioning Approach	Short-term, initiative based funding allocation has, in some cases, been prohibitive in terms of service ability to adopt a whole systems approach. Although collaborative working is considered at the point of design, initiatives can tend to operate as stand alone projects with integrated practice not developing as initially intended. In addition, specific thematic areas within the system are well catered for e.g. intermediate care and reablement, whilst there remains a gap in addressing deficits within other areas. **Action:** A more pro-active commissioning approach should be adopted to enable service development in line with evidence based need. Future funding allocation should align with transformational change as opposed to adding capacity to existing provision, which can result in duplication and multiple layers of service. This model of commissioning should link with work being undertaken regarding strategic commissioning. In relation to current initiatives, work will continue to evaluate and streamline provision. This will include on-going discussion via the Reablement Leadership Group and commissioning sessions for third sector providers, focussing on Partnership priorities and collaborative service development.
Financial Management	Financial management is an important aspect of overall programme management. The process has been challenging for a number of reasons. There is considerable variance in the financial processes across organisations in receipt of funds. On this basis, the process of maintaining an accurate overview of allocation and actual spend has been complex. Whilst maintaining accountability, the system must be flexible enough to allow initiatives to use funds allocated to achieve outcomes. It is recognised that this may result in changes to the structure of spend initially proposed. **Action:** Principles regarding financial governance have been developed. These principles have been applied to all initiatives to help inform how variance in actual expenditure to approved allocation is treated. Information regarding the principles and guidance about reporting variance and requesting changes will be communicated to all initiative leads. The implementation of the principles will ensure consistency of practice and clear accountability.

Our Performance

Financial Performance

The funding available to the Integration Joint Board to support the delivery of the Strategic Plan comes from contributions from the constituent authorities (Falkirk Council and NHS Forth Valley) and funding allocated from Scottish Government. This funding includes the Integrated Care Fund, Delayed Discharge Funds and the Primary Care and Mental Health Transformation Funds. The combined funding is used by the IJB to support the delivery of the Strategic Plan.

The Integration Joint Board then issues directions to the constituent authorities to utilise the funding available to deliver and/or commission services across the partnership on its behalf to deliver the priorities of the Strategic Plan.

For the financial year ended 31 March 2017 the partnerships underlying financial position was a net overspend of £0.103m. However, in line with the terms of the Integration Scheme, additional non-recurring funding was received which resulted in a net underspend of £0.585m.

The IJB adopted a reserves policy and strategy in March 2017. This sets out the framework for developing and holding financial reserves. To manage the difference in timing between the allocation of funding and investment for optimal benefit the Integration Joint Board will carry forward funding totalling £4.841m into 2017/18. This funding will be held in a combination of general and earmarked reserves.

The expenditure of the Integration Joint Board for year ended 31 March 2017 is detailed below.

Service Area	£'000
Set Aside Budget for Large Hospital Services (Note 1)	24,987
Community Learning Disability Services	1,535
Community Mental Health and Addictions Services	8,345
Older People, Reablement, Physical and Sensory Impairments	4,945
Other Social Care Services	1,108
Care at Home	29,835
Residential and Respite Care	29,347
Day Care	4,253
MECS and Telecare	546
Housing & Equipment and Adaptations	3,093
Other Community Health Services	26,809
General Pharmaceutical Services and Primary Care Prescribing	35,944
Other Primary Care Services	34,090
Shared Partnership Posts	334
Transformation	2,568
Provisions	50
TOTAL EXPENDITURE	**207,789**

Note:

1. Relates to large hospital services delivered in the Acute Sector for which the IJB is responsible for strategic planning but not operational delivery.

The underlying overspend for 2016/17 represents a significant risk to the IJB in 2017/18. The IJB will continue to work with the constituent authorities to identify actions to reduce this risk.

The IJB Annual Accounts 2016 – 17 report the financial performance of the IJB. Its main purpose is to demonstrate the stewardship of the public funds provided to the Board for the delivery of the Strategic Plan.

In this first year of operations the Partnership has taken responsibility for delegated functions and made significant progress in the planning and delivery of the Partnerships' Strategic Plan. Going forward, the Partnership will continue to face significant financial challenges in delivering better outcomes for people in a climate of growing demand within finite resources.

In order to achieve this we must continue to identify and implement more innovative ways to deliver customer focused services cost effectively, by driving service improvement and organisational change through a structured approach to managing change, optimising the use of change and improvement competencies, and developing and sharing best practice throughout the Partnership.

We will continue to work with staff, managers, services, partners and our communities to lead and support service redesign reviews, to identify and implement innovative, cost effective and person centred, outcomes focused service delivery models and pathways, and contribute to the delivery of the Partnership's Strategic Plan within resources available.

Best Value

Falkirk Council and NHS Forth Valley (the constituent authorities) delegate budgets to the Integration Joint Board (IJB). The IJB decides how to use these resources to achieve the objectives of the strategic plan. The IJB then directs the partnership through the constituent authorities to deliver services in line with this plan.

The governance framework is the rules, policies and procedures by which the Integration Joint Board ensures that decision making is accountable, transparent and carried out with integrity. The Integration Joint Board has legal responsibilities and obligations to its stakeholders, staff and residents of the Falkirk area.

Falkirk Integration Joint Board ensures proper administration of its financial affairs by having a Chief Finance Officer (section 95 of the Local Government (Scotland) Act 1973).

As part of the governance arrangements to oversee the change programme the Chief Officer chairs both a Change Programme Board and a Leadership Group.

The partnership views the triangulation of key performance indicators, measureable progress in delivering the priorities of the strategic plan and financial performance as forming the cornerstone of demonstrating best value. Therefore the evidence of best value can be observed through:

- The Performance Management Framework and Performance Reports
- Financial Reporting; and
- Reporting on Strategic Plan delivery through both the Chief Officer's reports to the Integration Joint Board and topic specific reports such as those relating to the implementation of the Scottish Living Wage.

This approach is visually demonstrated in the Best value diagram below (figure 14):

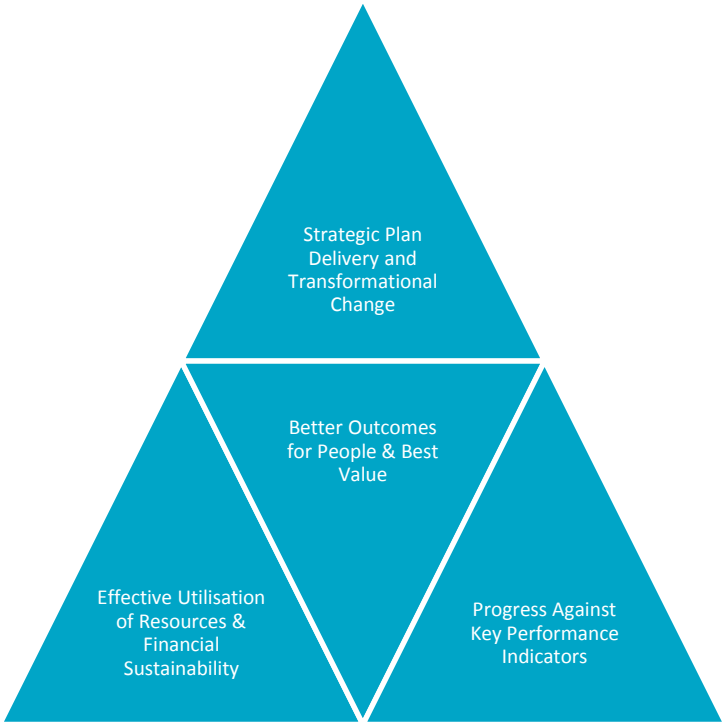


Figure 14

Financial Reporting on Localities

The 2016/17 financial information is not split into localities as this level of financial reporting will be developed during 2017/18 based on locality planning arrangements that the Integration Joint Board approved during 2016/17.

Performance Management

The IJB continues to develop a performance management culture throughout the Partnership. The Board has a responsibility for effective monitoring and reporting on the delivery of services and relevant targets and measures as set out in the Strategic Plan. A significant amount of progress has been made over the year in the development of performance management and reporting arrangements following the approval of the IJBs Performance Framework in March 2016.

A Strategy Map has been developed, which details the Partnership's vision, Local Outcomes and then maps these against the National Health and Wellbeing Outcomes and National Core Indicators. The national outcomes are high-level statements of what health and social care partners are attempting to achieve through integration, with an associated Core Suite of National Integration Indicators. These have been aligned with the Strategic Plan Local Outcomes and there is on-going development of local partnership indicators to meaningfully measure the delivery of local outcomes.

To support the delivery of the national priorities Partnerships have also been invited to set out the local improvement objectives for each of the following supporting 6 areas:

1. unplanned admissions
2. occupied bed days for unscheduled care
3. A&E performance
4. delayed discharges
5. end of life care
6. balance of spend across institutional and community services.

The IJB now receives a performance report at each meeting which along with financial reporting to give a rounded view of the overall performance and financial sustainability of the partnership. The triangulation of key performance indicators, measureable progress in delivering the priorities of the strategic plan and financial performance is regarded as forming the cornerstone of demonstrating best value.

The following table summarises the annual performance of Falkirk Health and Social Care Integration against the Core Suite of Integration Indicators.

	Indicator	Title	Current score	Scotland
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	93%	94%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	86%	84%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	79%	79%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	81%	75%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	82%	81%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	86%	87%
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	84%	84%
	NI - 8	Total combined % carers who feel supported to continue in their caring role	45%	41%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	87%	84%
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA
indicators	NI - 11	Premature mortality rate per 100,000 persons	440	441
	NI - 12	Emergency admission rate (per 100,000 population)	11,642	12,037
	NI - 13	Emergency bed day rate (per 100,000 population)	137,697	119,649
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	116	95
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%
	NI - 16	Falls rate per 1,000 population aged 65+	20	21
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	84%	83%
	NI - 18	Percentage of adults with intensive care needs receiving care at home	64%	62%

	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	1,023	842
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	25%	23%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA

During 16/17, progress has been made to developing a suite of local indicators in line with Falkirk HSCP outcomes. An example of this work is outcome information gathered from service users and carers. Information is collected relating to National Community Care Outcomes Measures as part of every assessment or review by Community Care Teams. An example of information gathered is provided below:

Self-management

	2015/16	2016/17
32. Percentage of carers satisfied with their involvement in the design of care package	92%	93% ▲
33. Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	89%	81% ▼

Autonomy and Decision Making

17. Self directed support (SDS) options selected: People choosing	Mar 2016	Mar 2017
SDS Option 1: Direct payments	33 (1%)	32 (1%)
SDS Option 2: Directing the available resource	46 (2%)	83 (3%)
SDS Option 3: Local Authority arranged	1,505 (62%)	1,749 (66%)
SDS Option 4: Mix of options, 1,2,3	30 (1%)	45 (2%)
No recorded SDS Option	805 (33%)	730 (28%) ▲

Safe

	2015/16	2016/17
23. Percentage of community care service users feeling safe	90%	91% ▲

Service User Experience

	2015/16	2016/17
30. % of service users satisfied with their involvement in the design of their care package	98%	98% ◄►

31. % of service users satisfied with opportunities for social interaction	93%	93% ◄►

We have been working on developing personal outcomes focussed assessment, which will implemented during 2017/18 in Community Care Teams.

Further information about locally reported performance indicators is available within published IJB Performance Reports and can be accessed here.

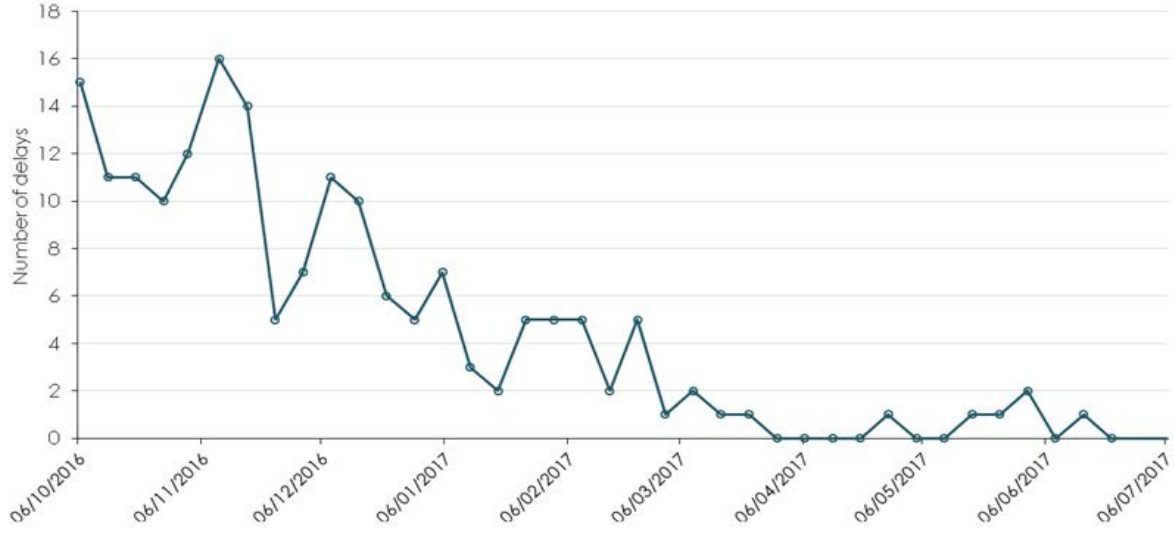
Delayed Discharges

The IJB has committed considerable financial investment to tackle the underlying causes of delayed discharge. The board receives regular updates on Delayed Discharge Performance at its Board meetings. The following table summarises the Partnerships performance in relation to Delayed Discharges.

Delayed Discharge Indicators	RAG Falkirk	
1. Standard delayed discharges	April	April 2017
	27	29 ▼
2. Delayed discharge over 2 weeks	April	April 2017
	18	14 ▲
3. Bed days occupied by delayed discharges	April	April 2017
	657	631 ▲
4. Number of code 9 delays	April	April 2017
	9	9 ◄►
5. Number of code 100 delays	April	April 2017
	6	5 ▲
6. Delays – including Code 9 and Guardianship	April	April 2017
	36	38 ▼

The graph below demonstrates improvement in reducing the numbers of people delayed in hospital awaiting a package of care.

Figure 15 – Weekly Falkirk delayed discharges awaiting a package of care



During the Discharge to Assess pilot, we have recorded information about the people who have benefitted from the service, which includes service user surveys. Figure 16, below provides information showing feedback received. As previously noted, further evaluation is scheduled to take place in 2017/2018.

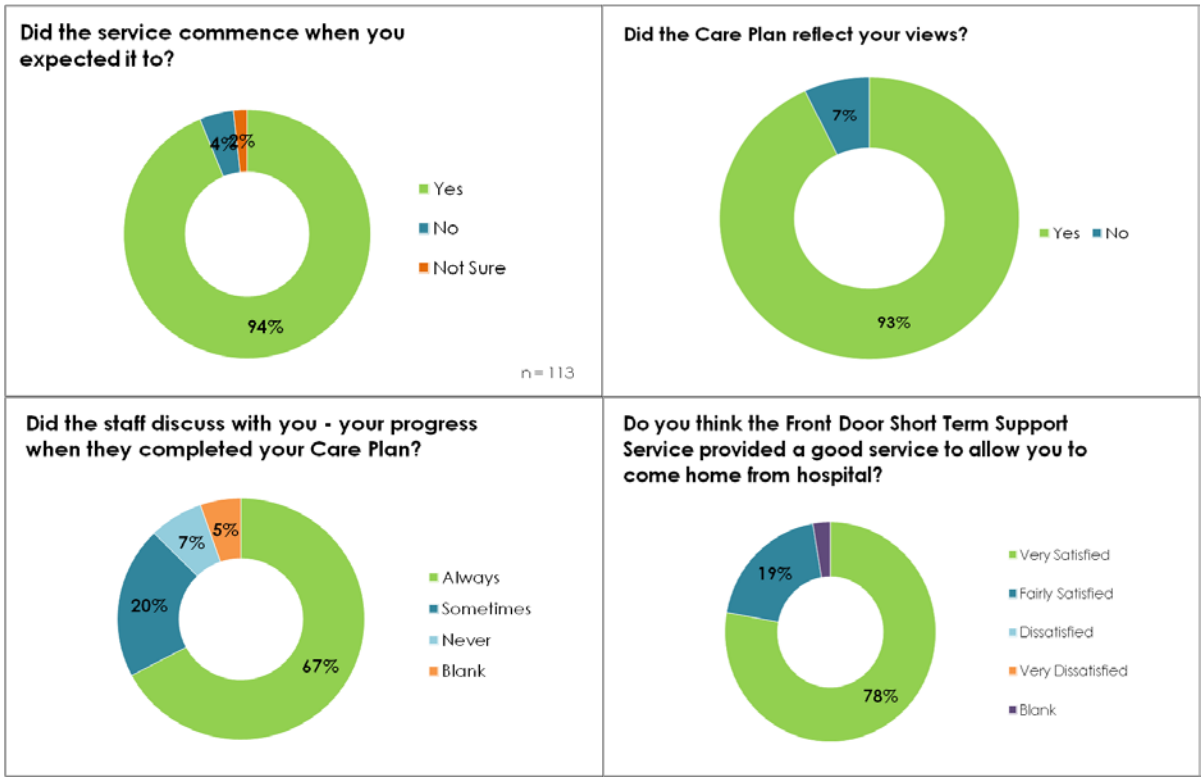


Figure 16

Inspection of our Registered Services

Many of the social care services provided by the Partnership must be registered and inspected by the Care Inspectorate. These services include care homes, care at home and housing support services. They include the services directly provided by the partnership and the services that we commission from the Third and independent sectors. The Care Inspectorate makes sure that the services provided meet the national care standards. They can also jointly inspect with other regulators, such as Healthcare Improvement Scotland.

Care Homes for Older People

There are 18 independently run care homes and 5 local authority care homes for older people in the Falkirk Council area. The bed capacity is 841 in the independent and 129 in the local authority care homes. The total beds are split between 758 nursing placements and 212 residential placements.

The following key matters emerged during the financial year 2016/17:

- Care Inspectorate grades for Care Homes improved
- there were no financial penalty actions imposed and there were no moratoriums on placements

- vacancies continue to be low, at only 1%
- annual spend in this sector increased by £1.4 million, primarily to support the payment of the living wage
- alongside ongoing contract reviews and service reviews, meetings are held with all independent sector care home providers every 2 months.

Care Homes for Adults

There were 11 independently run adult care homes in the Falkirk area. The bed capacity was 159 at the end of 2016/2017.

During the financial year 4 adult care homes attained a very good grade (5/6) for care and support. Falkirk Council agreed voluntary moratoriums with 2 adult care homes during 2016/2017 which was consistent with previous years.

Older People in Hospital Inspection

From 15 to 17 November 2016, there was an unannounced Healthcare Improvement Scotland (HIS) Care of Older People in Hospital Inspection in Forth Valley Royal Hospital. The inspection team, which was made up of inspectors and a public partner, visited the Acute Assessment Unit, 7 inpatient wards and the Discharge Lounge.

Both the inspectors and patients said that patient care was observed as very good. They identified areas for improvement and a working group has been set up to take these forward. The inspection report was published on 14 February 2017 and since then a further review has been undertaken, taking into account the inspectorate comments.

Mental Welfare Commission

During the period (April 2016 - March 2017) there were three Mental Welfare Commission reports published regarding local visits within NHS Forth Valley. These were:

- Ward 1, Forth Valley Royal Hospital
- Trystview Ward, Bellsdyke Hospital
- Russell Park, Bellsdyke Hospital.

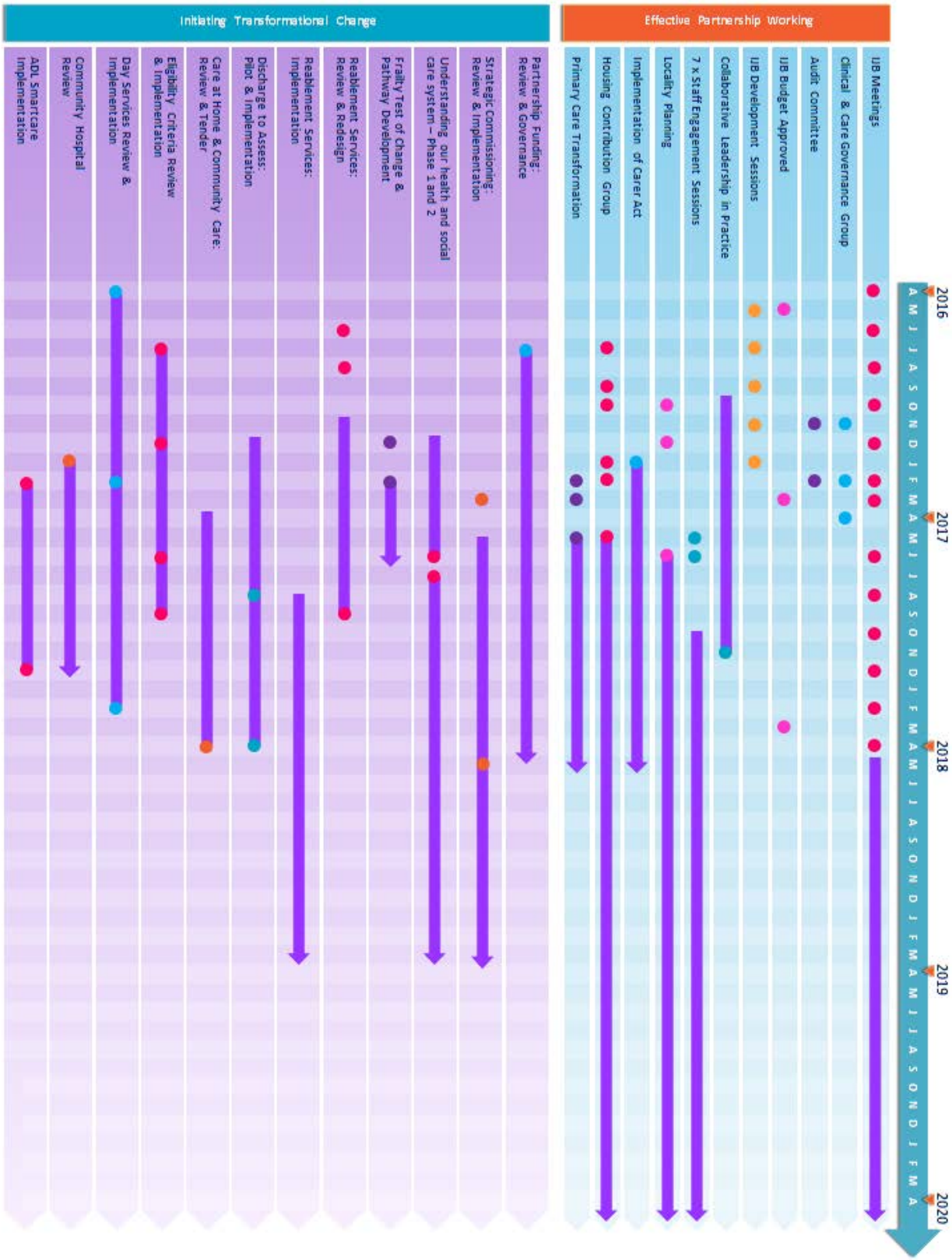
The reports identified a number of areas of commendation and good practice as well as areas for improvement. These are being taken forward.

Looking forward

During 2016/2017, the inaugural year of the Falkirk Health and Social Care Partnership being in operation and IJB accountability for in-scope adult health and social care services, a great deal of progress has been made.

Time has been taken to develop a robust governance framework, ensuring that the most appropriate people are involved in strategic and operational activity. We have also invested effort into gaining a good understanding of our health and social care system, by working with partners, neighbouring Partnership areas and importantly service users and carers, to help focus on key areas of good practice, improvement and transformational change.

This underpinning work has allowed us to effectively plan ahead, to ensure appropriate pace and scale of change, acknowledging a challenging landscape of finite resource and increasing demand. The following diagram provides an overview of the key areas of activity that will be progressed during the coming years.


Effective Partnership Working
IJB Meetings
Clinical & Care Governance Group
Audit Committee
IJB Budget Approved
IJB Development Sessions
Collaborative Leadership in Practice
7 x Staff Engagement Sessions
Locality Planning
Implementation of Carer Act
Housing Contribution Group
Primary Care Transformation
Initiating Transformational Change
Partnership Funding: Review & Governance
Strategic Commissioning: Review & Implementation
Understanding our health and social care system – Phase 1 and 2
Frailty Test of Change & Pathway Development
Reablement Services: Review & Redesign
Reablement Services: Implementation
Discharge to Assess: Pilot & Implementation
Care at Home & Community Care: Review & Tender
Eligibility Criteria Review & Implementation
Day Services Review & Implementation
Community Hospital Review
ADL Smartcare Implementation
2016
2017
2018
2019
2020
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A

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