

Director-General Health & Social Care and
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Committee
Room T3.60
The Scottish Parliament
EDINBURGH
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Dear Gary

I have attached the information I agreed to provide following the evidence session on 16 March.

I am happy to provide further information if the Committee would find that helpful.

Yours sincerely

Paul Gray

Health and Social Care Delivery Plan

1. The Health and Social Care Delivery Plan sets out the actions needed to achieve the triple aim of better care, better health, and better value. These are grouped into four major programmes of activity, as follows:

- health and social care integration;
- the National Clinical Strategy;
- public health improvement; and
- NHS Board reform.

2. As I explained at the Committee we are putting in place the governance arrangements to deliver on the actions we committed to in that plan. We have established a National Programme Board, with responsibility for ensuring the implementation of the Delivery Plan and monitoring its progress. The Programme Board reports to me through the Health and Social Care Management Board. It is chaired by the Scottish Government's Director for Health Workforce and Strategic Change, and met for the first time on 13 April. Its membership includes the Scottish Government Directors with responsibility for the key programmes in the Delivery Plan, representatives from Local Government, Integration Authorities and NHS Board Chairs. The Board also includes five Implementation Leads: there are three Regional and two National Implementation Leads, drawn from our existing NHS Board Chief Executive cohort, and they have additional leadership responsibilities for the regional and national aspects of the Delivery Plan.

3. The guiding principle of the Plan is that health and social care services should be planned and delivered at the level where they can provide the best, most effective outcomes for individuals – whether that is at individual, community, local, regional or national level. This will require a different approach to planning and delivery, particularly at regional and national levels. We are building on existing regional planning arrangements and have, through our Local Delivery Plan process, also commissioned regional delivery plans, which will set out how the regional aspects of the Delivery Plan will be taken forward. The Regional Implementation Leads, working with the local Health Boards and Integration Authorities, lead on coordinating these plans for the east, north and west regions, ensuring the overall design and planning of services takes into account the particular features of their areas and local populations. We have asked for draft plans by the end of September 2017, and final plans by the end of March 2018.

4. These delivery arrangements will continue to be supported by financial planning at a national, regional and local level. Funding is being allocated specifically to support the Delivery Plan and to provide the reform required to meet the changing needs of our population and shift resources from an acute to a community setting.

5. In 2017-18, £128 million of this resource funding will be allocated to Boards to stimulate change and support best use of NHSScotland's total resources. This package of investment will include funding for primary care, the Mental Health Strategy, cancer care, Trauma Networks and other transformational change programmes. While funding for this investment in reform of services in future years will be subject to approval of future Budgets by the Scottish Parliament, the £128 million in 2017-18 is the first part of total planned investment in reform, which is expected to exceed £1 billion by 2021-22.

6. Additional capital investment of £200 million in new elective treatment centres will improve scheduled care. This will lead to significant productivity improvements and reduce overall hospital stays.

7. We plan to continue to invest £357 million per annum in health and social care integration to support sustainability in the social care sector. In addition, we plan to use a further £30 million per annum to support continued reductions in delayed discharge.

8. The regional delivery plans will provide a further level of detail on financial plans at regional level. Following the submission of the draft regional plans, I intend to write to the Committee by the end of 2017 to provide further information on the funding of the Delivery Plan.

Examples of Integration of Health and Social Care

9. During the evidence session, I provided examples where integration was working well. I have expanded on these.

- **Dumfries and Galloway** developed a Single Point of Access to community health and social care services, STARS (*Short Term Augmented Response Service*) and third sector for people registered with two of the GP practices in Dumfries. Referrals are screened by health and social services leads, discussed at a daily multi-agency meeting and the care provided coordinated between the teams. Results have shown: a reduction of up to 15 days in referral time from GP to care input; quicker inter-service handovers with increased capacity; greatly improved communication, staff morale and team working; and greater understanding and knowledge of third sector support and services, and what each discipline offers across the care pathway.
- Three community wards in **Ayrshire and Arran** manage high-risk patients with COPD, falls, heart failure and diabetes, and have achieved high satisfaction scores. They show 49% fewer admissions and 36% less bed days in the first 6 months for the caseload. The model offers: a unique point of patient-centred integration between GPs, primary and secondary care, and social care services; sufficient time for proactive intensive medical support and problem solving to develop and implement enhanced Anticipatory Care Planning; targeting help to the most resources intensive SPARRA patients; and greater use of GPs with Special Interests and Advanced Practitioners.

10. Other examples are:

- The three **Ayrshire** Health and Social Care Partnerships (East, North and South) works closely with a range of sectors including the third sector to support people with multiple conditions to live well in their communities. One of these is the Red Cross Home from Hospital Service which aims to reduce admissions to hospital, facilitate discharge and to provide resettlement support and follow-up reassurance. The service has supported just over 1,600 people across the three Ayrshire Partnerships since commissioned, and as a result, a substantial number of hospital bed-days have been avoided. Stakeholder feedback on the service is extremely good and personal experience measures, very positive.
- The **Glasgow City** Partnership has seen significant improvement in performance following the introduction of discharge-to-assess, which aims to ensure patients are discharged within 72 hours of being medically fit. This, alongside the increase in step-

down intermediate care beds, commissioned from private sector care homes, has resulted in a reduction of the number of bed-days lost to delay by over 42% between April 2015 and June 2016.

- Improvements have been seen this year in **Aberdeen City**, which faced long-running issues with recruiting and retaining care staff in the area, including bed-days lost to delay being reduced by around 27% since the start of this year. The partnership is also working with cornerstone Community Care and the Aberdeen and Grampian Chamber of Commerce to develop a social care campus to provide a training and accommodation package, designed to raise the profile of care work.
- Boleskine Community Care had been established as a local charity to deliver voluntary care and support to enable older people to remain in their own **Highland** community. It provides a lunch club and other social activities, along with a handy-person scheme. It has identified a need for a care-at-home service as neither the independent sector nor the in-house service had been able to provide a service. Boleskine Community Care identified local people prepared to train as care workers but who did not have the experience or capacity to register with the Care Inspectorate. An independent provider company agreed to support Boleskine Community Care to deliver a care at home service using Individual Service Funds (SDS Option 2). This enabled the local community to provide local care in consultation with the community charity and individuals and families who require care and support.
- The **Edinburgh** Health and Social Care Partnership has introduced Multi Agency Triage Teams (MATTs) with the objective of identifying people who can be supported to leave hospital early and preventing admissions. It is intended that the MATTs will operate 24/7, supporting weekend discharge and increasing capacity by 29%. The partnership has also redesigned its care-at-home contract with providers linked to localities, clauses that insist providers pick up packages of care and an increased hourly rate to help attract recruits to the sector.
- **South Lanarkshire** Integrated Community Support Team of nurses, Advanced Health Practitioners, social workers and home care workers support people with complex needs to prevent emergency admission and support timely return home from hospital. Medical care is provided by the person's own GP who links, when needed, with hospital consultants. 90% of referrals to the team are able to remain at home at 30 days.
- **North Lanarkshire** ASSET (Age Specialist Service Emergency Team) assess, diagnose, treat and support frail older people within their own home as a rapid specialist alternative to emergency admission to Monklands Hospital. The team take referrals from GPs, Emergency Response Centre (ERC), Emergency Department, Emergency Receiving Unit (ERU) and SAS paramedics. The service has around 100 new referrals per month and a daily caseload of between 10 and 32. Of over 2,150 patients managed by ASSET, 76% have been maintained at home, at a cost of £689 per admission avoided. Mortality is lower than for inpatients.
- **ELSIE (East Lothian Service for Integrated Care for the Elderly)** provides local GPs direct access to emergency care at home for their patients with a single point of contact for people who are at risk of admission to hospital. It also allows patients to be discharged earlier from hospital and supported at home. The system works by local GPs overseeing the local population's health and social care needs, including triaging, treating and directly admitting patients to local hospitals if required.

11. You also asked about cost differences between social care workers employed directly by the NHS and Integration Authorities and those employed by private care companies. The latest social service workforce data for Scotland shows that there was a total of 203,200 people working in the sector. Of this total, 85,110 were employed by the private sector, 62,040 by Local Authorities and 56,050 by the voluntary sector. The largest sub sectors (out of the 203,200) are housing support/care at home employing a total of 69,690 and care home for adults employing 53,980. Unlike the NHS there is no national pay structure, and wage rates for the social care workforce vary depending on qualifications, grade and local demand and supply labour market conditions.

12. In part to address recruitment and retention the Scottish Government took the decision to invest in the adult care sector and enable the payment of the Living Wage to adult care workers as a minimum, regardless of whether they are employed by the private, voluntary or public sectors. This commitment has, therefore, enabled all adult care workers in the private and third sector to be paid the Living Wage of £8.25 per hour from October 2016 and £8.45 from May 2017.

13. An agreement was reached with Unison that all workers working for a Local Authority would be paid the Living Wage rate, as set by the Living Wage Foundation (plus 1%), for 2016-17. An agreement for 2017-18 has yet to be reached. This would mean that for 2016-17, Local Authority-employed care workers would be paid a minimum £8.33 per hour.

Health Visitor Information

14. NES Management Information indicates that, at 27 March 2017, 470 health visitors have completed training since June 2014, with an additional 303 currently in training that will be completed within the next two years. We are on track to have 500 additional health visitors working by the end of 2018.