CLACKMANNANSHIRE COUNCIL

THIS PAPER RELATES TO ITEM 6

ON THE AGENDA

Report to: Partnership & Performance Committee

Date of Meeting: 31 October 2019

Subject: Clackmannanshire and Stirling Health and Social Care Partnership Annual Performance Report 2018-19

Report by: Chief Officer, Health and Social Care Partnership

1.0 Purpose

1.1. This report outlines the statutory requirement for the Partnership to deliver and publish an Annual Performance Report before the end of July 2019.

2.0 Recommendations

2.1. Note the Annual Performance Report and note that this was published on the Partnership website by the end of July 2019 as required.

3.0 Considerations

3.1. The draft Annual Performance Report for 2018-19 included in Appendix 1, has been compiled with input from colleagues across the Partnership. The Annual Performance Report reflects the Partnership activity in relation to the Strategic Plan 2016-19 and the core delivery priorities agreed as part of the Delivery Plan. Where possible this report also provides comparator information from the previous 3 years of performance to help track the impact of the work being undertaken.

3.2. The focus for the presentation of the Annual Performance Report is to make it an interesting and easy to read document, written in plain English and making use of charts, diagrams, photographs and graphics as much as possible.

3.3. Timescales were challenging, particularly as the timeframe coincides with production of the annual accounts and verified data from the Information Services Division (ISD) is not fully available during the drafting period of the report. This is a national issue, and has been raised with Scottish Government via the Chief Officer Network. The statutory requirement to publish by end July remains however.

3.4. The Annual Performance Report is an opportunity to highlight the milestones and successes of the Partnership over the duration of the Strategic Plan 2016-19, as well as identify next steps and areas for improvement.

3.5. Section 4 of the report summarises the outcomes achieved and includes benchmark information against the Scottish average and comparator partnerships wherever possible.

3.6. The Partnership performs positively in 16 out of a total of 20 relevant indicators covering areas such as; service user experience, good health, independence, inequalities and effective use of resources.

3.7. The report also reflects upon the Strategic Inspection carried out during 2018, noting that the Partnership were graded 4 – Good overall for performance.

3.8. As the final Annual Performance Report for the Strategic Plan 2018-19, it also reflects on areas for development and continuation in the new Strategic Commissioning Plan for 2019-22.

4.0 Sustainability Implications

4.1. N/A.

5.0 Resource Implications

5.1. Financial Details

5.2. The full financial implications of the recommendations are set out in the report. This includes a reference to full life cycle costs where appropriate. Yes **X**

5.3. Finance have been consulted and have agreed the financial implications as set out in the report. Yes **X**

5.4. Staffing

6.0 Exempt Reports

6.1. Is this report exempt? Yes ☐ (please detail the reasons for exemption below) No **X**

7.0 Declarations

The recommendations contained within this report support or implement our Corporate Priorities and Council Policies.

(1) **Our Priorities** (Please double click on the check box ☑)

Clackmannanshire will be attractive to businesses & people and ensure fair opportunities for all ☐

Our families; children and young people will have the best possible start in life ☐

Women and girls will be confident and aspirational, and achieve their full potential ☐

Our communities will be resilient and empowered so

that they can thrive and flourish X

(2) **Council Policies** (Please detail)

8.0 Equalities Impact

8.1 Have you undertaken the required equalities impact assessment to ensure that no groups are adversely affected by the recommendations?
Yes ☐ No **X**

9.0 Legality

9.1 It has been confirmed that in adopting the recommendations contained in this report, the Council is acting within its legal powers. Yes **X**

10.0 Appendices

10.1 Annual Performance Report 2018-19.

11.0 Background Papers

11.1 Have you used other documents to compile your report? (All documents must be kept available by the author for public inspection for four years from the date of meeting at which the report is considered)
Yes ☐ (please list the documents below) No ☐

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Clackmannanshire & Stirling
Health & Social Care Partnership

Annual Performance Report

2018 – 2019

Clackmannanshire Council

Stirling Council

NHS Forth Valley

CONTENTS

Our Third Year 1
Message from the Chair 1
Introduction by Interim Chief Officer 2

Section 1 About Us 4
Background 4
Our Strategic Plan 2016-2019 and Partnership Priorities 4
Localities 7
Inequalities 9

Section 2 Delivery Priorities 2016-19 10
Models of Neighbourhood Care 10
Learning Disability and Mental Health 11
Intermediate Care 14
Technology Enabled Care 15
Stirling Health & Care Village 19
Day Support, & Care Homes 21
High Health Gains 23
General Practice 24
Delayed Discharge 25

Section 3 The Enablers 26
Strategic Needs Assessment 26
Housing Contribution 26
Alcohol and Drug Partnership 27
Commissioning: Market Position Statement & Providers 27
Workforce 28
Unpaid Carers 29
Financial Statement 30

Section 4 Outcomes: Our Performance 33
National Outcomes and our Local Framework 33
Performance Under Integration 34
Our Performance: A Summary 35
Our Performance: In Detail 37
Inspections 44

Section 5 Next Steps 51

Section 6 Glossary 53

Our Third Year

Message from the Chair

Welcome to our third Annual Performance Report which reflects on our progress together as a Partnership since it was established on 1 April 2016.

We are the only Health and Social Care Partnership in Scotland incorporating two Local Authorities and one Health Board – and this provides us with some unique opportunities to work together to develop our services to improve the outcomes for the people of Clackmannanshire and Stirling.

As an Integration Joint Board we recognise the considerable contribution of the workforce of Clackmannanshire Council, NHS Forth Valley, Stirling Council, providers of services in the independent and voluntary sectors, and wider partners to the delivery of high quality, effective care and support. Their knowledge, skills and experience along with the feedback from the people who use services and their communities has been invaluable in shaping the ambitious change agenda.

The recent independent joint inspection evidences that there is much to be proud of but it also shows that we have work to do to continue to meet the challenge of the growing and changing level of need in our population, against a backdrop of financial challenge.

The Partnership now has its own visual identity which will help staff working across the constituent authorities to identify themselves within the Partnership and work towards the seamless service we aim to become.

Special thanks must go to the service users and carers who have been willing to share their story with us throughout this report and online.

John Ford, IJB Chair

Clackmannanshire & Stirling
Health & Social Care Partnership

Introduction

Our vision is:
'to enable people in the Clackmannanshire and Stirling Health and Social Care Partnership area to live full and positive lives within supportive communities.'

Our Strategic Plan sets out how we work together to achieve this vision. Delivery of the Health & Care Village marks the **achievement of one of the eight priorities identified within the 2016-2019 Strategic Plan**. Other key achievements over this year include:

- ✓ Supporting primary care services to develop their services in local clusters.
- ✓ Working with communities to develop a model of neighbourhood care based upon the Buurtzorg principles.
- ✓ Working to change the way we support unpaid carers in line with the new carers legislation.

The Partnership published a new strategic plan 2019-2022 on 1st April 2019 and this will be the focus of our annual performance report going forward. You will find this document on our new website clacksandstrilinghscp.org

This report tells us that we have maintained a **good performance** against the national Health and Wellbeing Outcomes, with the Partnership performing above or in line with the national average in most of the core indicators. This performance is set against a backdrop of the increasingly complex needs of the people who require care and support and a challenging financial environment.

Stirling Adult Social Services were delegated to the Chief Officer in Autumn 2018. Discussion around the delegation of NHS Forth Valley services is expected in 2019.

We are undertaking a range of reviews of services to ensure they offer best value in terms of both effectiveness and efficiency to help us live within the available resources.

We have continued to work closely with the Alliance in Clackmannanshire and the Community Planning Partnership in Stirling, clinicians, staff groups, providers of services, volunteers, local communities and not least patient, service user and unpaid carer groups to help us develop our services to deliver safe, effective care and support to people and to begin to address some of the issues for our wider communities.

"The partnership has delivered some positive performance in shifting the balance of care and towards enabling more people to stay at home"

Source: Inspection Report

A Strategic Inspection took place between January and June 2018 by the Care Inspectorate and Health Improvement Scotland, with the findings published in November 2018.

The purpose of the inspection was to help the Integration Authority answer the question "How well do we plan and commission services to achieve better outcomes for people." Key performance outcomes were evaluated as good which means there are important strengths with some areas for improvement.

Operational and strategic planning arrangements were evaluated as adequate which means that strengths just outweigh weaknesses or areas for improvement. Whilst leadership was not evaluated within this inspection there was commentary on this area.

The report highlights strengths as well as areas for development, there is a particular focus on work with Housing services, locality planning and delegation of services into the Partnership. An improvement plan is in place and this is monitored by the Care Inspectorate Strategic Link Inspector. Fuller details can be found later on in this report.

"A review of the partnership's performance against national outcome measures shows that across a number of social care indicators Clackmannanshire and Stirling has consistently performed well either at or above the Scotland average. The partnership benchmarks itself against comparator authorities and performs well against them."

Source: Inspection Report

The Forth Valley Primary Care Improvement Plan 2018-2021 has demonstrated how partners are working together to redesign primary care services through a multi-disciplinary approach, including the integration of mental health services. Primary care Mental Health Nurses have been introduced to General Practice in three clusters across Forth Valley and provide assessment and treatment for mild to moderate mental health presentations for adults in Primary Care. This work done under Action 15 of the national Mental Health Strategy, is particularly important to our Partnership given the concerns where we know we are outliers in some areas of poor mental health outcomes for our residents.

Thanks go to the members of the Strategic Planning Group and to our partners and their staff, clinicians, and not least to the many people who use our services and local communities for their willing engagement, ideas and energy.

Within the Stirling Rural Locality we are seeing emerging volunteering models; handy person service development; support around palliative care and partnerships with Trossachs Search and Rescue; Strathcarron Hospice; Dementia Friendly activities and support for unpaid carers.

Finally, I would also like to take the opportunity to thank the Chair of the Integration Joint Board during 2018/2019, John Ford, the Vice Chair Les Sharp and the members of the Integration Joint Board for their work and support over this year.

Marie Valente Interim, Chief Officer

1. About Us

Background

The Clackmannanshire and Stirling Integration Authority and its governing Integration Joint Board is a separate legal body which became responsible for the strategic planning and delivery of community based health and social care services to adults and older people from April 2016.

The Integration Joint Board, often referred to as the IJB, has 10 voting members: 4 are NHS Forth Valley Board and 6 are Elected Members from the two Councils [3 from Clackmannanshire Council and 3 from Stirling Council]. There are also advisory members, and representatives from service user, patients, unpaid carers and the third sector. The Board is supported in its work by the Strategic Planning Group which has membership drawn from across the Partnership area. Importantly, it includes the third and independent sector, carers' organisations, the local Hospice and palliative care services, service users/patients and unpaid carers.

Our Strategic Plan and Partnership Priorities

The first Strategic Plan 2016-2019 established the Partnership's vision and outlined the local and national outcomes which formed the basis for the performance framework. The Partnership has recently reviewed and published a new strategic plan 2019-2022 and this will be the focus of our annual performance report going forward.

The high level priorities, expressed as a series of ***'we will'*** statements, in the Strategic Plan 2016-2019 are –

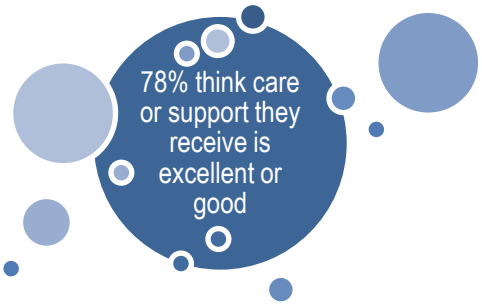
- Further develop systems to enable front line staff to access and share information
- Support more co-location of staff from across professions and organisations
- Develop single care pathways
- Further develop anticipatory and planned care services
- Provide more single points of entry to services
- Deliver the Stirling Health & Care Village
- Develop seven day access to appropriate services
- Take further steps to reduce the number of unplanned admissions to hospital and acute services.

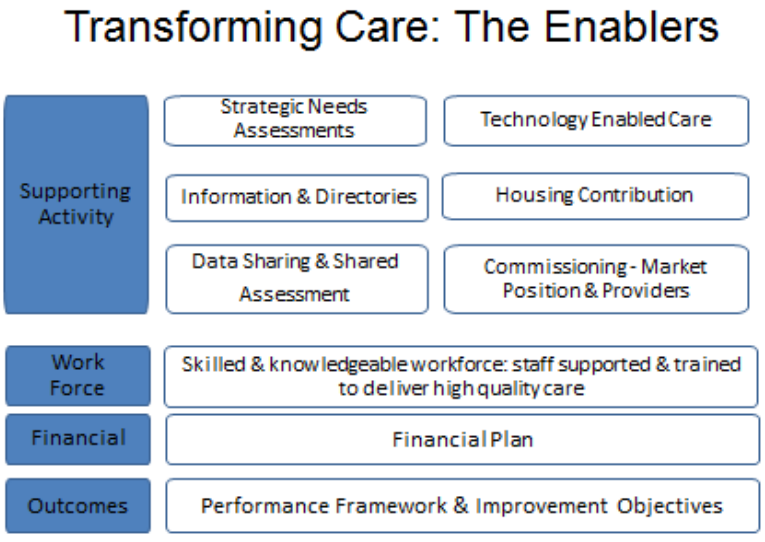
"There is evidence that the partnership has a focus on transformational change and improvement and that this links to the strategic plan. This is seen in recent improvement activity and the development of new models of care."

Source: Inspection Report

The following diagrams represent the core Partnership delivery priorities for 2016-2019 and the underpinning enablers, which also involve redesign activity. Together they make up the content of the Partnership's Transforming Care Programme and focus on the actions the Partnership can take together to strengthen and develop the building blocks for community based services.

The enablers are a set of activities which support the delivery of priorities.





There are strong links between this work and Community Planning Local Outcome Improvement Plans (LOIP) for Clackmannanshire and Stirling.

"Given our long-term demographic projections and the strength of feedback from partners and communities we have agreed to keep a watching brief on inequality and our older people in Clackmannanshire. We will do this through our Health and Social Care Partnership and where it is considered appropriate we will develop specific multi-agency partnership strategies to tackle particular disadvantage to this age group."

Clackmannanshire LOIP

Planning Localities

The Strategic Plan 2016-2019 identified the planning localities for the Health and Social Care Partnership.

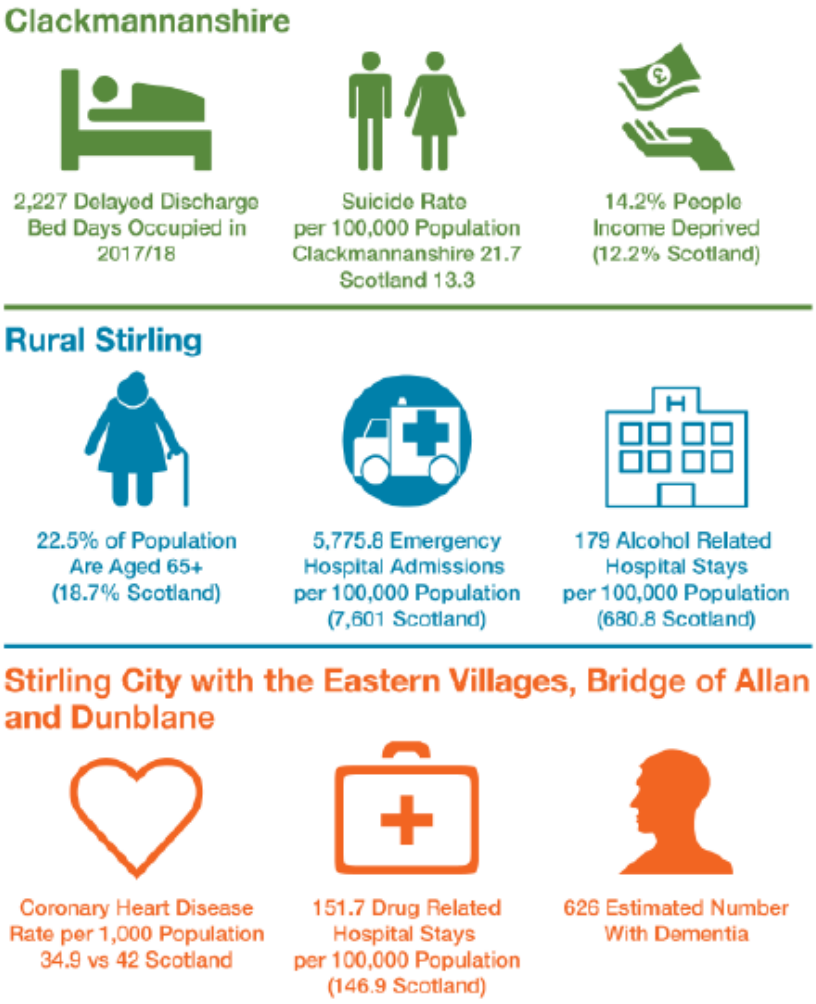
Locality Managers have now been appointed in all three areas, with interim arrangements supporting the transition.

As Localities become fully established, it will be a requirement of Locality Managers to lead on the development of Locality Plans with communities which reflect the priorities outlined within the Strategic Commissioning Plan. As these are developed, they will be brought to the Integration Joint Board for approval and on-going monitoring of progress.

There has been ongoing engagement through the Strategic Planning Group and the Public Partnership Forums to identify and agree the high level priorities and how these should support the development of locality plans.

As part of the over-arching programme we have work-streams which are specific to each of the Localities and reflect their priorities. A considerable amount of work has been carried out with our communities, building on the work already taking place through the Community Justice Partnerships, Community Planning Partnership for Stirling and Clackmannanshire Alliance.

Locality profiles are publically available, and management information provided for a range of indicators. This data continues to develop along with the localities.



Clackmannanshire Locality

- The rate of unplanned hospital admission/bed days (especially mental health) are highest in the Partnership, and attendance at the Emergency Department is rising.
- Alcohol related deaths and hospital stays are much higher than the national rate in the most deprived areas of the locality.
- Prevalence of problem drug use is higher than national average. Drug hospitalisation is much higher than the national rate in the most deprived areas of the locality.
- Has some of the most deprived areas in Scotland with associated health challenges.
- Locality Workstream – work ongoing to review commissioning of care at home services and review delivery the model of intermediate care.

Stirling City, Eastern Villages, Bridge of Allan and Dunblane Locality

- Rising trend of attendances at the Emergency Department and emergency hospital admissions.
- Alcohol related deaths and hospital stays are much higher than the national rate in certain areas within the locality.
- Drug hospitalisation is much higher than the national rate in certain areas within the locality.
- Areas of marked contrast in terms of inequalities with some of the least deprived areas in Scotland sitting alongside some of the most deprived.
- In more deprived areas, levels of heart disease, cancer, stroke, emergency admissions and other conditions are much higher than other areas in Stirling.
- Locality Workstream - in the initial operational phase for our integrated model of care to support people accessing the Stirling Health and Care Village and in particular the services which are provided from the Bellfield Centre for older people.

Rural Stirling Locality

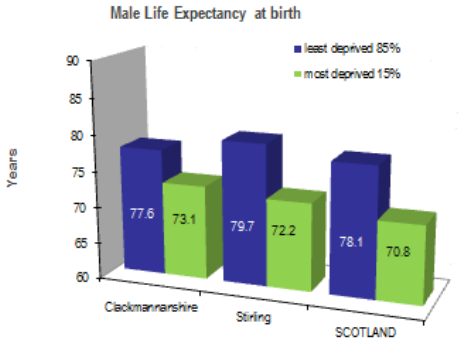
- Least populated area in the Partnership with the lowest rate of Emergency Department attendance.
- Most of the northern part of the rural area lies within the most deprived 5% nationally for accessibility. This is calculated using drive times and public transport travel times to facilities such as GPs, shops, post offices and schools.
- Health in the rural area is generally better than the Stirling and Scotland averages. Where deprivation and older populations are more prevalent rurally, there are greater incidences and early deaths from coronary heart disease and cancer.
- Locality Workstream - the work on the Models of Neighbourhood Care continues. The integrated team is in place supported by a Team Coach & Resource Worker. Weekly Team huddles are reducing bureaucracy and making positive changes.

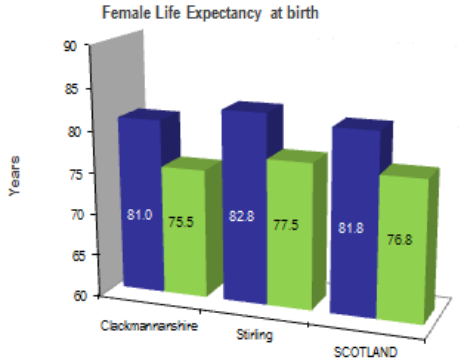
Inequalities

What are health inequalities?

They are the unfair and avoidable differences in people's health across social groups and between different population groups.

We know there are a disproportionate number of people in poverty across the partnership in comparison to the Scotland average.





Source: Strategic Needs Assessment Refresh

It is noted that in order to successfully support localities, there is a need to work closely to promote healthy living initiatives which tackle inequalities in line with Scotland's Public Health Reform priorities. To be meaningful, these initiatives may differ across the localities, but should be aligned to the Local Outcomes Improvement Plans produced by each constituent Community Planning Partnership.

It is concerning that Clackmannanshire had the highest crude rate per 100,000 population in Scotland for male, and female suicides.

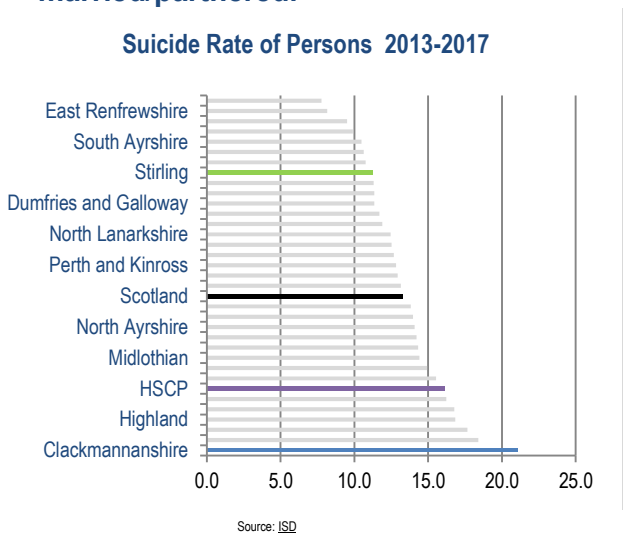
Rank	Top 10 conditions/ diseases in the most deprived areas	Burden of disease in most deprived areas (percentage of overall DALYs)
1	Drug-use disorders	8.1
2	Ischaemic heart disease	7.9
3	Depression	5.6
4	Lung cancer	5.3
5	COPD	4.7
6	Alcohol dependence	3.9
7	Low back and neck pain	3.9
8	Stroke	3.8
9	Anxiety disorders	3.8
10	Chronic liver disease	3.7

Source: The Scottish Burden of Disease Study: Deprivation Report, ISD 2016

Suicide

Deprivation is a significant determinant of suicide. Published analysis tells us that suicide deaths:

- Are three times more likely among those living in the **most deprived areas** than among those living in the least deprived areas.
- The majority (86-97%) have a **diagnosed or undiagnosed mental health problem** at the time of death.
- Are disproportionately higher amongst **males, people in their 'middle years', people who are not married/partnered.**



Source: ISD

2. Transforming Care: Core Delivery Priorities 2016/19

This section highlights some of the work taking place across the Partnership to deliver our Transforming Care Programme.

The Buurtzorg Model of Neighbourhood Care

Models of Neighbourhood Care

The Partnership set out to develop a model of neighbourhood care on a pilot basis in rural southwest Stirling, which will provide a framework for the service delivery with the three Localities across the Partnership. The model is based on the Buurtzorg principles of neighbourhood care, adapted to our local circumstances. This provides an opportunity to build services with this neighbourhood, supported by a community reference group.

The pilot team consists of staff currently delivering reablement, adult social care and district nursing to people in rural southwest Stirling.

Primary Care Implementation Funding supported the recruitment of a Team Coach and a Resource Worker. Coaching is seen as pivotal in facilitating growing team autonomy as opposed to a line management function. The Resource Worker's role is to act as the key link with the community building up informal support networks, focusing on self - management and early intervention.

The team are co-located within the locality at Buchlyvie Health Centre. Huddles enable the team to discuss mutual cases and develop more detailed and holistic care plans and create a smoother path for inter-team referrals. This approach has led to numerous advantages including the reduction of paperwork and has had an impact on manager's approaches to the guidance of workers. Team huddles are an example of how the team have built their approach to working together and support holistically the people they care for.

The multi-disciplinary, integrated team will work on the principles of placing the individual at the centre, with promotion of supported self-management, independence, and active involvement of friends, family and the community.

Neighbourhood Care Team Case Study

At the end of her 6/8 week Reablement period it was assessed that Jean could manage independently without any support. Jean felt that she did need some support but more community based. She was advised that the Neighbourhood Care Team had a Resource Worker who could discuss local community supports and opportunities, and Jean agreed to the offer of support.. Jean advised she would like to become involved in some community activities around volunteering, as she was running a small group for people within the housing development where she lived, delivering chair based exercises.

Jean also joined the Neighbourhood Reference Group who work along with the Neighbourhood Care Team. Through Strathcarron Hospice, Jean was made aware there were a number of End of Life Palliative Care people living in the village where she lives, and she volunteered as Befriender with the Hospice.

Jean has been connected to volunteering initiatives in her area which keeps her connected to her community and was one of her pesonal outcomes. This supports the early intervention and prevention agenda through helping people build a network of support around them in their community.

Taking the time to have a good conversation and listen to Jean's views on what she needed, and having a network of community supports were key to achieving her outcomes. Jean said that participating had helped her feel empowered to make a meaningful difference to the people she had helped in her community.

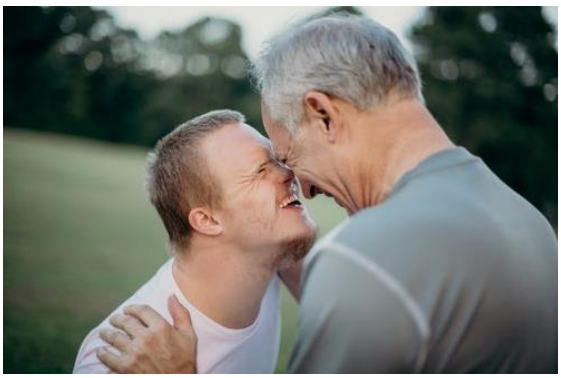
Learning Disability & Mental Health

Social Care

The Learning Disability Service and community adult Mental Health Services offer a range of assessment, support and intervention services.

The redesigns of both Learning Disability and Mental Health have common strategic and operational priorities: ensuring cost effective single management system providing consistency of approach across health and social care professionals and the development of an integrated single care pathway.

Work is ongoing to redesign the community services to **ensure Best Value and consistency of service** across the Partnership. This includes the re-design of day services and the wider use of Self-directed Support to support service users and their unpaid carers to exercise choice and control over their care.



Action in Mind

The provision of support services for people with mental health problems. This includes the Hub Centre which provides a planned programme of social and group services, counselling services, and befriending services for adults and young people.

Commissioned Services

We will also continue to work with a wide range of partners to develop our services in line with the national Mental Health Strategy 2017-2027.

The rates of detention under the Mental Health (Care and Treatment) Act 2003 have risen. The increase in the use of orders has been due to a variety of factors including a rise in the rate of those affected by drug induced psychosis, as well as mental ill health presenting in the older people population.

There were 40 compulsory treatment orders at March 2019

Primary Care

This helps deliver a seamless journey for patients and supports multi-professional collaboration with Primary Care Colleagues. Advanced Practice roles have been scoped and will provide key elements of Mental Health Services in the future.

Care Providers

The partnership has also begun engaging on the strategic commissioning of third-sector Mental Health Services. This work is invaluable in ensuring cohesive working between all partner organisations delivering care and providing access to support.

Acute Care

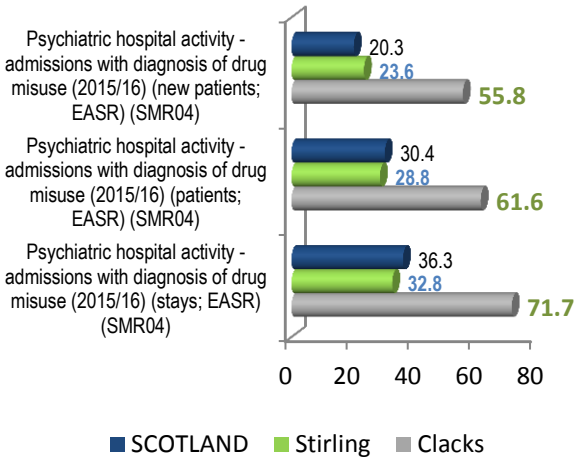
Over the past three years there have been significant changes in the delivery of hospital based Mental Health Services with redesign of existing teams and additional resources to meet the increasing demands on service. There is now a joined up, 24/7 Mental Health Assessment Services based in FVRH which also fields calls for people calling NHS 24 with Mental Health Concerns.

Scotland's Mental Health Strategy calls for parity of esteem with physical ill health. Services across the partnership are working to ensure that people accessing services for support with mental health problems do not experience a lesser service than those accessing support for physical ill health.

We aim to:

- Deliver 20 new posts by 2021 in line with Action 15 of the Mental Health Strategy. Focussing on areas of high need; the Police, Custody, Emergency Department and in Primary Care.
- Provide access to pre-hospital triage to people who come to the attention of Police Scotland with Mental Health problems.
- Improve pathways for people using mental health services.
- Implement a commissioning plan to ensure joined up working across statutory and non-statutory organisations.

Psychiatric Hospital Stays – Drug Misuse



Source: ScotPHO – www.scotpho.org.uk

Alcohol & Drug Partnership ADP

- The recent ADP Needs Assessment has reflected the impact that substance use and mental health difficulties are having on people who use our services. The ADP will work to increase staff competence and confidence relating to substance use within the Mental Health workforce.

- We will further develop and strengthen our alcohol treatment pathway to ensure that staff are more able to initiate a referral to substance use services at the earliest opportunity. We will ensure that the revised pathway is marketed appropriately to social care / health staff to increase the treatment ratio levels across the life stages for those with substance use problems.

Dementia

The Partnership is working to ensure that services delivered to people with dementia are as seamless as possible and that people get access to the right support at the right time.

Scotland's third National Dementia Strategy moves away from a healthcare model and places more emphasis on people being supported to live well within their own communities following a diagnosis, as well as reducing the amount of time people with dementia spend in a hospital environment.

There is also an emphasis on the importance of good quality post diagnostic support and the impact this can have on outcomes for people with dementia. **It is therefore important that all people newly diagnosed and beyond, as well as their unpaid carers, have access to support that suits their needs.**

We aim to:

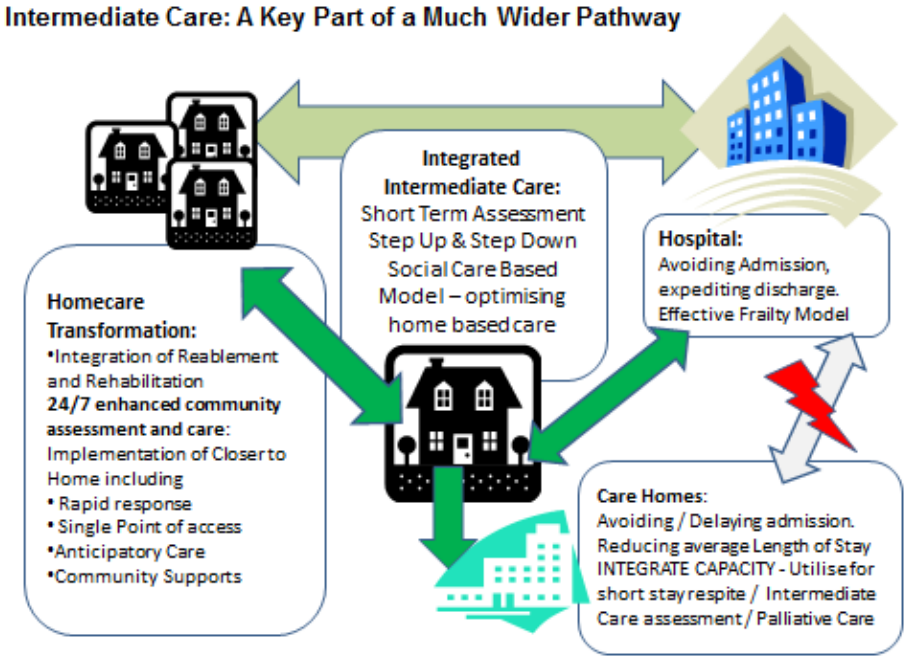
- Develop a Forth Valley Health and Social Care Dementia Strategy.

- Continue to progress the redesign of services.

- Develop knowledge and skills within Primary Care and Community Teams to support people with dementia to stay at home for longer.

- Spread dementia friendly community work to all areas within the partnership.

Intermediate Care



The Partnership has a range of intermediate services all operating within the national framework. A plan was published in November 2018 aiming to improve personal pathways within Intermediate Care provision. It stated that in order to successfully integrate and transform, an Intermediate Care Development Group would be established. This group will set out the full ambitions of the programme alongside the Partnerships Strategic Commissioning Plan for 2019-2022.

Intermediate Care at Home

This provides people with **rapid access to assessment, rehabilitation and support at home** in order to **promote independence and prevent crisis** situations. It can **prevent unnecessary and avoidable hospital admission** for people who have experienced an acute health event that has resulted in a change in physical functioning. It is usually provided by a mix of health and social care professionals. This model is often referred to as Reablement.

People using reablement experience greater improvements in physical functioning and improved quality of life compared with using standard home care.

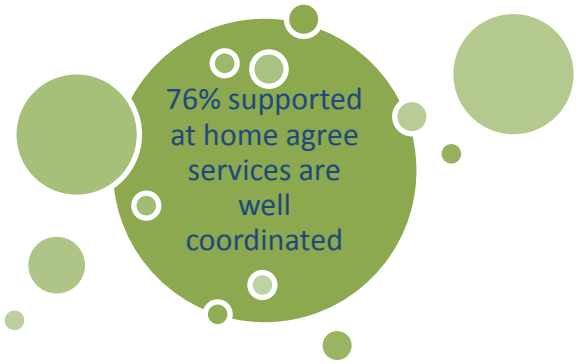
Carers Guide

Currently there are differing models of Intermediate care across the Partnership but the range has reduced over the year through rationalisation. A preferred model has now been developed which is integrated with community healthcare services, and progress to a fully costed model of care is required as the next step.

653 clients completed reablement in 18/19 with 48.5% receiving reduced hours afterwards.

Technology Enabled Care (TEC) supports people to maintain their independence and self-management, and provides the means to summon assistance in an emergency. This service is available across the Partnership localities and has successfully increased access to technology and telecare over the previous 3 years.

- Increased provision of basic telecare community alarm units and monitoring equipment such as falls monitors, smoke and heat detection, front door contacts etc.
- Technology such as Just Checking is now used regularly to support reablement and home care assessment.
- Increased use and awareness of GPS technologies to support people living with dementia to remain safe in their own homes.
- Improved referral pathways have been developed with Scottish Fire and Rescue Service to promote access to Home Safety Visits, including information sharing to support people to keep safe.
- Testing of improved referral pathways with Scottish Ambulance Service to support the care needs of uninjured fallers in the communities.



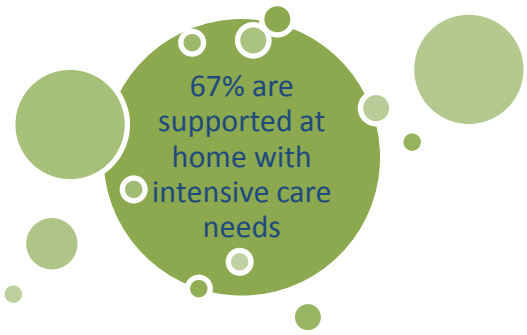
Technology Enabled Care .Case Study

The TEC team worked with a private care home where a resident who required full assistance from staff with all aspects of daily living activities, and regularly required to summon help due to her medication condition.

She was becoming distressed constantly shouting for staff and the other residents were becoming distressed because of her shouting. The team worked with the care home manager and her care manager to introduce "Alexa" (amazon echo dot). This was connected to the home's Wi-Fi and the app was downloaded both to her mobile phone and the home's mobile phone. The service user could then ask "Alexa call help", and a call would be made to the home's mobile phone asking staff for assistance. Further support options were available to enable her to be more independent, e.g. switch on her own TV, lights, and fan using the echo dot.

This was cost effective for the care home and a good outcome and experience for the resident, staff and other residents. Expensive "Telecare equipment" isn't always required. Involving service users in identifying solutions, listening to what matters to them, and allowing them to make decisions is key.

The resident and family felt her needs were met and she is looking forward to her next adventure with smart technology.



Enhanced Community Team

The Enhanced Community Team is a Community Nursing led model of care which supports people who have been assessed as requiring additional care and treatment for a short period of time, avoiding their admission to hospital. This team has rapid access to Allied Health Professionals as well as including Health Care Support Workers to support the delivery of this service.

These services provide a bridge between health and social care, with the aim of supporting people to live in their own homes or in a homely setting, reducing dependence on acute hospital facilities. The Team provides an urgent response 24 hours a day, 7 days a week.

Enhanced Community Team Case Study

After breaking her hip and a lengthy stay in hospital, my mum got discharged from hospital not long ago. She fell three times in the three weeks she was home. On the second fall her own GP placed her under the care of an Enhanced Community Team based in Stirling Community Hospital.

This team looked after her at home for 6 days before placing her for her own safety into emergency respite. The ECT, which we had not heard of, were excellent, they checked her health, reviewed her medication and collected it from her chosen chemist, checked her legs which were badly swollen, and sent in Physios to try to increase her mobility.

My two brothers were on holiday and I was looking after mum on my own while working. They were great at keeping me informed of mum's daily health and their plans for her i.e. respite care.

Enhanced Community Team ECT Case Study

An 85 year old gentleman was referred by his GP with a short history of increased confusion and falls. The GP had started the patient on antibiotics for a suspected Urinary Tract Infection. The man lived alone in a 2 storey house and was having difficulty with the stairs, struggling to get to bed and toilet, and had no services in place. He wished to remain at home, but had no family locally, and had been struggling for several months prior to illness.

A full medical, nursing social and environmental assessment was undertaken and included:

- ReACH for assessment of poor mobility
- MECs for Telecare
- Social work for assessment of care needs

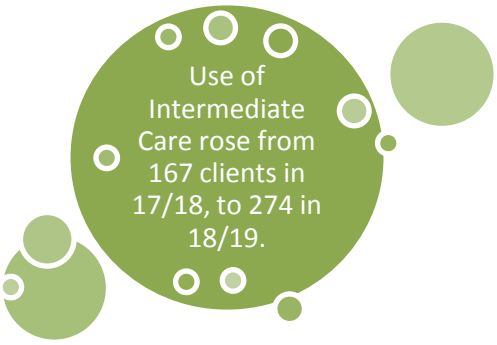
Carers attached to ECT provided care initially, and he was referred to 3rd sector for assistance with shopping tasks.

The man's urinary tract infection resolved with medication, his mobility improved, and he was able to remain at home. An onward referral was made to the Anticipatory Care Planning team to develop a plan for his future needs.

All health and social care services involved in this gentleman's care worked together to support him to meet his outcome, which was to remain at home with support.

Bed Based Intermediate Care

Similar to Intermediate Care at Home, this is a **time limited episode of care currently provided in Bellfield Centre [116 rooms Stirling] and Ludgate [4 rooms Clackmannanshire]**. It often provides an **alternative to admission to hospital** [step-up] or to provide further assessment and rehabilitation, following discharge from hospital [step-down].



This work being done within the Intermediate Care Implementation Plan will collaboratively develop integrated service provision for:

- Closer to Home services including Reablement and Enhanced Care Team.
- Evaluation of the Bellfield Centre and development of a bed based model for the Clackmannanshire locality.
- Technology Enabled Care Services and how these can be used more effectively across the whole system.
- Workforce planning including job profiles and skills/competence.
- Pathways which complement Unscheduled Care workstreams and improved experience for the person.
- Recommendations for single points of access/community front door, aligned to work being undertaken at a Forth Valley level.

We will embed short stay assessment care within the Bellfield Centre and review bed based provision within Clackmannanshire Community Healthcare Centre.

Bellfield Centre Case Study

Mrs B was referred to the Bellfield Centre for a period of rehabilitation and discharge planning following an admission to hospital,. She had fallen at home which resulted in a hip replacement. She had also been assessed as not having mental capacity, and her family had raised concerns around her return home, and not managing daily living skills.

Mrs B and her daughter completed a Pre Admission Assessment with staff from the Hospital Discharge Team, which included a 'good conversation' to ensure that Mrs B understood the service. The Intermediate Care process was explained and outcomes were reviewed and agreed. Mrs B and her daughter agreed to a period of Intermediate Care in the Bellfield Centre and she was admitted shortly after.

Through assessing and engaging with Mrs. B, staff were able to identify the right support at the right time in the right place, which included Occupational Therapists, Physiotherapists, Psychiatric Liaison Service, and Third Sector supports.

Mrs B was transferred to an Assessment Flat within the Bellfield Centre, which simulates the home. Staff encouraged daily living skills, supported Mrs B to carry out housekeeping and personal business, visit social work services herself, visit local shops to buy her own shopping; promoting her to live independently and to make her own choices. This informed the care package required for a return home.

Mrs B is now waiting on a care package to return home to independent living, and said that she was grateful that staff continued to work with her and support her until she was able to return home.

Stirling Health & Care Village

Stirling Health and Care Village is a health and social care development on the Stirling Community Hospital site which has been taken forward through an innovative partnership between NHS Forth Valley, Stirling Council, the Scottish Ambulance Service, Forth Valley College and the Health and Social Care Partnership.

The construction phases for the main buildings of the Health and Care Village site were completed by Autumn 2018, allowing occupation of the GP and Minor Injuries Centre, Scottish Ambulance base, and Bellfield Centre comprising of 32 nurse led health rooms and 84 intermediate care rooms.

As this service became operational during winter 2018/19, the development of pathways, team and skills mix within the service, will continue to evolve over the next 3 years. It is important that this links to the core priorities and the Implementation Plan for Intermediate Care for the Partnership.

During 2018 Partnership staff worked closely with Care Inspectorate colleagues to secure registration for the 84 Intermediate Care beds.

Given the change in ratio of Health to Intermediate Care rooms from the previous model of care, NHS discharge and referral pathways were reviewed and updated. There are now clearly defined routes from Frailty at the Front Door, the Discharge Hub, as well as FVRH wards.

There are improving levels of awareness within community and primary care teams of the opportunities that exist to 'step up' into the Bellfield Centre for short term rehab/reablement and assessment which avoid admission to acute services, minimise lengths of stay, and maximise independence to support successful return to the community.

A Clinical & Care Governance Group has been established to monitor and evaluate the quality of all of the services provided at the Bellfield Centre.

This development is a corner stone of the Strategic Plan 2016-2019, and replaces intermediate bed based services previously provided in local care homes and community hospital settings in Stirling. This innovative project establishes the Health and Social Care Partnership and is a model for the integrated approach intended.

Care will be delivered in a comfortable, homely environment for older adults to help them recover, regain their independence and, where possible, return to their own homes.

Bellfield Centre Case Study

Mrs L was admitted to Forth Valley Royal Hospital after having a fall at home and suffering from a fractured femur. She was non-weight bearing on her left side, using a pulpit frame for mobilising and required a further period of rehabilitation before returning home. Staff met with Mrs L to talk about the Bellfield Centre, and what she could expect. Her main goal was to return home with a minimum care package. They discussed the outcomes focussed assessment and agreed a number of personal outcomes.

Using an Outcomes Focussed Approach they looked to Mrs L's future care needs and what could be done to support her to meet these outcomes. Mrs L received support from Physiotherapists, Occupational Therapists, and Intermediate Care Staff, helping her to build strength in her leg, and plan her safe discharge home which included environmental visits, and supporting her to build confidence and make her own decisions about her care.

Regular reviews were held between Mrs L, her daughter, Physiotherapists, Occupational Therapists, and Intermediate Care workers to develop an outcomes focussed plan for returning home. Mrs L was thankful for the opportunity, stating that she would not have felt prepared to go home straight from hospital and acknowledged if she had then she would have probably failed.

Day Support

The growing older population, along with the drive for people to be supported to live in their own homes means that there is a requirement for services to be able to respond in different ways.

A management review of Day Services has been undertaken with the aim of identifying how a more responsive service could be developed. This work has focussed on service provision within the Clackmannanshire locality.

Following outcome-focused reviews of the remaining users of Ludgate House Day Service, alternative provisions were put in place including utilising the Whins Resource Centre. The Care Inspectorate registered service operated by the Partnership ceased to operate in January 2019.

A collaborative approach with the Third Sector ensured co-production of supports for older people and their carers, utilising part of Ludgate House as a Third Sector resource, while developing CCHC's Day therapy unit as a key location to support people with more complex needs (often referred to as High Health Gain needs).

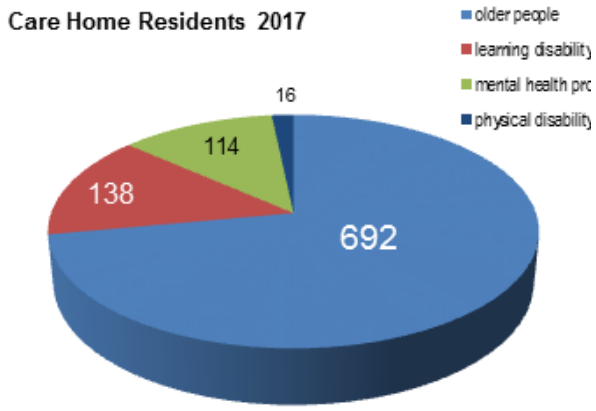
We know that people with dementia wish to remain at home for as long as possible and ensuring that people with dementia and their families remain included in their communities, and in society more generally, should be the 'norm'.

Dementia Friendly community groups are established within the partnership with the aim of working with local businesses and service providers to raise awareness of dementia and what role they can play in supporting individuals and their carers.

- Clackmannanshire Third Sector Interface continues to identify alternative services and organisations that are able to use Ludgate House as a community hub.
- Hosting of a number of events including information sessions, and food/healthy eating events.
- The Carers' Centre is also using this to host networking meetings weekly.

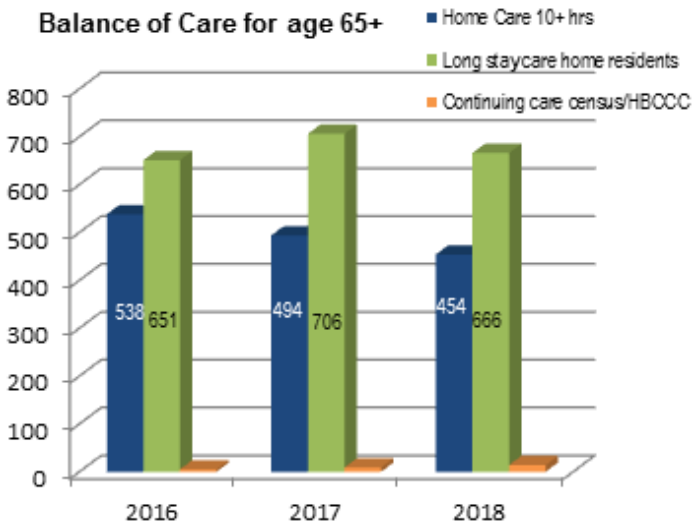
Care Homes

Registered care home places are low for the size of the population, and the Partnership continues to be in the lowest quartile.



- The most recent Care Home census tells us that in Clackmannanshire 72% of residents require nursing care, and 52% in Stirling.
- Average length of stay is above Scottish average [2.4] in Clackmannanshire [2.8] and below in Stirling [2.2]. But it is higher for both areas for those under 65 years.
- Average age is younger than Scotland for both areas for all adults. But similar for older people.

Redesign of the models of care has seen the reduction of local authority owned care homes within the Partnership, whilst resources are shifted to new integrated care models. As these develop, bed-based services for intermediate care will be provided in both Stirling Health and Care Village and in Clackmannanshire Community Healthcare Centre **with long term care focussing more on nursing care home provision where residents can no longer be supported at home.**



Adult Support and Protection (ASP) referrals from Care Providers are monitored, along with the quality of care grades awarded by the Care Inspectorate.

In a recent example where ASP concerns were identified within a care home, a Large Scale Inquiry (LSI) was set up to identify specific risks and thereafter support the Provider to deliver practice improvements across a number of areas. Families and carers were involved and kept informed throughout.

This LSI had a collaborative approach involving the Partnership, the Care Inspectorate and third sector agencies to support the provider to deliver improvement within an agreed and planned programme of work. As a consequence of this activity there was an the increase in the grades awarded to the provider. This reflects significant improvements to the outcomes for residents.

The Matrix provides a framework for identifying priorities and should enable services to use resources effectively to deliver proportionate care and support for adults at risk of harm.

Source: ASP Biennial Report

High Health Gains

It is notable that a small percentage of people, with complex and intensive needs, account for half the total health expenditure in the local area.

There was a slight increase in the number of individuals in the Partnership who accounted for 50% of health expenditure. Rising from 2,860 individuals in 16/17 to 2,941 in 17/18.

It is therefore important that the Partnership focusses on this group to ensure that services are as efficient and effective as they can be and that people's experience of services is positive, with their outcomes met as far as possible.

The ongoing focus over the last year was to **"Support full and independent lives through innovative technology approaches"**. We have worked with people to get access to equipment that meets their needs, and avoid preventable hospital admission.

The inequality gap within the Partnership is equivalent to 3,329 hospitalisations each year. This is the difference in preventable emergency hospitalisations for a chronic condition between deprivation groups.

In Stirling the most deprived areas have 58% more hospitalisations than the overall average, Clackmannanshire 47%.

Source: Scotpho Health Inequalities

89% spend their last 6 months of live at home or community setting in 18/19

The Primary Care Improvement Plan 2018-2021 encourages GP practices to work together and take a multi-disciplinary approach to improving primary care. This involves developing the role of health professionals such as pharmacists, physiotherapists, mental health professionals and advanced nurse practitioners and freeing up GPs to focus on the people who need them most.

We know that access to GPs and primary care support matters greatly to people and to the wider health and care system. We asked the public at two public partnership forums, in September 2018, what matters when seeking healthcare advice or support. They said;

- Quick access to the right professional or service, be it GP, Physiotherapist, specialist care or other. "We want to nip health problems in the bud"
- Good communication between health and care professionals and people "We don't want to be bounced between services and professionals"
- To be informed about new ways of working in clear and understandable language.

We will scale up the support to all GP practices in Clackmannanshire and Stirling through implementation of our Primary Care Improvement Plan. The key components of this are:

Vaccination Transformation

Vaccine delivery will change in light of the increasing complexity of vaccination programmes in recent years. This change will see the development of a community vaccination team who will maintain the highest levels of immunisation and vaccination uptake.

Pharmacotherapy Support

Pharmacists will support activities in all general practices. They will provide services including acute and repeat prescribing and medication management activities.

Additional Professional Roles

Practitioners, such as physiotherapists, mental health practitioners and advanced nurse practitioners will work closely with GPs. They will be a first point of contact to assess and direct care for urgent health issues, muscle and joint problems and mental health issues.

Link Workers

Community Link Workers work directly with patients to help them navigate and engage with wider services. We will employ link workers to support people in the most socio-economically deprived communities, assisting people who need support because of (for example) the complexity of their conditions or rurality.

Advanced practice Physiotherapists, Primary Care Mental Health Nurses and pharmacists roles now developing across GP practices. New phlebotomy service is being developed and tested in Stirling GP centre.

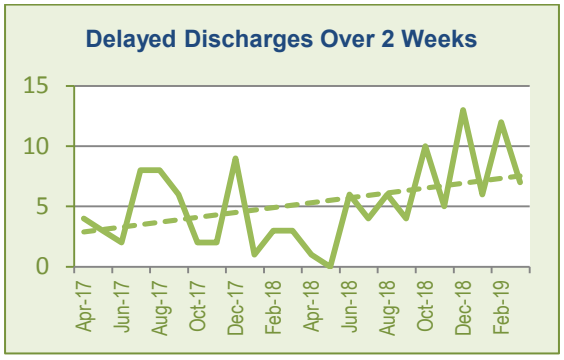
Delayed Discharge

We continue to work together to minimise any delays to discharge, and redesign services to support avoidance of unnecessary admission.

"We saw examples of changes to systems to reduce delayed discharges and improve discharge planning by better use of performance data. "

Source: Inspection Report

Our performance in the graph below shows a rising trend for 18/19 attributable in part to the temporary loss of some key providers over the period. The biggest reasons for delayed discharges in 18/19 were care arrangements and place availability.



Source: FV NHS 18/19

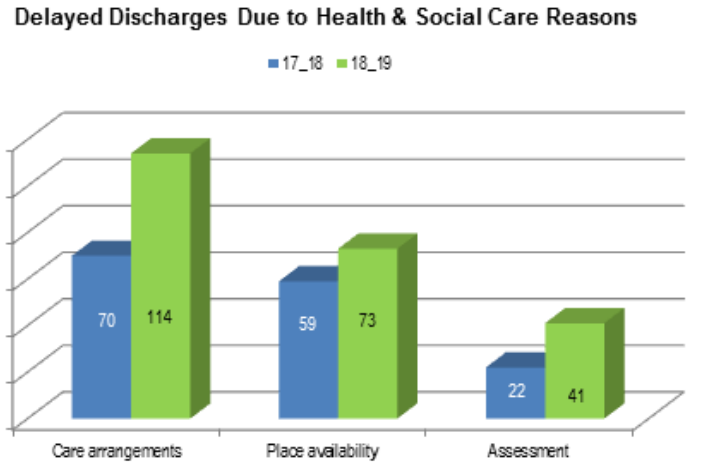
We know that many adults can be supported at home, even when unwell, and that to stay unnecessarily in hospital can be detrimental to people's ability to manage their own care, leading to a loss of function. This has led to a strong focus on working to improve pathways to reduce delays in discharge.

At the end of 2018/19 our performance for all delayed discharges continues to be well above our peers and national average. Ranked 18 out of 31 Partnerships (where 1 is the highest).

As at March 19	Number of all delayed discharges		
	16/17	17/18	18/19
Partnership	23	24	22
Comparators	34	33	36
Scotland	41	43	43

Source: ISD 18/19

In 18/19 people aged 75+ spent more days in hospital waiting to be discharged than 17/18



Source: ISD 18/19

3. Transforming Care: The Enablers

This section of the Annual Performance Report outlines the supporting activities (the underpinning Enablers) which involves re design activity, but is also about information, research, or planning work that help us to understand our population and services.

Strategic Needs Assessment

The existing strategic needs assessment informed our first Strategic Plan 2016-2019, the key messages remain relevant and a recently published focussed update provides further insight into areas of concern.

- The number, and proportion, of older adults is projected to double, and our area will have growing numbers of individuals living with long term conditions, multiple conditions and complex needs.
- Reducing behaviours such as smoking, alcohol consumption, drug use and poor diet could have a positive effect on an individuals health.
- Health inequalities persist between the most and least deprived areas. Within the Partnership the rate of emergency bed days is highest in the most deprived areas and decreases as deprivation decreases. The gap between the most and least deprived areas has widened in both local authorities. This may have an impact on demand for services.

Housing and Social Care Contribution

The Partnership is working closely with Housing services in both Clackmannanshire and Stirling Council, in developing a new Housing Contribution Statement for 2019-2022. There are aspirations that this relationship will develop further, with a focus on place based care and support within local communities.

An innovative approach has been taken in developing a new housing with care model within the town centre of Alloa, with construction taking place over 2019/20. This development has been done in collaboration with Housing colleagues, and Stirling University, along with the Contractor, and will provide opportunities for people to live and access the town centre as well as other local amenities and services.

There are some developments within housing policy which over the next five years are going to significantly impact health and social care services, including the Rapid Rehousing and Housing First agenda. Rapid rehousing is at the heart of Scotland's response to homelessness. It means quickly housing and providing support to people who are homeless or at risk of homelessness and offering Housing First to those with a range of complex needs.

There are a core group of homeless people with complex and enduring support needs who frequently use homelessness services; unable to access and sustain settled housing:

- mental health problems
- drug and/or alcohol dependency
- engagement with the criminal justice system
- limited independent living skills
- interacting with homelessness services for extended periods of time.

The Alcohol and Drug Partnership (ADP) have contributed to the development of the Strategic Commissioning Plan with substance use being identified as a key priority. A workshop was facilitated in May 2019 with the Strategic Planning Group and, from that, the ADP are developing a plan which outlines how we will deliver against the priority areas agreed by the group.

"Integrating health and social care provides the opportunity for better coordination of alcohol and drug treatment services. It also allows these services to be managed alongside housing, mental health and other health and social care services."

Source: Audit Scotland

Commissioning: Market Postion & Providers

We recognise that commissioning, procurement and contract monitoring can act as drivers for transformational change, and challenge existing models of service delivery.

Our Market Position Statement sets out key pressures, and messages about future priorities. The Statement and Market Facilitation Plan describes how we will work with providers to deliver high quality, person-centred and cost effective services and supports.

"We were provided with a number of documents by the partnership detailing the processes undertaken for the recent commissioning and procurement of

independent advocacy services across the Forth Valley area. It is evident that there has been a thorough approach undertaken that stems from the strategy for advocacy provision 2016-2021."

Source: Inspection Report

The Partnership worked with the commissioning teams from both Councils to establish a Care Provider Forum where care homes, and care at home services are represented. This forum provides opportunities to stimulate professional relationships and support practice improvements. The Thresholds Matrix for ASP referrals was rolled out through the Forum, with good support from agencies.

The Board has previously indicated that **a single strategic commissioning approach must be implemented across the Partnership for the commissioning of services**; this has been a delayed due to capacity issues within services. While this is implemented, current arrangements to ensure continuity of care for existing service users has been extended.

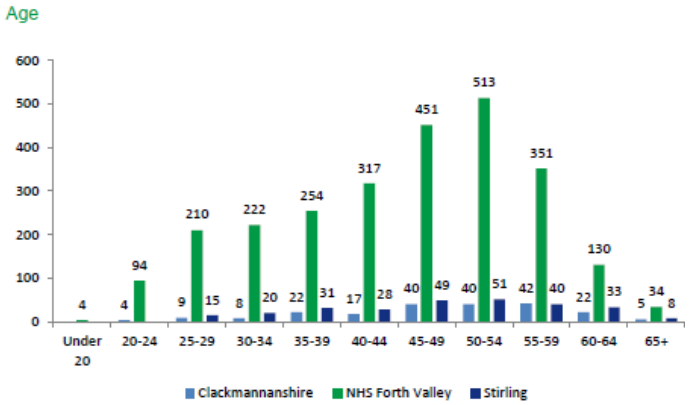
Workforce

The full benefits of integration of health and social care services can only be realised when services appear seamless from the perspective of users and carers. Successful workforce planning is pivotal to this.

The Partnership knows that the workforce is the single most important resource in delivering high quality services and the transformation required to ensure the delivery of the Scottish Government 2020 Vision for Health and Social Care.

"A combination of increased demand for services, coupled with continued reductions in funding at local authority level will mean that our Partnership workforce cannot continue to work in ways which maintain the status quo."

Strategic Workforce Plan 2019-2022



The age profile of some of our workforce is challenging.

"From our staff survey, we saw that the majority of staff are enthusiastic about the development of integrated working arrangements."

Source: Inspection Report

"Redesign on this scale is not an instant 'answer 'to the growing pressures on all service areas and planning with the Integration Joint Board has developed a short and medium approach which bridges between the current Strategic Plan and the developing Strategic Plan for 2019-2022."

Chief Officer Report September 2018

We recognise that this radical shift in both operational practices and our working culture cannot happen overnight. We also recognise that to enable this change we need to focus on key development areas which will act as catalysts for transforming our Partnership.

- There has been a focus on promoting awareness of Adult Support and Protection across all staff groups within the Partnership and key partners.
- The Bellfield Centre opened late November 2018. The underlying change in the mix of Healthcare and Intermediate Care beds from the previous model required significant workforce preparations and change management. These changes were progressed via constructive dialogue with staff, management, and trade unions/staff side representation across the Partnership.
- The new Duty of Candour Regulations 2018 came into force for organisations that provide health and social care. To ensure staff were aware of their responsibilities local guidance was developed and training provided to all staff. Engagement is being monitored to ensure that all staff feel competent and confident reporting and managing incidents that trigger this process.

71% of respondents agree or strongly agreed that they have effective line management that includes supervision.

Inspection Report

Unpaid Carers

Unpaid Carers are a key group within the community who care for many of the most frail and vulnerable residents in our Partnership. The impact on their health and wellbeing can be considerable.

The Strategic Inspection indicated that feedback from carers suggested that the **Partnership still has work to do to ensure that carers feel like equal partners**. However Carers recognised that the Partnership has made some significant strides in involving carers and carer representatives. It stated that the Partnership should continue to develop this work to ensure meaningful carer participation and engagement.

The Partnership has published a Carers Strategy 2019-2022 to outline how the Partnership will support unpaid carers and meet its statutory requirements as detailed in the Carers (Scotland) Act 2016. This strategy dovetails with the Short Break Services Statement. Although this is a formal document required by law, the Partnership is aiming for the Statement to be a genuinely useful and accessible document that can be relied upon by carers and cared-for persons.

1. What short breaks are
2. Who can access them
3. What is available
4. How they can be accessed

Hours of Care per Week
(of self-identifying carers):

57% - 19 hours
9% - 20-34 hours
34% - 35+ hours

Town Break

Person-centred support for people with dementia, their carers and families to help them live within their communities. This is achieved through a number of methods including supported lunch clubs, social activities and befriending services to improve the quality of life.

Commissioned Services

Alzheimer Scotland

Provider of a day care service to people with dementia, as a support for their carers and families which will help service users live a full and positive life within the community. This includes support at the Alva Day Care Centre for people with dementia and providing respite breaks for unpaid carers.

Commissioned Services

Our Priorities

Our Carers Strategy will focus on delivering the following key priorities over the next few years:

1. Recognising Carers
2. Including Carers
3. Supporting Carers
4. Health and Wellbeing of Carers
5. Creating Carer Aware Communities

"I always sort everyone else out first, and sometimes don't have time to look after myself"

Financial Statement

We will continue to utilise the resources available to the IJB, including the Integrated Care Fund (ICF), Delayed Discharge Funds, Technology Enabled Care, Primary Care Improvement Plan and Mental Health Strategy allocations to support our Transforming Care Programme, aligned to the Strategic Commissioning Plan priorities.

"The partnership should develop financial reporting so that IJB members have an improved understanding of the relationships between performance and investment against the strategic priorities"

Source: Inspection Report

Financial Performance

The funding available to the Integration Joint Board to support the delivery of the Strategic Plan comes from payments from the constituent authorities (Clackmannanshire and Stirling Councils and NHS Forth Valley), the Set Aside budget for Large Hospital Services and allocations for specific purposes from Scottish Government.

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 Integration functions aligned to the priorities of the Strategic Commissioning Plan.

For the financial year ended 31 March 2019 a balanced financial position is reported. However, it is important to understand that this position has been achieved through a combination of budget recovery actions, utilisation of earmarked reserves without specific spending plans and, subject to final agreement, an additional payment for 2018/19 only from the constituent authorities on an agreed risk share basis. The Partnership requires to address the recurrent deficit along with other financial pressures to allow service delivery to be sustainable.

The expenditure of the Integration Joint Board for year ended 31 March 2019 is detailed in the table below. These figures are subject to statutory audit.

Service Area	£'000
Set Aside Budget for Large Hospital Services (Note 1)	20,633
Adult Social Care: Clackmannanshire Locality	17,136
Adult Social Care: Urban and Rural Stirling Localities	34,889
Health Services under Operational Responsibility of Integration Joint Board	36,039
Universal Family Health Services including Primary Care Prescribing	70,365
Integration (Social) Care Fund	8,808
Shared Partnership Posts & Statutory Costs of Integration Joint Board	293
Transformation	2,734
TOTAL EXPENDITURE	**190,897**

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.

Best Value

Clackmannanshire Council, Stirling Council and NHS Forth Valley (the constituent authorities) delegate budgets, referred to as payments, to the Integration Joint Board which decides how to use these resources to achieve the objectives of the Strategic Plan. The Board then directs the partnership through the constituent authorities to deliver services in line with this plan.

"There is a risk to longer-term financial sustainability in the partnership's reliance on the non-recurring integrated care fund ICF and reserves. The purpose of the integrated care fund is to provide service change to shift the balance of care towards early intervention, the prevention of ill health, and care and support for people with complex and multiple conditions. Using the funds to offset overspends will eventually allow this to happen, however a more financially sustainable approach is required. "

Source: Inspection Report

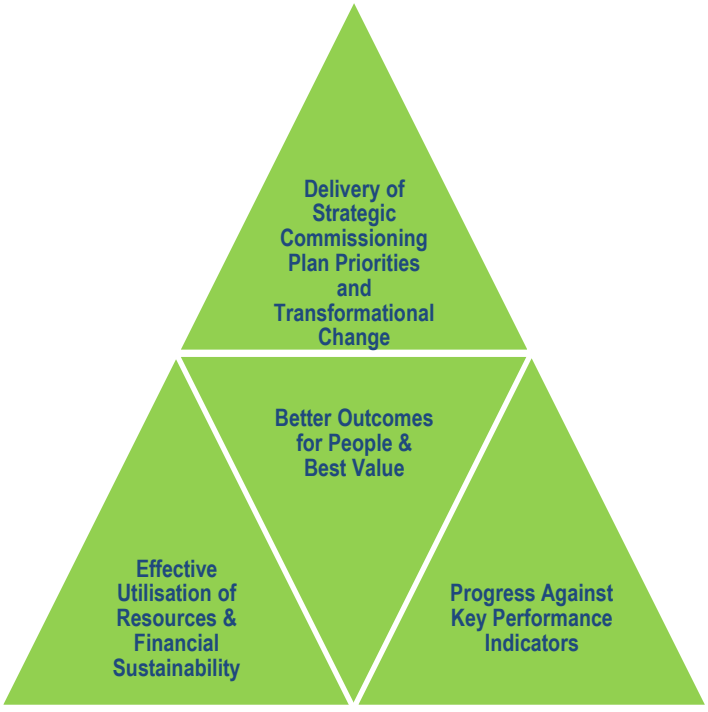
The governance framework is the rules, policies and procedures by which the Integration Joint Board ensures that decision making is accountable, transparent and carried out with integrity. The Integration Joint Board has legal responsibilities and obligations to its stakeholders, staff and residents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

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

The recent inspection found that "The partnership has good joint working between finance officers. Finance officers meet and communicate regularly both formally and informally to discuss current and emerging issues about integration. The finance officers group provides briefings to the other integration working groups. The partner finance officers have been providing accurate financial information in a timely manner, allowing the chief finance officer to pull together the monitoring reports for the IJB. This meets with the assessments made by the external auditors around financial performance monitoring/reporting in annual audit reports. IJB members are supported by the Chief Finance Officer in understanding and carrying out their finance role through a programme of seminars covering a wide number of areas including the partnership budget."

The Board has further reviewed its committee structure in 2018/19. As a result, the functions and Terms of Reference for the IJBs committees have been revised with the Audit Committee becoming an Audit and Risk Committee and the Finance Committee becoming a Finance and Performance Committee. Both committees perform a scrutiny role for the IJB and their review is part of a process of continuous improvement

As part of governance arrangements the Chief Officer leads the Core Integration Team and chairs the Partnership Management Team which oversees the change programme.



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
- Topic Specific Reporting e.g. in relation to the Carers Act.
- Reporting on Strategic Plan through both the Chief Officer's reports to the Integration Joint Board and topic specific reports.

There is however, appreciation that the approach to Best Value in Health and Social Care Partnerships requires to further develop. In this regard the integration Joint Board Chief Finance Officers section intends to examine this area with the intention of developing best practice guidance.

"The risks relating to the financial resilience and sustainability of the IJB are included in the partnership's strategic risk register and are matched against mitigating actions. Risk management arrangements, including the risk management strategy, were concluded to be appropriate by external auditors and are subject to regular review."

Source: Inspection Report

Financial Reporting on Localities

The 2018/19 financial information is not yet split into localities. The Partnership has approved and established a locality management structure linked to GP clusters. Developing locality plans aligned to the Strategic Commissioning Plan priorities and developing locality level reporting is a priority as localities develop.

Transformational Change & Strategic Planning

The Partnership received £2,480,000 from the Integrated Care Fund (ICF) and £0.744m from the Delayed Discharge Fund from Scottish Government during 2018/19. This was allocated to a number of initiatives in support of our strategic priorities for 2016-2019. Work is ongoing to identify linkages and collaborative working in order to improve service delivery and ensure financial efficiencies.

Funding was allocated to the following initiatives:

- Overnight Care & Night Nursing
- Enhanced Community Team
- Advice Line For You
- Reablement & Intermediate Care
- Care Home Psychiatric liaison
- Anticipatory Care Planning
- Alcohol Related Brain Injury case management model
- Alzheimers Scotland
- Town Break Stirling
- Ideas Innovation & Improvement fund
- Carers Centres
- Rapid Response Frailty Clinic
- Discharge Hub & Hospital Discharge teams
- Strathendrick
- HSCP Support

Work in relation to Transforming Care will be revised in light of the priorities identified in the Strategic Commissioning Plan 2019-2022, as well as the Ministerial Strategic Group proposals for progressing health and social care integration.

A Programme Board is being established to facilitate monitoring and review of progress in line with medium term financial planning.

It was noted in the recent inspection that one of the key challenges for the partnership in moving forward with integration will be to ensure closer and more effective collaboration between the two councils, NHS Forth Valley and all stakeholders. This is essential to maximise the impact of available resources in response to local needs.

4. Outcomes: Our Performance

National Outcomes & Our Local Framework

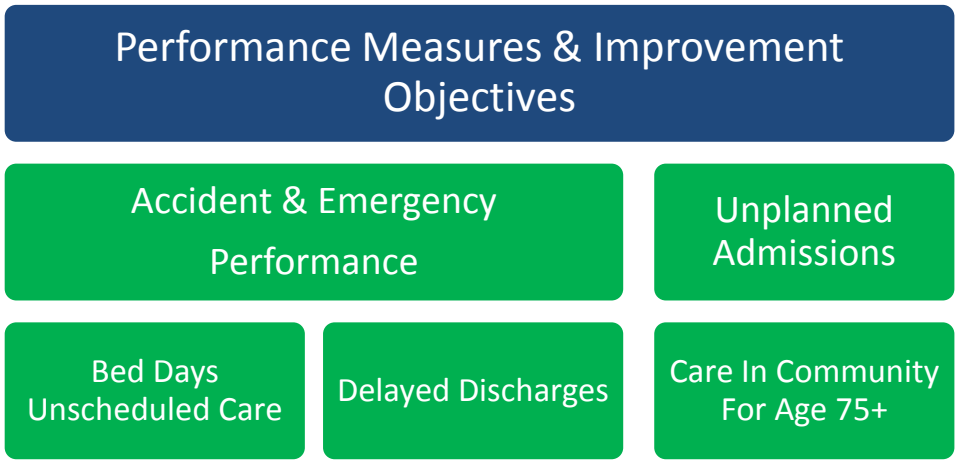
Integration Joint Boards are responsible for effective monitoring and reporting on the delivery of services and relevant targets and measures, included in the Integration Functions and as set out in Strategic Plans.

The Scottish Government has developed National Health and Wellbeing Outcomes, supported by a Core Suite of Integration Indicators to provide a framework for Partnerships to develop their performance management arrangements to help them understand how well services are meeting the individual outcomes of people using services and for communities.

The National Outcomes are-

- **Outcome 1:** People are able to look after and improve their own health and wellbeing and live in good health for longer
- **Outcome 2:** People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting
- **Outcome 3:** People who use health and social care services have positive experiences of those services, and have their dignity respected
- **Outcome 4:** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- **Outcome 5:** Health and social care services contribute to reducing inequalities
- **Outcome 6:** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
- **Outcome 7:** People using health and social care services are safe from harm
- **Outcome 8:** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- **Outcome 9:** Resources are used effectively and efficiently in the provision of health and social care services

To support the delivery of the National Priorities Partnerships were invited to set out local improvement objectives and agree targets for the following supporting key areas:



The progress around these measures is overseen by the Forth Valley Unscheduled Care Programme Board. Partnership and some locality data is provided by national sources.

The Outcomes are supported by a Core Suite of Integration Indicators. This data is provided nationally by the Information Services Division of the Scottish Government to each Partnership.

Where appropriate, we will continue to refer to data at local authority level because historical trend information for the two areas is very useful to help inform locality planning.

We will continue to benchmark against similar Partnerships to give a context around progress.

The Strategy Map will be aligned to national outcomes and priorities within the 2019-2022 Strategic Plan.

Our Performance: A Summary

Indicators 1-9 of the core indicators draw on questions from the Health & Care Experience Survey. The Partnership set baseline data in the first annual report, due to publication timescales this was the most current data available at the time of production.

Core Suite of Integration Indicators - Annual Performance (as at May 19)

	Indicator	Title	Partnership		Comparator Average	Scotland
			15/16	17/18	17/18	17/18
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	95%	94%	94%	93%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	82%	82%	80%	81%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	76%	74%	74%	76%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	73%	76%	74%	74%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	78%	78%	80%	80%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	87%	87%	82%	83%
	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	77%	79%	79%	80%
	NI - 8	Total combined % carers who feel supported to continue in their caring role	32%	38%	37%	37%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	82%	86%	83%	83%
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	no data	no data	no data	no data

This data is for 17/18 as the survey is every 2 years

Core Suite of Integration Indicators - Annual Performance (as at 6th June 19)

* Indicators that rely on health records SMR01, SMR01_1E, and SMR04 will not contain 100% of records for 18/19 at time of the statutory publication date of 31st July 2019. Data is therefore likely to change retrospectively as completedness improves for Forth Valley. Where possible an average of the first three quarters where completedness is 100% has been applied to the fourth quarter (where all the data has yet to be submitted). This has given a guide figure. Scotland and Comparator figures are also affected and will be updated retrospectively. In compliance with the UK Code of Practice for Statistics, the Scotland figure will not be available in this report until after national publications are publicly available.

	Indicator	Title	Partnership				Comparator Average 18/19	Scotland 18/19
			Baseline 15/16	Current				
				16/17	17/18	18/19		
Data indicators	NI - 11	Premature mortality rate per 100,000 persons aged under 75 years	425	389	379	no data	no data	no data
	NI - 12	Emergency admission rate (per 100,000 adult population)	10,371	10,007	10,696	10,525 * 3 quarters plus 4th averaged	11,357 *	not published
	NI - 13	Emergency bed day rate (per 100,000 population)	118,792	112,544	112,941	111,730 * 3 quarters plus 4th averaged	107,130 *	not published
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	103	105	106	103 * 3 quarter average	102 *	not published
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%	87%	89.7%	89.2%	89.2%
	NI - 16	Falls rate per 1,000 population aged 65+	18	16	20	22 * 3 quarter average	20 *	not published
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	82%	88%	96%	93%	84.5%	82%
	NI - 18	Percentage of adults with intensive care needs receiving care at home	69%	67%	no data	no data	no data	no data
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	640	723	503	593	867	not published
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23%	22%	22%	23% * 3 quarters plus 4th averaged	23% *	not published
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	no data	no data	no data	no data	no data	no data
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	no data	no data	no data	no data	no data	no data
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	no data	no data	no data	no data	no data	no data

Source: ISD are still developing these indicators where no data is available yet. Comparators: South Ayrshire, East Lothian, Angus, Moray, Perth & Kinross, Falkirk. Figures as at 4th June 2019

This section outlines the Partnership's performance in each of the national Health and Wellbeing Outcomes where national data is available.

Table Symbols			
✓	Achieved	?	More work required

Outcome 1

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

NI 1	% of adults able to look after their health very well or quite well				
	15/16	16/17	17/18	18/19	
Partnership	95%	no data	94%	no data	✓
Comparators	95%	no data	94%	no data	
Scotland	95%	no data	93%	no data	
4. Source ISD 17/18					

The NI 1 percentage reflects a positive position and is similar to national and comparator average. The vast majority of those surveyed reporting that they are **able to look after their own health and wellbeing** and did not have any limiting illness or disability.

Outcome 2

People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

NI 2	% of adults supported at home who agree that they are supported to live as independently as possible				
	15/16	16/17	17/18	18/19	
Partnership	82%	no data	82%	no data	✓
Comparators	82%	no data	80%	no data	
Scotland	83%	no data	81%	no data	
5. Source ISD 17/18					

This NI 2 indicator reflects whether people who need support feel that it helps them maintain their independence as much as possible. **This is a positive reflection of the support provided by the Partnership to those living in the community.**

Outcome 2 cont'd

This is an area prioritised through the Transforming Care Program to support the development of services such as bed based intermediate care and reablement care at home. **Other improvements being made are through outcome focussed assessments within Social Care**.

NI 18	% of adults aged 18+ with intensive care needs receiving care at home				
	15/16	16/17	17/18	18/19	
Partnership	69%	67%	no data	no data	✓
Comparators	62%	62%	no data	no data	
Scotland	62%	61%	no data	no data	
6. Source ISD 16/17					

The NI 18 figure for the Partnership is a positive position. This indicator reflects the **work to shift care from hospitals and care homes to the community**.

The number of people in receipt of care overall is relatively stable, similar to national average but more than comparators. However the number of hours is rising and far higher than the national or comparator average. This may be reflecting in some part the **above average for the % of the population living in the community with support**.

NI 15	Proportion of last 6 months of life spent at home or in a community setting				
	15/16	16/17	17/18	18/19	
Partnership	85.9%	86.9%	87%	89.7%	✓
Comparators	87.5%	87.3%	88%	89.2%	
Scotland	86.7%	87%	87.9%	89.2%	
7. Source ISD 18/19					

The NI 15 figure for the Partnership **reflects a positive position, overall this is a rising trend** and the Partnership is aiming to achieve 90% by the end of 2020.

We are doing this through core funded Out of Hours Palliative Care and Cancer Helplines, and initiatives include the Hospice at Home Project, night time MECS and nurse wound support.

The End of Life and Palliative Care Transformation Group works to improve the patient pathway, workforce and communication.

The Health & Care Village is now operational. This will **better support the delivery of more effective, person centred end of life care for residents** of the Partnership.

Outcome 3

People who use health & social care services have positive experiences of those services, and have their dignity respected.

NI 3	% of adults supported at home who agree that they had a say in how their help, care or support was provided				
	15/16	16/17	17/18	18/19	
Partnership	76%	no data	74%	no data	?
Comparators	79%	no data	74%	no data	
Scotland	79%	no data	76%	no data	
8. Source ISD 17/18					

The NI 3 figure has reduced since the last survey reflecting national trends. Work is being done at a local level to develop our own Partnership service user and unpaid carer surveys for 2020.

The Partnership invested £123,196 from the Transformational Change programme on Anticipatory Planning.

We have further work to do to **more fully embed choice and control through the range of Self-directed Support options for individual service users and unpaid carers**.

NI 6	% of people with positive experience of the care provided by their GP practice				
	15/16	16/17	17/18	18/19	
Partnership	87%	no data	87%	no data	✓
Comparators	86%	no data	82%	no data	
Scotland	85%	no data	83%	no data	
9. Source ISD 17/18					

The NI 6 figure for the Partnership reflects a positive position. **GP services are central to the delivery of community based health and social care services** and the Partnership continues to work together to support Primary Care services through, for example, investment of the Primary Care Transformation Fund and the developing cluster and Locality work.

NI 5	% of adults receiving any care or support who rate it as excellent or good.				
	15/16	16/17	17/18	18/19	
Partnership	78%	no data	78%	no data	✓
Comparators	82%	no data	80%	no data	
Scotland	81%	no data	80%	no data	
10. Source ISD 17/18					

The NI 5 figure for the Partnership reflects a positive position and is only slightly less than national. **Services are provided by a range of organisations and are guided by the Partnership's commissioning strategies and most are regulated by the Care Inspectorate** [NI17]. For those services directly provided by the Partnership, a proactive approach is taken in regard to complaints and learning from them to make improvements.

Outcome 4

Health and social care services are centred on helping to maintain or improve the quality of life of service users.

NI 7	% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life			
	15/16	16/17	17/18	18/19
Partnership	77%	no data	79%	no data
Comparators	84%	no data	79%	no data
Scotland	83%	no data	80%	no data

11. Source ISD 17/18

The NI 7 figure for the Partnership is a positive one and similar to the national average. Within the Neighbourhood Model of Care work we have developed an **outcomes focussed framework, which will be rolled out across the Partnership** area. The Partnership will review and identify any areas for further development.

NI 12	Emergency Hospital Admission Rate per 100,000 adult persons			
	15/16	16/17	17/18	18/19
Partnership	10,371	10,007	10,696	10,525*
Comparators	11,366	11,456	11,762	11,357*
Scotland	12,226	12,213	12,183	not published

12. Source ISD 18/19

Robust NI 12 data is not currently available. Indicators that rely on health records SMR01 will not contain 100% of records for 18/19 at time of publication. Data is therefore likely to change retrospectively as completedness improves for Forth Valley.

However, using guide figures this would indicate that it is a positive position for the Partnership, with an improvement on the previous year and is likely to be well below comparator and national average.

Getting Forth Right and the FV Six Essential Actions performance improvement action plan is helping to stabilise and address fluctuating trends in performance within Acute services. It targets actions such as capacity and patient flow realignment, patient management rather than bed management, a seven-day service and ensuring patients are cared for in their own homes.

The Partnership is aiming to achieve a 5% baseline reduction on admissions by 2020.

The Partnership increased (by 28%) the number of clients that were moved into Intermediate care directly from the community, in comparison with the previous year. This is a key pathway to avoiding preventable emergency admissions [44 clients 17/18 to 61 18/19].

NI 13	Emergency bed day rate per 100,000 adult persons			
	15/16	16/17	17/18	18/19
Partnership	118,792	112,544	112,941	111,730*
Comparators	129,029	128,090	118,993	107,130*
Scotland	128,630	126,988	123,035	not published

13. Source ISD 18/19

Robust NI 13 data is not currently available. Indicators that rely on health records SMR01 will not contain 100% of records for 18/19 at time of publication. Data is therefore likely to change retrospectively as completedness improves for Forth Valley.

Using guide figures, this would indicate that there might have been a reduction on previous year. It is likely that the Partnership figure is much higher than national or comparator rate.

The Unscheduled Care Programme Board (UCPB) continually monitors performance against the MSG indicators and the six essential actions prescribed by the Scottish Government. Bed usage is audited via the Day of Care Audit to ensure acute and community hospital beds are occupied appropriately and to take action where necessary to have patients relocated to a facility which best addresses their care needs.

NI 14	Readmission to hospital rate within 28 days per 1,000 persons			
	15/16	16/17	17/18	18/19
Partnership	103	105	106	103*
Comparators	103	106	107	102*
Scotland	97	100	102	not published
14. Source ISD 18/19				

Robust NI 14 data is not currently available. Indicators that rely on health records SMR01 will not contain 100% of records for 18/19 at time of publication. Data is therefore likely to change retrospectively as completedness improves for Forth Valley.

Using guide figures, this would indicate that the rate has improved on the previous year but is likely to be higher than national rate and slightly higher than our comparators. Within the Partnership the Clackmannanshire locality has the highest rate.

This is a crude measurement that does not consider the reason for the readmission which might be different to the original admission. Within Forth Valley the readmissions data is standardised by specialty and condition at readmission. This means that it only counts those who return to the same speciality within 28 days. **This local figure shows a reducing trend in readmissions to FVRH for the Partnership.**

The partnership is involved at a national level in the development of Anticipatory Care Planning documentation for primary care. Some initial work to assess the impact of anticipatory care planning on readmissions suggests a positive impact on readmissions among a group of people over 75 experiencing frequent admissions to acute services with a pattern of failed discharges.

NI 16	Falls rate per 1,000 population aged 65+ who were admitted to hospital as an emergency			
	15/16	16/17	17/18	18/19
Partnership	18	16	20	22*
Comparators	20	23	20	20*
Scotland	21	21	22	not published
15. Source ISD 18/19				

Robust NI 16 data is not currently available. Indicators that rely on health records SMR01 will not contain 100% of records for 18/19 at time of publication. Data is therefore likely to change retrospectively as completedness improves for Forth Valley.

Using guide figures, this would indicate that it remains a positive position for the Partnership and is likely to be similar to our comparators and national rate.

Work in this area includes; **the development of our Falls Pathway, and expanded Technology Enabled Care services such as personal alarms and responder services.**

NI 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections			
	15/16	16/17	17/18	18/19
Partnership	82%	88%	96%	93%
Comparators	84%	80%	86%	84%
Scotland	83%	84%	85%	82%
16. Source Care Inspectorate/ISD 18/19				

The NI 17 figure reflects a positive position and is higher than the national and comparator average. This indicator includes all services registered within the Partnership provided by third, independent and local authorities.

Outcome 5

Health &social care services contribute to reducing health inequalities

NI 11	Premature mortality rate per 100,000 persons aged under 75 years old				
	15/16	16/17	17/18	18/19	
Partnership	425	389	379	no data	✓
Comparators	387	401	383	no data	
Scotland	441	440	425	no data	
17. Source ISD 17/18					

Premature mortality, people who die under the age of 75, is an important indicator of the health of the population. The fewer deaths that occur under the age of 75, the healthier the population is judged to be.

The Partnership NI 11 figure is lower than our comparators and national average. This is a positive figure. The Partnership will continue to explore and address inequalities through locality planning and working closely with Stirling CPP, Clackmannanshire Alliance, Community Justice Partnerships, and other key partnerships.

Outcome 6

People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.

NI 8	% of carers who feel supported to continue in their caring role				
	15/16	16/17	17/18	18/19	
Partnership	32%	no data	38%	no data	?
Comparators	41%	no data	37%	no data	
Scotland	40%	no data	37%	no data	
18. Source ISD 17/18					

This NI8 indicator highlights a need to continue to work closely with unpaid carers and our local carer organisations to develop our services in line with the provisions of the Carers (Scotland) Act 2016 and to focus on the way we gather local feedback on the experiences of unpaid carers.

Improvement work around SDS and Dementia pathways will ensure resources are outcome based and available within the community.

Carer's centres received a total of £173,744 funding from the Partnership in 18/19.

Outcome 7

People who use health and social care services are safe from harm.

NI 9	% of adults supported at home who feel safe				
	15/16	16/17	17/18	18/19	
Partnership	82%	no data	86%	no data	✓
Comparators	83%	no data	83%	no data	
Scotland	83%	no data	83%	no data	
19. Source ISD 17/18					

The NI9 figure has improved on the last survey and is positive for the Partnership. It reflects good partnership working within the **Adult Support and Protection ASP Committee, and the Alcohol and Drug Partnership ADP**.

The ASP Biennial Report noted that 67% of service users agreed or strongly agreed that the service or help they received made them safer.

Adult Support and Protection activity has increased throughout the year. With 744 referrals, 170 investigations, and 9 case conferences.

Audit activities focus upon the effectiveness of Adult Support and Protection practices and the structured programme includes a wide range of activity:

- Annual multi agency audit
- Monthly internal case file audits
- Monthly internal audits of all referrals
- Six weekly audits of effectiveness of partnership information sharing
- Unscheduled audit in response to new concerns
- Independently and anonymised service user surveys.

The Adult Protection Committee Risk Register complete with a Scoring Matrix was new in 2018. Its purpose is to assist the Committee in reviewing the strategic risks which may pose a threat to the successful delivery of strategic outcomes.

The Alcohol and Drug Partnership ADP has reviews of all local drug related deaths, which includes Social Care and Housing. This has resulted in changes to Housing Policy in relation to identifying vulnerable people at an earlier stage and linking them with support as appropriate.

All substance services completed self assessments in relation to compliance with the Health and Social Care Standards. This exercise involves services looking at how they keep people safe.

Public Protection training undertaken in this year shows the interface between the Adult Support and Protection Committee, ADP and the other public protection areas.

Social Inclusion Partnership is an ADP funded project across Clacks and Stirling. It provides an opportunity for vulnerable individuals aged 16+ years who reside in the Partnership to improve engagement with community services and access to appropriate support in relation to issues such as:

- Substance Misuse
- Mental Health
- Physical Health
- Learning Disabilities
- Housing and Social Problems

This initiative specifically targets people that satisfy a number of criteria some of which include those:

- Who commit crimes in order to finance their drug/alcohol/substance dependency;
- Who may be subject to the Adult Support and Protection (Scotland) Act 2007;
- Who are subject to Vulnerable Person Reports and significant police concerns;
- Who are frequent attenders at NHS Forth Valley and Emergency Department.

Outcome 8

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

NI 10	% of staff who say they would recommend their workplace as a good place to work		
Partnership	no data	no data	
Comparators	no data	no data	
Scotland	no data	no data	
20	Source ISD		

In the absence of any national data for NI 10 we can report on the independent findings from our Strategic Inspection (staff survey and consultation sessions):

- The majority of staff are enthusiastic about the development of integrated working arrangements.
- 71% of respondents agree or strongly agreed that they have effective line management that includes supervision.
- Staff are uncertain about future roles and management arrangements.
- There is awareness of ongoing work to identify and formalise the management structure.

The Partnership is undertaking a number of pieces of work locally that support this outcome. Such as the introduction of iMatters tool across all of the Health and Social Care staff by 2019/20. iMatters is the continuous improvement tool designed with NHS Scotland to help individuals, teams and Partnerships understand and improve staff experience.

Outcome 9

Resources are used effectively in the provision of health and social care services, without waste.

NI 4	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated				
	15/16	16/17	17/18	18/19	
Partnership	73%	no data	76%	no data	✓
Comparators	76%	no data	74%	no data	
Scotland	75%	no data	74%	no data	
21. Source ISD 17/18					

This NI4 measure is a positive figure for the Partnership. In terms of service examples, work carried out in relation to the use of single shared assessment, anticipatory care plans, and the development of the model of neighbourhood care will provide further opportunity **to develop community based integrated responses.**

NI 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population				
	15/16	16/17	17/18	18/19	
Partnership	640	721	503	593	✓
Comparators	859	962	777	867	
Scotland	915	841	762	805	
22. Source ISD 18/19					

The NI 19 Partnership figure is a poorer position than the previous year, but continues to be lower than both the national and comparator rate. This is still a positive position for the Partnership.

More work is required however, to support people when unwell at home, and to develop further community based solutions such as Intermediate Care.

This work is supported by the Unscheduled Care Programme Board and Delayed Discharge Steering Group, regular performance management reports, and a discharge improvement plan.
An example of collaborative working is the deployment of Social Care staff within the Discharge Team at FVRH which has proved very successful. It is hoped that this will eventually cover all of the Partnership.

In 18/19 the Partnership funded £304,409 directly into Discharge services through the Transformational Change programme.

NI 20	% of Health & Social Care spend on hospital stays where the patient was admitted in an emergency				
	15/16	16/17	17/18	18/19	
Partnership	no data	21%	22%	23%*	✓
Comparators	25%	25%	26%	23%*	
Scotland	25%	25%	25%	not published	
23. Source ISD 17/18					

Robust NI 20 data is not currently available. Indicators that rely on health records SMR01 will not contain 100% of records for 18/19 at time of publication. Data is therefore likely to change retrospectively as completedness improves for Forth Valley.

Using guide figures, this would indicate that the 18/19 Partnership figure reflects a positive position and it is likely that the rate is similar to national and comparator average. It reflects the 'shift' to receiving care and support at home or within the community.

We know that the rate of emergency admissions is reducing within Forth Valley, and for those residents who are admitted on an emergency basis to hospital out with the area.

Work is ongoing to prevent admissions to hospital, and improve access to services within the community. This includes; upgrades and improvements to the Contact Centre within Stirling. Review of processes for Clackmannanshire Adult Care, single point of contact for District Nursing, and Community Front Door.

The ultimate aim is a single point of access, and some preliminary scoping has been undertaken with a view to developing a single model which will operate across the various services within the Partnership. This will be trialled on a small scale and if successful will be adopted across the whole Partnership.

Inspections

The Partnership underwent a strategic inspection in early 2018 and the outcome was published late 2018 which examined the effectiveness of strategic planning in the Partnership and the outcome was published in late 2018.

"The decision to stagger the delegation of operational responsibility for services is not allowing the potential of integration to be fully realised. This decision prolongs single-agency approach to service delivery rather than a partnership one. The plans in place to develop new models of care, while now underway, could have taken place earlier and with a more strategically defined partnership approach. "

	Evaluation
Quality indicator 1	
Key performance outcomes	Good
Quality indicator 6	
Policy development and plans to support improvement in service	Adequate
Quality indicator 9	
Leadership and direction that promotes partnership	**Not subject to evaluation against the six-point scale. This areas has not been given a formal grading but is the subject of commentary**

Areas for improvement as at March 2019	Progress
1. As the partnership progresses the review of the strategic plan and strategic needs analysis, it should review and update all other related plans to ensure a whole-system and collaborative approach is being taken to service planning.	
Review of the Strategic Commissioning Plan 2019-2022 has been carried out and approved at IJB 27 March 2019	**COMPLETE**
Review of the Strategic Needs Assessment complete and approved at IJB 27 March 2019	**COMPLETE**
Needs assessment for unpaid carers and Carers Strategy aligned to Strategic Plan – co produced.	**COMPLETE**
Consultation time table in place for Strategic Plan – first stage consultation via Big Team Meetings and PPF. Second stage consultation and engagement carried out – public meetings, attendance at community forums, carers groups and online survey done between November 2018 and March 2019	**COMPLETE**
Housing Needs Assessment will be reviewed when Heads of Housing in place for each Local Authority.	**ONGOING**
Housing Contribution Statement completed for Clackmannanshire	**COMPLETE**
Housing Contribution Statement - awaiting outcome of Stirling review of Housing Strategy and consultation in order to integrate/combine – planned for June 2019	**ONGOING**
Review of Workforce Plan carried out and approved at IJB 27 March 2019	**COMPLETE**
Timetable reviews across 19/20 – dependent on capacity	**ONGOING**
Market Position Statement to be done during 2019/20	**ONGOING**
Equalities Impact Report to be done during 2019/20	**ONGOING**
Refresh of Dementia Strategy – to include FV wide work and the dementia friendly communities	**ONGOING**

Areas for improvement as at March 2019	Progress
2. Greater clarity and clear timescales are needed for the staged programme of delegation of operational management. This should allow the IJB and the chief officer to exercise their roles and responsibilities more effectively and efficiently. The IJB should be able to demonstrate that they can provide full assurance of all the services legally delegated to them in April 2016.	
Support service work shop to agree the arrangements for key support functions took place in November 2018	**COMPLETE**
Delegation of Stirling Council Services completed by September/October 2018	**COMPLETE**
Ongoing discussion within each constituent party on support service arrangements	**ONGOING**
Job description for Locality Manager positions approved and recruitment taken place. Interim positions in place where awaiting permanent post-holders taking up posts	**COMPLETE**
Delegation timescale to be agreed with NHS Forth Valley	**ONGOING**
3. The partnership should ensure that it plans for and develops an integrated framework of accommodation, care and support. This needs to support a whole-system approach to developing care pathways in line with local need and priorities, the national health and wellbeing outcomes and the national health and social care standards. The framework should be sustainable and be evaluated to ensure that improvements in operational performance and personal outcomes are being delivered.	
Whole systems approach described in the Rich Picture 2018	**COMPLETE**
Further work being discussed with iHUB in terms of supporting Partnership to deliver on the new Strategic Plan priorities and the areas for improvement arising from this strategic inspection.	**ONGOING**
Further development of the frailty pathway and the Unscheduled Care Programme work aligned to the front door development	**ONGOING**
Step into Bellfield Centre within the Health and Care site from November 2018, integrating the health and social care workforce for bed based intermediate care.	**COMPLETE**
Alignment of models of care closer to home, integrating reablement and enhanced care services to support people in their own homes. Continue this from service modelling work supported by iHUB.	**ONGOING**
Intermediate Care Implementation Plan approved at IJB November 2018	**COMPLETE**
4. The partnership should work with both council housing departments and registered social landlords to produce a coherent and shared strategic plan for accommodation across the integration authority. This needs to be responsive to local need and priorities and should include review of the recommendations within the externally commissioned study on specialist housing for older people published in 2016.	
Chief Officer to establish links to the Chief Housing Officer [Stirling] when they come into post	**ONGOING**
Work with local authority Housing to review the Housing Contribution Group and service links	**ONGOING**
Work with local authority Housing services in their role as the strategic housing authority to review the needs assessment for older people and homeless groups and establish links with the RSL groups	**ONGOING**
Review Housing Contribution Statement as a single document across the HSCP	**ONGOING**
Delivery of Housing with Care development within Clackmannanshire locality – construction phases planned for Autumn 2019 [Primrose Street development]	**ONGOING**

Areas for improvement as at March 2019	Progress
5. The partnership needs to accelerate the progress of locality development. It should provide timely and appropriate opportunities for local communities and professionals to meaningfully engage in locality planning in respect of all care groups.	
Health and social care staff moving to co-locate with primary care in the rural area of Stirling as part of the model of neighbourhood care	**COMPLETE**
Locality manager posts have been filled – final shape of snr management structure dependent on hosted services	**ONGOING**
Strategic Planning Group meeting during workshop sessions to plan the Strategic Plan priorities in locality groupings	**COMPLETE**
Engagement took place to align with Strategic Commissioning Plan 2019-2022 timeline which will focus on what matters to localities/communities	**COMPLETE**
Engagement with local communities as part of model of neighbourhood care and housing with care development	**ONGOING**
Approval of Strategic Commissioning Plan 2019-2022 with view to develop Locality Plans thereafter	**COMPLETE**
The Neighbourhood Care Team has developed a Community Reference Group – comprising of local people; third sector and Community council reps. This group has a focus on discussion of care issues locally and the keeping well approach.	**ONGOING**
Neighbourhood Care Team has a Resource Worker post which helps connect formal services and informal supports	**COMPLETE**
6. The partnership needs to demonstrate sufficient care at home capacity through the care at home review to sustain new models of care. There should be equity of access to care at home, respite and long-stay care home provision allowing people to remain in their local communities.	
Model of neighbourhood care for Rural Stirling to support sustainable care at home provision in this area – integrated community based teams, working in and with communities and including volunteering and informal supports	**ONGOING**
Evaluation of model of neighbourhood care will support further implementation in other localities/communities	**ONGOING**
Commissioning plan for Partnership to be agreed and implemented for Care at Home	**ONGOING**
Working group reviewing access and approach for Respite Care in support of Unpaid Carers	**ONGOING**
Development of pathways to support people who are unwell or require additional short term support at home as an alternative to crisis admission to care homes	**ONGOING**
Commissioning teams working with care homes to support improvement activities and monitor performance.	**ONGOING**
Development of Strategic Commissioning Plan 2019-2022 will focus on outcomes of localities	**COMPLETE**
Work with Third Sector colleagues in supporting communities to self-manage and provide meaningful support	**ONGOING**
Transforming Care Board to be established with programme focus on Care at Home commissioning and model of care	**ONGOING**
Short Breaks Statement developed as part of the Carers Implementation Group. The development of approaches for short breaks will be delivered in partnership with unpaid carer representatives.	**COMPLETE**

A meeting was held with the Strategic Inspection team and Care Inspectorate Link Inspectors on 1 February 2019 to finalise the action plan for improvement from the Strategic Inspection report. **This marked the finalisation of the inspection process**, and progress will continue to be monitored by the Link Inspectors to ensure adherence to areas for improvement.

Registered services owned by the Partnership are inspected annually by the Care Inspectorate, there were 6 services inspected during 2018/19. Additional information and full detail on inspections can be found at the Care Inspectorates website www.careinspectorate.com.

The Care Inspectorate introduced a new approach to inspecting the quality of care and support in care homes for older people in July 2018. However some services were inspected using the previous approach against the four Quality Themes. Since 1 April 2018, the new Health and Social Care Standards have been used across Scotland. The Care Inspectorate's expectation is that they will be used in planning, commissioning, assessment, and delivering care and support. In response to these new standards in July 2018, the Care Inspectorate introduced a new framework for inspections of care homes for older people and have been using this framework on our inspections.

Unit	Date Inspection Completed	Quality Theme Care Grades (out of 6)				Number of recomm-endations	Number of require-ments	Areas for Improve-ment
		Care and Support	Environment	Staffing	Management & Leadership			
OLD FRAMEWORK								
Allan Lodge	25/7/18	Very Good	N/A	N/A	Good	0	0	2
Clacks Reablement and TEC Service	23/1/19	Very Good	N/A	N/A	Very Good	0	0	1
Stirling Reablement and TEC service	22/2/19	Very Good	N/A	N/A	Good	2	0	0

NEW FRAMEWORK									
Unit	Date Inspection Completed	How well do we support people's wellbeing?	How well is our care and support planned?	How good is our leadership?	How good is our staff team?	How good is our setting?	Recomm-endations	Require-ments	Areas for improvement
Ludgate House Resource Centre	24/1/19	Very Good	Very Good	N/A	N/A	N/A	0	0	1
Menstrie House	9/11/18	Good	Good	Good	Good	Good	0	0	12
Strathendrick Care Home	5/11/18	Very Good	Very Good	N/A	N/A	N/A	0	0	0

Source Care Inspectorate

Rec - A recommendation sets out actions that a provider should take to improve or develop service quality, but where failure to do so would not directly result in enforcement.

Req - A requirement sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in statutory requirements. Requirements are enforceable in law.

Inspection Requirements, Recommendations, and Areas For Improvement

Unit	Action
Allan Lodge	
Area For Improvement - Assessment and support planning must improve to support the staff in effectively assessing people's needs, lifestyles and outcomes. Last year we recommended that the level of assessment and evaluation develop.	Allan Lodge Care Plan Audit documentation to be updated to ensure that support plans detail people's choices and evidences that their needs are being met. Audit activity to include an evaluation process which clearly establishes the effectiveness of the care being delivered to service users. **Action complete**
Area For Improvement - Embedding quality assurance and improvement processes should support Allan Lodge in continuing to offer people a high quality supportive service when they join the integrated teams in Bellfield centre this November.	Quality assurance processes and documentation being revised and updated in preparation for Allan Lodge moving to the new intermediate care facility at the Bellfield Service towards the end of 2018. **Action complete.**
Clackmannanshire Reablement and TEC Service	
Area For Improvement –Staff described responding to more people with mental health support needs. Mental health first aid/learning was not consistently available. So that staff feel competent and more confident, there should be regular learning opportunities in this area. We met with several staff and they all very much enjoyed their work and were committed to providing high quality care and support. When we asked them what could be better about the service, they all described the financial challenges faced by the council and how this had been a strain. Temporary contracts and limited recruitment had meant less staff had been available so the reablement service had reduced in size. The TEC staff were also affected when experienced staff left for permanent jobs. The week we visited, the service had been told that they could recruit new staff and the whole team were delighted. We were pleased to hear that the service manager is due to attend the next staff meeting which means that the management and staff can more formally discuss resources and the development of the service. Developments in these areas will support the service in meeting the increasingly complex needs of those using services	A consultation is currently taking place with staff to ascertain the specific areas of mental health they feel they would benefit from training in. This is in the form of a short questionnaire and the results will be collated once these are returned. Discussion will then take place with SSLD to identify training opportunities to meet this need. Staff have been encouraged to complete "Managing Stress" course on Social Care TV. Training Matrix has been expanded to include Supervision, PRD and Observations of Practice to allow the service to see more easily when this has taken place. The manager raised some observation at the recent Social Services Learning and Development Meeting in relation to Supervision and PRD Proformas, these will be passed to a group who are working on these. **Action by: October 2019 – work is being progressed with the actions on target by the completion date.**
Stirling Reablement and TEC Housing Support Service	
Recommendation In order to ensure that people consistently receive a personalised care service that focuses on enablement (service aims and objectives), the provider should review the service structure including staff's roles and remit. A review of the core training requirements of staff should be undertaken in line with the provider's policy and the organisational development team. Learning opportunities should be developed to meet the needs of the staff team and those people using the service. This is in order to ensure that care and support is consistent with the Health and Social Care Standards.	Will work with Adult Assessment and the HSCP to look at developing the service further by care at home staff being the lead with the reablement and other care at home services assessments and reviews for the Reablement and TEC service. This will give more autonomy and flexibility to staff and the service. Staff are innovative but need the autonomy to be able to put this into practice. **Action by March 2020** A review of core training will be conducted involving corporate learning and development to ensure staff have the confidences in this changing environment. The new neighbourhood team will be a great opportunity to move forward with learning needs to ensure the workforce is fit for purpose also once the review of provisions has been completed this will assist with learning needs and a full training needs analysis can be conducted. **Action by August 2019**

Unit	Action
Ludgate House Resource Centre	
Area For Improvement - The service encouraged relatives to visit and we heard that many people went out with their relatives for the day. Some activities/pastimes were offered to people. Daily provision of meaningful activity needs to be put in place to replace what was previously offered in the day service that is no longer operating. This is important in particular for people who are awaiting a care home placement and may be living in the service for a number of months. Without structure to their day, or social interaction, people are at risk of low mood.	The senior team are currently working with the respite staff to develop the care planning around meaningful activity in particular for people who are awaiting a care home placement to be able to evidence more clearly daily meaningful activities or pastimes that take place in Ludgate. There has been an offer from a relative to provide some musical entertainment once a month for people using the service, we are in the process of arranging this. Learning sessions are being arranged for the senior team with colleagues from other areas of the Health and Social Care Partnership. The dependency tool we have in place is also being developed to be able to identify the time staff spend with individuals as in 1.25 of the health and social care standards "I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities both indoors and outdoors." **Action complete August 2019.**
Menstrie House Care Home	
Area for Improvement - We did not see in some instances required consents being obtained if a person was unable to agree to a course of action due to their incapacity to make decisions. This mainly related to methods of restraint such as bed rails or monitoring of movement being used, for example door and mat sensors. The service should obtain the consent of the welfare appointee in these circumstances.	Consent/POA Involvement (where required). POA certificates to be added to residents care plan (where required). **Action complete May 2019**
We heard that when the activity staff member was absent, residents did not appear to have continuing meaningful structure to their day. We also heard that not all staff felt this was part of their duties, or that staff had time to spend with people out with their care tasks. The service should ensure that all staff demonstrate willingness and participation in this area, and in particular, evidence a structured programme when the activity staff member is absent.	Develop unit activity record plan for residents' activities. **Action complete May 2019**
In order to maintain and promote dignity and independence for people, the service should undertake thorough continence assessments and review regularly when the needs of people change. It should be demonstrated how continence is promoted, including how people are orientated within the environment using dementia friendly signage and contrasting toilet equipment where possible.	Promotion of continence assessment/review. Care plans to evidence continence promotion. Actions ongoing to promote continence, use of dementia friendly signage and contrasting toiled equipment for people's individual needs. **Action complete May 2019**
Unit	Action
Menstrie House continued	
Area For Improvement - Record keeping should routinely demonstrate that both the care and physical safety of people have been met, in particular for people who cannot summon assistance.	Improve detail of recording of care delivered to residents being cared for in bed at the time of the event. **Action complete** Anticipatory Care Plan (ACP) to be evident in all files in event of unexpected decline in health. **Action ongoing**
Area For Improvement - The audits could be strengthened by undertaking observations of staff practice in a variety of areas, this could include the delivery of personal care, meal times and how people are assisted with their mobility or medication. This is an opportunity to confirm and evidence staff competency, highlight if additional training is identified and also to discuss and reflect on practice during supervision.	Include in the audit schedule: • Plan observations of staff competencies and practice records. • Personal Care • Meals Continue current audit process for medication, care plans and accidents. **Action complete January 2019**
Area For Improvement - We were not able to see how the views of people living in the home were gathered if they did not attend meetings, or if people needed additional support from either advocacy or welfare appointee to express their views. The service should consider linking the Health and Social Care Standards to their audits and subsequent	Develop methods to gather views of people living in the home on their care/support/choice. Schedule more regular meetings for residents and relatives through forums and surveys.

development plan. Gathering the views of people should take into account a variety of methods if people are unable to attend meetings.	**Action complete June 2019**
Area For Improvement - As part of the audit process relating to staffing levels and demonstrating whether current numbers meet the needs of people, the views of staff, relatives and residents should also be undertaken alongside observations to include staff practice and presence. (Reference is also made under 'How good is our staff team').	Network with other care homes to look at how the dependency tool is scored and reviewed. Develop the existing tools to include all needs. **Action complete April 2019**
Area For Improvement - We were unable to see from information provided to us, how staffing levels were calculated based on the needs of residents. This was also not undertaken each month as required that would take into account the fluctuating needs of people. The service should endeavour to improve on how the current needs of people are gathered and effectively demonstrate how the staff numbers meet these.	Explore new models of dependency scoring to ensure effective staffing numbers meet the needs of the residents. **Action complete April 2019**
Area For Improvement - We previously recommended that cleaning records should indicate the frequency of cleaning tasks and demonstrate when deep cleaning has been undertaken in line with infection control procedures. We did not see the improvements we expected and we have therefore asked the service progress with this without further delay.	Meet domestic staff / supervisor to plan / review deep clean / infection control procedures. Cleaning records to indicate frequency of infection controls measures / cleaning schedules. Ensure the environment is clean and tidy, has well maintained furniture and equipment. **Action complete November 2018**
Are For Improvement - The service must ensure that all supporting, statutory maintenance documentation is kept within the home and made available and in addition, if there are changes in contractors for any statutory maintenance, this should be immediate and ongoing without gaps or delays in the maintenance programme. This ensures that the health and safety of residents is paramount in line with legislation.	Maintenance documentation should be available in the home and not held centrally by council property services department. Ensures Health and Safety is paramount in the home Property Service / Maintenance certificates evidences inspection programmes carried out. These certificates must remain in the home in easy to an access file. **Action complete November 2018**
Area For Improvement - We did not see information recorded on how care would be delivered should someone's health deteriorate. Anticipatory care planning should be discussed with all relevant parties and recorded to ensure end of life care meets the needs and wishes of people. This ensures that in the event of an unexpected decline in health, there is a plan in place to address this.	Improve detail of recording of care delivered to residents being cared for in bed at the time of the event. Anticipatory Care Plan (ACP) to be in place in event of unexpected decline in health. ACP to be in place in event of unexpected decline in health. **Action complete May 2019**
Area For Improvement - From the sample of care plans we looked at, it was not evidenced in some instances, who held welfare powers for an individual, although named appointed persons were recorded in the file. It is important that a legal framework regarding welfare decisions is clearly evidenced to ensure people's wishes and choices are being made by the legally appointed person. In addition, we did not see meaningful views of residents or appointed persons being recorded for the six monthly reviews for those who were unable to have input. A focus should also be made regarding forward planning and how this improves quality of life for people.	Consent/POA Involvement (where required). POA certificates to be added to residents care plan (where required). **Action complete May 2019**
Source Care Inspectorate	

5 Next Steps

This Annual Performance Report highlights the range of activity taking place within and between services as part of the Transforming Care programme. The focus of the activity in this third year has been to jointly work on the actions the Partnership can take together to strengthen and develop the building blocks for community based services.

- Work has been taking place to **delegate further services from NHS** Forth Valley over 2019/2020.

- Development of a **Programme Board** arrangement to oversee the Transforming Care Programme. This will ensure that projects developed in support of the Strategic Commissioning Plan are effectively monitored and are efficient.

- We will continue to work with others including housing services **to develop opportunities for people such as 'housing with care'** in local communities as scoped out within the Strategic Needs Assessment supporting the Housing Contribution Statements.

- We will continue to develop our services and whole systems approaches to support people to be **discharged timeously from hospital** and to develop our early intervention approaches including the avoidance of unnecessary admission to hospital through, for example, the more recent iHub supported **Frailty** work across Forth Valley.

- We are currently working on a refresh of our approach to Self- directed Support and will continue to work to embed a culture of services which **promote an enabling approach** and help us to better manage the available resources in an equitable, transparent manner.

- Over the next year we will develop performance monitoring for the **Strategic Plan 2019 – 2022**.

- We will review or develop the following key strategic plans:
  - Participation & Engagement Strategy
  - Shared Commissioning Strategy
  - Mental Health Plan
  - Mid-term Financial Plan
  - Forth Valley Dementia Strategy Implementation Plan
  - Intermediate Care Strategy

- **The model of neighbourhood care has the capacity to be implemented across localities.** It fits the strategic plan ambition of place based, focus on informal supports and unpaid carers. This needs to be done in collaboration with GP clusters.

- There is a requirement to **replace both user management systems** currently used within both Clackmannanshire and Stirling's social care services. This needs to reflect the needs of health and social care, and provide opportunities via cloud hosting for remote working and appropriate data sharing. In order to progress this, a programme board has been established.

- It is anticipated that there will be significant change in TEC over the next 5 years, as technologies **shift from analogue to digital.** This provides the Partnership with significant opportunities to transform service provision, but requires to be

carried out within an appropriate financial framework.

- An **Equalities Mainstreaming** Report should be carried out during 2019/20.
- Complete a review of commissioned services to support **unpaid carers**.
- A **review of the progress of integration** of health and social care has been taken forward, led by the Ministerial Strategic Group and Convention of Scottish Local Authorities. The findings of this review were published in February 2019, with a series of proposals for all Integration Joint Boards, to act upon collaboratively with constituent and national improvement bodies.
- Roll out of the iMatters **staff survey** for all HSCP staff. This went live in June 2019.
- The partnership is working with all three constituent bodies in preparation of **business continuity arrangements** for Brexit. This is a fluid situation and the partnership is working to guidance from the Scottish Government's resilience arrangements via East of Scotland Regional Resilience Partnership.

6. Glossary, Abbreviations, and Useful Web Links

Accident & Emergency (A&E) Services	Emergency Departments (Forth Valley Royal Hospital Larbert); Minor Injury Units (Stirling Community Hospital), community A&Es or community casualty departments that are GP or nurse led. See also Emergency Department (ED).
Acute services	A branch of 'secondary' health care where a patient receives short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery.
Admission	Admission to a hospital bed in the same NHS hospital following an attendance at an Emergency Department service.
Admission rate	The standardised figure representing the number of admissions attributed to a group or region divided by the number of people in that group (the population).
ADP	Alcohol and Drug Partnership http://forthvalleyadp.org.uk/
AHP	Allied Health Professionals are a range of professionals who provide preventative interventions. They can include; Dietitian, Occupational therapist, Physiotherapist, etc. More information can be found in this link http://www.gov.scot/Topics/Health/NHS-Workforce/Allied-Health-Professionals.
ASP	Adult Support and Protection
Anticipatory Care Plan (ACP)	For individuals, particularly those with long term conditions, to plan ahead and understand their health to help have more control and to manage any changes in their health and wellbeing. It's about knowing how to use services better, helping people make choices about their future care.
Attendance	The presence of a patient in an A&E or ED service seeking medical attention.
Attendance rate	The number of attendances attributed to a group or region divided by the number of residents in that group (the population).
Balance of Care	Shifting the Balance of Care describes changes at different levels across health and care systems, all of which are intended to bring about better health outcomes for people, provide services which reduce health inequalities, promote independence and are quicker, more personal and closer to home.
Benchmark	A benchmark is a standard or point of reference against which other things can be compared.
CAB	Citizens Advice Bureau
Census	An agreed date to take a snapshot count to measure agreed information e.g. Annual Care Home Census on 31 March and the monthly Delayed Discharge Census on the last Thursday of every month.
CCHC	Clackmannanshire Community Health Care Centre
Circa	Means about or approximately.
Code 9	This is a very limited category for measuring reasons for delayed discharge from hospital where it has not been possible to secure a patient's safe, timely and appropriate discharge.
Comparator	A group of Partnerships who share agreed similarities. The group is then used to compare performance against. Comparator Partnerships are; Angus, East Lothian, Moray, Perth & Kinross, Falkirk, South Ayrshire.
CPP	Community Planning Partnership (Stirling), Clackmannanshire's CPP is called the Alliance.
COPD	Chronic obstructive pulmonary disease (lung disease).
Delayed Discharge	A delayed discharge is experienced by a hospital inpatient who is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons.
Discharge to Assess	'Discharge to Assess' approach supporting people to leave hospital, when safe and appropriate to do so, and continuing their longer term care and assessment out of hospital.
Emergency Department (ED)	The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. 4 hour wait standard - is that new and unplanned return attendances at an ED service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care.
Enablers	These are people or things that help to make something happen.
GP Cluster	A grouping of GP practices who work together to discuss the quality of care provided to patients in the locality. Each GP cluster will have a GP designated as a Cluster Quality Lead who will have a coordinating role within the cluster.
GP Fellows	A trial project which aims to develop the skills and experience of recently qualified GPs in caring for older people. The doctors, known as GP Fellows, will provide support to a number of local GP Practices, develop strong links with staff in community hospitals and assess patients referred to the Frailty Unit at Forth Valley Royal Hospital.
Health and Social Care Integration	Integrating health and social care services has been a key government policy for many years. What Is Integration? - short guide Clackmannanshire and Stirling Health & Social Care web page
High Health Gain	The term used for the group of people who collectively account for 50% of the total health expenditure of their local area during the financial year.

Holistic	A holistic approach looks at the "whole" person, not just individual parts.
ICF	Integrated Care Fund. Additional resources available to health and social care partnerships to support delivery of improved outcomes from integration help drive the shift towards prevention and tackling inequalities. http://www.gov.scot/Resource/0046/00460952.pdf
iHub	Healthcare Improvement Scotland's Improvement Hub (iHub), supports health and social care organisations to redesign and continuously improve services. https://ihub.scot/about/who-we-are/
IS0 9001	Internationally recognized Quality Management System (QMS) standard. Designed to be a powerful business improvement tool, to continually improve, streamline operations and reduce costs.
In Scope	Services that are delegated to the Partnership Integration Scheme
Integration Joint Board (IJB)	A legal body established under the Public Bodies (Joint Working) (Scotland) Act 2014. The Parties to our IJB are Clackmannanshire and Stirling Councils and NHS Forth Valley. The Parties agreed the Integration Scheme for our Health and Social Care Partnership, which sets out the delegation of functions by the Parties to the IJB.
Intermediate Care/STA	An umbrella term used to describe services which provide a bridge between health and social care with the aim of supporting people to live in their own homes, or in a homely setting, reducing dependence on acute hospital facilities.
iMatter	A staff experience continuous improvement tool http://www.staffgovernance.scot.nhs.uk/monitoring-employee-experience/imatter/
ISD	The Information Services Division (ISD) is a division of National Services Scotland, part of NHS Scotland and provides health information, statistical services and advice to support the NHS in progressing quality planning and improvement in health and care. http://www.isdscotland.org/
LDP	Local Delivery Plan standards for NHS http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/NHS-Performance-Targets
Locality Planning	A locality is defined in legislation as a smaller area within the borders of an Integration Authority – their purpose is to provide an organisational mechanism for local leadership of service planning.
LSI	Large Scale Enquiry – Adult support and protection
MECS	Mobile Emergency Care Service https://www.clacks.gov.uk/social/mecs/ https://my.stirling.gov.uk/services/housing/adapting-homes/telecare
MSG	Ministerial Strategic Group for Health and Community Care agreed an initial framework for measuring progress against national priorities. http://www.gov.scot/Publications/2016/03/4544/5
Naloxone	Medication used to block the effects of opioids, especially in overdose.
NI	National Indicator. In this case, the suite of National Core Integration Indicators set by the Scottish Government to help measure performance. http://www.gov.scot/Resource/0047/00473516.pdf
Palliative Care	For people with an illness that can't be cured, palliative care makes them as comfortable as possible, by managing pain and other distressing symptoms. It also involves psychological, social and spiritual support for the person and their family or carers.
Primary Care	The first point of contact for health care for most people, mainly provided by GPs (general practitioners) but community pharmacists, opticians and dentists are also primary healthcare providers.
RAG	Is a quick visual way of identifying areas or concern or progress that is good, not so good, or poor. It refers to the use of colours Red Amber Green.
Reablement	Services for people with poor physical or mental health to help them accommodate their illness, by learning or re-learning the skills necessary for daily living.
Readmission	This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay.
SAS	Scottish Ambulance Service
Self Directed Support (SDS)	This gives people choice and control over their individual budget which helps to buy services, such as help with dressing and personal care, to help meet agreed health and social care outcomes. http://www.audit-scotland.gov.uk/uploads/docs/report/2017/nr_170824_self_directed_support_summary.pdf
SIMD	Scottish Index of Multiple Deprivation - The area based measurement of multiple deprivation ranking areas. http://www.gov.scot/Topics/Statistics/SIMD
SSSC	The Scottish Social Services Council (SSSC) is the regulator for the social service workforce in Scotland.
Technology Enabled Care (TEC)	Technologies which have the potential to transform the way people engage in and control their own healthcare, empowering them to manage it in a way that is right for them.
Telecare	Telecare is technology to help people to stay living independently at home for longer.
Third Sector	An umbrella term for a range of organisations belonging to neither the public nor private sectors (e.g. voluntary sector or non-profit organisations). http://ctsi.org.uk/
Transformation Care Fund	Primary Care Transformation Fund - allocated over three years to GP practices to prototype the new vision for the GP contract, including those wishing to use new ways of working to address current demand. This work will inform the design of primary care in the future. https://news.gov.scot/news/primary-care-investment
Unscheduled Care	NHS care which is not planned in advance, or is unavoidably out with the core working period of NHS.
Website	Clackmannanshire & Stirling HSCP https://clacksandstirlinghscp.org/

If you need help or this information supplied in an alternative format please call 01786 404040.

Web: clacksandstirlinghscp.org

Clackmannanshire & Stirling Health & Social Care Partnership

Clackmannanshire Council

Stirling Council

NHS Forth Valley

STIRLING COMMUNITY PLANNING PARTNERSHIP

Clackmannanshire Alliance
Clackmannanshire Alcohol & Drug Partnership

Forth Valley Alcohol & Drug Partnership