Clackmannanshire & Stirling Health & Social Care Partnership Annual Performance Report 2017 – 2018

“Our vision is to enable people in Clackmannanshire and Stirling to live full and positive lives in supportive communities”.

Clackmannanshire Council

Stirling Council

NHS Forth Valley

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Our Second Year

Message from the Chair

Welcome to our second 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 Clinicians and 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.

I would also like to thank the members of the Integration Joint Board for their contributions during the year and in particular Councillor Scott Farmer for his chairmanship of the Board over the last year.

I am pleased that we are able to provide so many examples of effective joint working in this report. There is much to be proud of but we know that we still 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. I hope that this report will give you a welcome insight into the wide range of excellent work already taking place across our services and communities.

John Ford, IJB Chair

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.

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. Some of our key achievements over this year include:

- ✓ Delivering a range of intermediate care bed based and care at home health and social care services
- ✓ Engaging our workforce, stakeholders and communities in service transformation and redesign, including preparation for the opening of the Stirling Health and Care Village
- ✓ Continuing to reduce delays in discharge from hospital
- ✓ Supporting primary care services to develop their services in local clusters
- ✓ Achieving our Technology Enabled Care Programme objectives with 1,226 new users of telecare over a 2 year period
- ✓ 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

To help drive improvement and change, the Joint Management Team is reviewing its performance reporting and data to achieve a more consistent approach to the gathering and reporting of performance.

We have been working in partnership with organisations such as Healthcare Improvement Scotland's Improvement Hub [iHub], the Scottish Health Council and Glasgow Caledonian University to explore and develop how we work together to prioritise our resources and to improve the experiences of people who are in receipt of services.

We are undertaking a range of reviews of services to ensure they offer best value in terms of both effectiveness and are efficient 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.

At a wider Partnership level we are involved with the emerging regional planning for health and social care services.

This report tells us that we have maintained an **overall 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 increasingly complex needs of the people who require care and support and a challenging financial environment.

Towards the end of 17/18 the Partnership engaged in a Strategic Inspection which looked at how well we are planning and delivering our services. This inspection was carried out by the Care Inspectorate and Healthcare Improvement Scotland. We await the report from the Inspection which is due in early Autumn 2018.

Models of Neighbourhood Care approach in Stirling has taken a ground up approach to developing a community based service, with the development work supported by a community reference group.

Finally, I would also like to take the opportunity to thank the Chair of the Integration Joint Board during 2017/2018, Councillor Scott Farmer, the Vice Chair John Ford and the members of the Integration Joint Board for their work and support over this year.

Further thanks also 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.

We look forward to 2018/19 and the next year of our journey towards greater integration of services.

Shiona Strachan, 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 12 voting members: 6 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 7 non voting members, including representatives from service user, patient and unpaid carer groups and from 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 carers.

Our Strategic Plan and Partnership Priorities

The Strategic Plan [2016-2019] established the Partnership vision and outlined the local and national outcomes [the basis for the performance framework], a high level approach to locality planning and the eight local priorities. Work is ongoing through 18/19 to review and update the Strategic Plan.

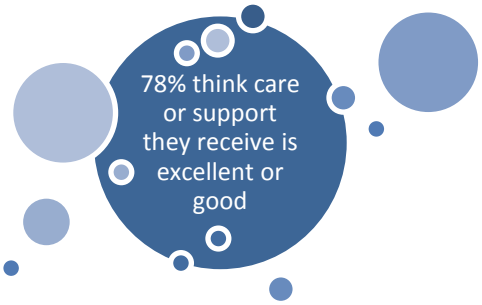
The high level priorities, expressed as a series of ***'we will'*** statements, in the Strategic Plan are –

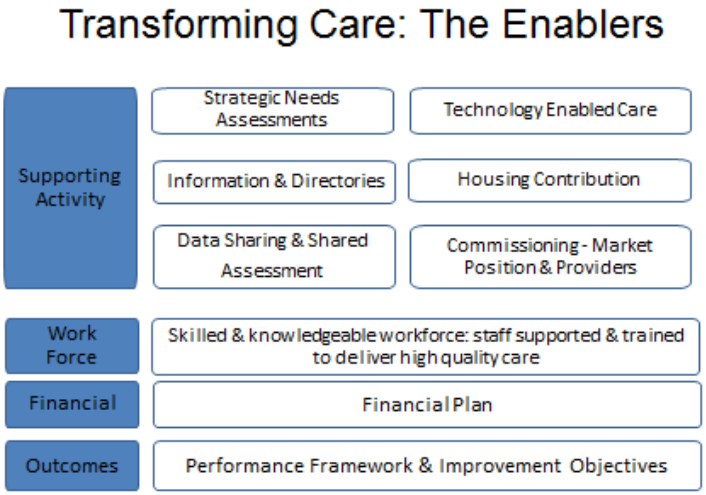
- Further develop systems to enable front line staff to access and share information
- Support more co location of staff from across professions and organisations
- Develop single care pathways
- Further develop anticipatory and planned care services
- Provide more single points of entry to services
- 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

The Partnership Annual Audit Report (Audit Scotland), published in September 2017, highlighted:

- **IJB open and transparent in the way it conducts business – public can attend meetings and access agendas and meeting papers**
- **The IJB has appropriate governance arrangements in place that support scrutiny of the Board.**

The following diagrams represent the core Partnership delivery priorities for 2017-2019 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 development and delivery of the priorities.

Planning Localities

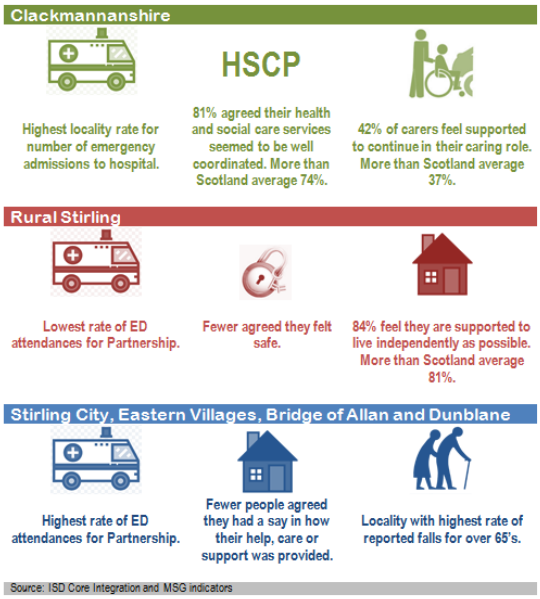
The Strategic Plan identified the planning localities for the Health and Social Care Partnership.

The population of the Partnership area is estimated at 142,770, with 64% of the population residing in Stirling and 36% in Clackmannanshire. The age profile of the population is similar to that of Scotland as a whole - with growing numbers of older people.

Locality profiles were established in 2016 and work is ongoing at a local level to develop the data for the 3 designated localities within the Partnership.

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.

The Strategic Planning Group oversees locality performance and planning and this will develop over 18/19.



Clackmannanshire Locality

- The rate of unplanned admission and readmission to hospital are highest in the Partnership, and attendance at ED is forecast to rise.
- Satisfaction around coordination of services and support to Carers.
- Clackmannanshire has some of the most deprived areas in Scotland with associated health challenges. Life expectancy is lower for a wide range of the population, especially females.
- Locality Workstream - as a Partnership we have strong investment in the development and delivery of bed based and care at home (reablement) services, which support people in their recovery from ill health, and are key to the Partnership's approach to supporting effective discharge from hospital and preventing readmission.

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

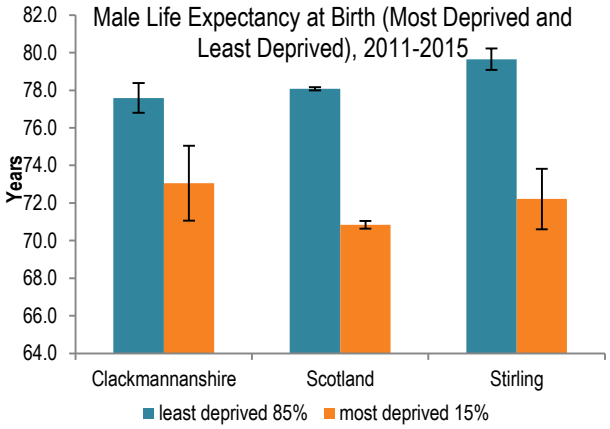
- Rising trend of attendances at ED and hospital admissions, with highest rate of reported falls.
- Locality with the highest density and number of individuals in Partnership.
- Lowest for those who felt they had a say in how their help, care or support was provided.

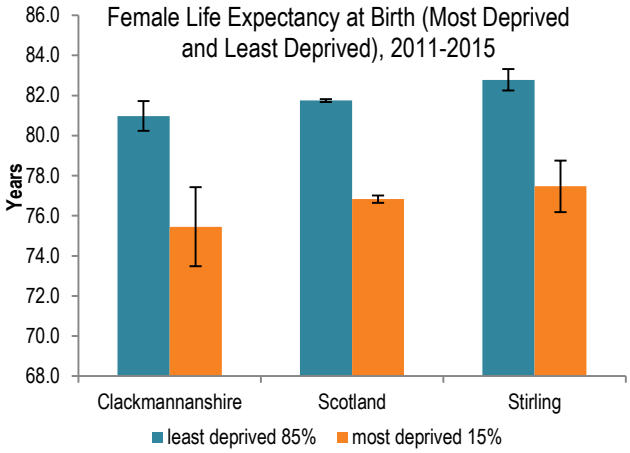
- Stirling has areas of marked contrast in terms of inequalities with some of the least deprived areas in Scotland sitting alongside some of the most deprived.
- In more deprived areas of the City and eastern villages, levels of heart disease, cancer, stroke, emergency admissions and other conditions are much higher than other areas in Stirling.
- Locality Workstream - we are currently working with iHub to further develop our integrated model of care to support people accessing the Stirling Health and Care Village and in particular the services which will be 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 Stirling's 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.
- Fewer people feel safe.
- 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 within the Stirling Rural locality will see the operational development of place based services through a Locality planning agenda. Changing the way services are delivered to suit the needs identified within a locality and ensure a better fit.

Inequalities



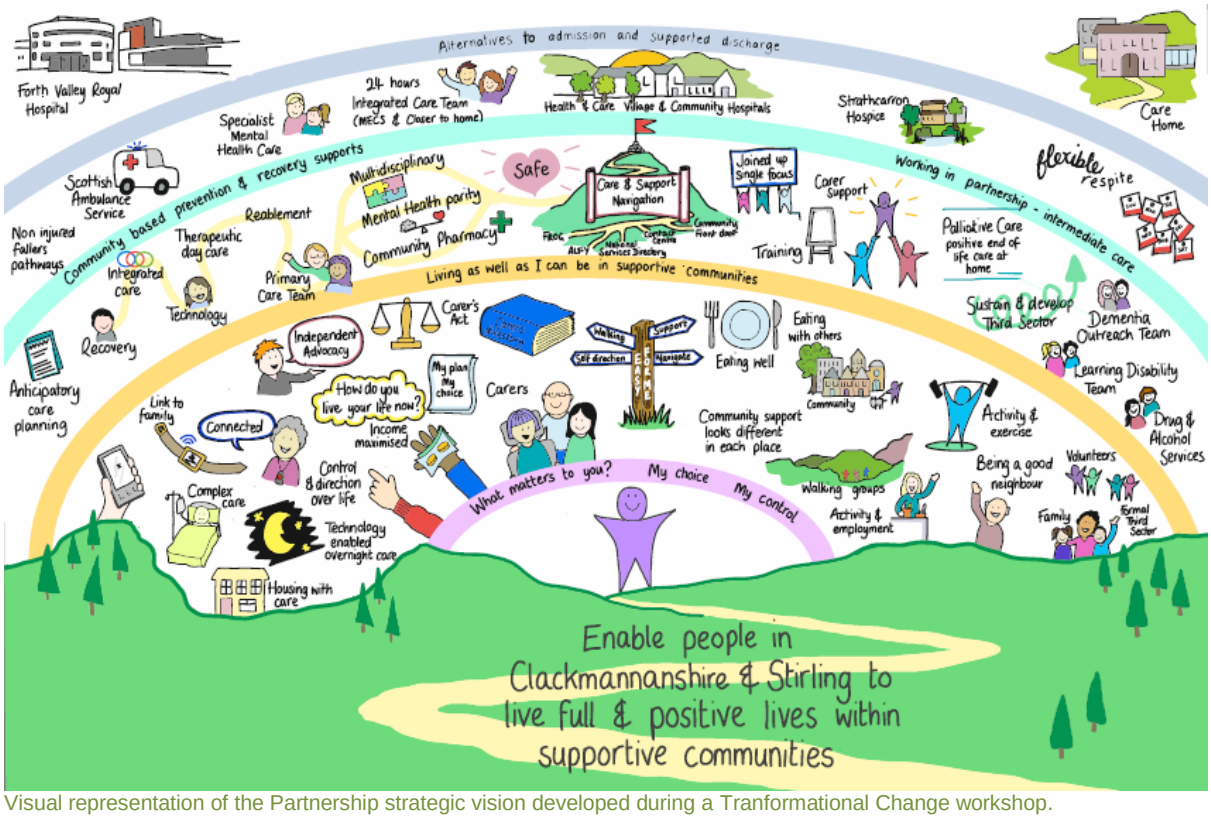


NHS Forth Valley Keepwell Service

Aims to increase the rate of health improvement, particularly those identified as being most at risk of preventable ill health and least likely to access services early. This is achieved by providing effective therapeutic engagement, goal setting and individual support which deliver on improved outcomes.

Over the 17/18 period 1,674 full assessments were completed and 2000 follow up appointments were delivered within the Partnership. Most of the people who attended for health assessments and support, live in areas of relative poverty or were identified as being at risk of preventable ill-health due to social or cultural inequalities e.g. 1 in 9 were carers, 10 were homeless and 15 were attending addiction services.

2. Transforming Care: Core Delivery Priorities 2017/19



Visual representation of the Partnership strategic vision developed during a Tranformational Change workshop.

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

Models of Neighbourhood Care

The community of the rural south west of Stirling have identified the care of older people as a priority. We have been working together to develop a new and innovative model of neighbourhood care based on the Buurtzorg principles (person centred, staff autonomy and admission avoidance). This will **change the way health & social care services are provided in the locality**. The multi disciplinary, place based services are scheduled to commence during 2018.

Staff engagements sessions have been taking place with key staff and have been facilitated by Scottish Social Services Council & Organisational Development.

The pilot team will consist of staff currently delivering reablement, adult social care and nursing.

The success and impact of the pilot will be measured using an approach that focuses on the following outcomes:

- Peoples' needs are met by the right person, first time, every time.
- People have improved health and wellbeing.
- People live at home independently for as long as possible with the right level of support.
- Staff are valued, motivated and empowered.

Learning Disability & Mental Health

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

Work is ongoing to redesign the community services provided across Clackmannanshire and Stirling 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.

In addition there are other enabling activities ongoing, including development of an information resource to improve post diagnostic support for Autistic Spectrum Disorders.

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

We have carried out positive work in areas such as mental health and dementia services, including the development of post diagnostic support and supporting communities to become Dementia friendly.

Our redesign of dementia services is in line with Scotland's national Dementia Strategy [2017-20]. We are working together to ensure **more effective pathways** across Forth Valley for people with dementia supporting **access to the right support at the right time**.

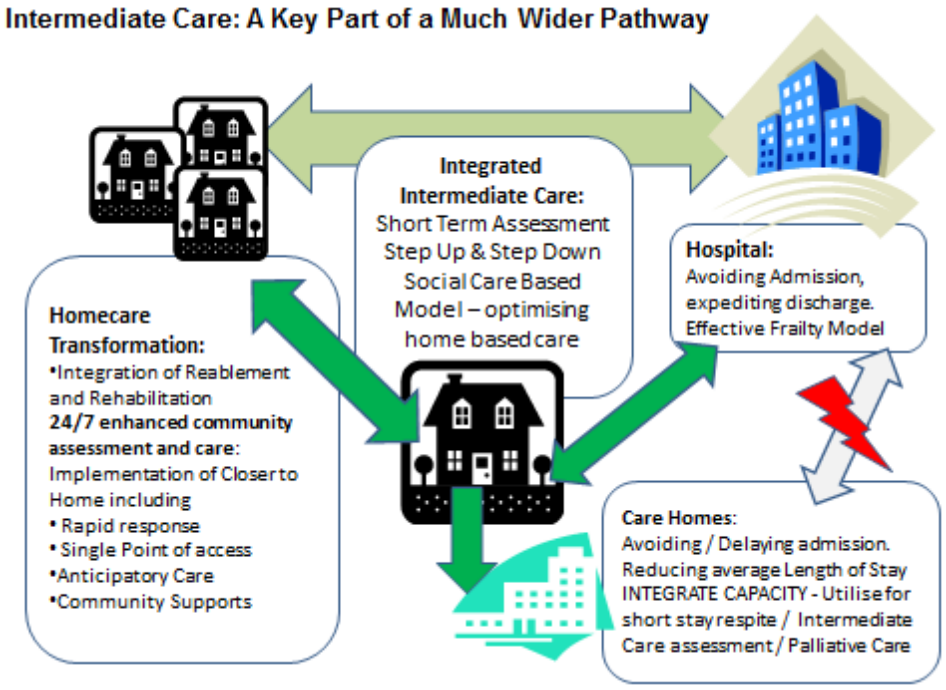
This is part of a wider requirement to look at appropriate supports for people with dementia and reflects the success of local dementia friendly communities work across the Partnership, offering a range of community based approaches with clear links to unpaid carers.

Post-diagnostic dementia training was delivered in partnership by Carer Centre,NHS FV, and Alzheimer Scotland

82% agree they are supported to live independently

Intermediate Care

The Partnership has developed a range of intermediate care services for older people all operating within the national framework.



Work is currently taking place [supported by iHub] to develop our approach to intermediate care both in terms of our bed based models and our reablement care at home models. This work is linked to the Health & Care Village and other services. It will also feed into the Commissioning Strategy development for older peoples services.

The rising trend of the number of care at home hours provided is similar to national trends, and the number of clients is similar to other partnerships. However the number of actual hours is much higher than other similar partnerships. This may be reflecting in some part the 'balance of care' within the Partnership which is above average for the % of the population living in the community with support.

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 is usually provided by a mix of health and social care professionals.

This model is often referred to as reablement. These services help the Partnership to support reduction of bed days lost.

An average of 484 hours of reablement support per week was provided for people living in the community.

Jean's Story - Step Up/Step Down

Jean was referred for a short stay assessment to step down from acute hospital after a period of ill health. Her daughter had expressed that her mother may require long term care.

The Intermediate Care Team:

* Developed an exercise programme
* Supported Jean's personal care
* Provided Jean with confidence building on stairs
* Increased confidence and independence in managing medication

Jean was able to return to her home in the community with a package of homecare, three times daily

The service

* Worked collaboratively with Jean and her daughter, involving them in all aspects of care and support
* Used the skills of all professionals to maximise Jean's potential

Bed Based Intermediate Care

Similar to Intermediate Care at Home, this is a **time limited episode of care currently provided in dedicated care homes** across the Partnership localities. It often provides an **alternative to admission to hospital** [step-up] or to provide further assessment and rehabilitation, following discharge from hospital [step-down].

Clackmannanshire Bed Based Care services celebrated 21 years of gold standard quality management ISO 9001 this year.

A total of 158 people used the Intermediate Care service, a rise on last year.

Approval was granted April 2017 to review the model of service delivery in preparation for the:

- Move into the Bellfield Centre on the Stirling Health and Care Village site by November 2018 with an integrated model of care and support
- Ongoing re-design activity to align teams and services appropriately to maximise outcomes and efficiency

This work will support the **integration of skilled multi-disciplinary teams** across the Partnership, and will support the development of a more integrated community front door to services. This will also align with Models of Neighbourhood Care, Enhanced Care Team services and models of support for Overnight Care.

Over the coming year further work will take place in Clackmannanshire to further develop our bed based integrated care and support services.

The Clackmannanshire locality reduced those service users who were readmitted to hospital from Intermediate Care. From 23% in 16/17 to 8% in 17/18.

Stirling Health & Care Village

Stirling Health and Care Village is a £37m 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 focus for the services which will be delivered from the site is to **support people to live full and positive lives within supportive communities**. For many older people this will mean having appropriate services built around a model of rehabilitation and reablement.

Work is well underway, with the iHub supporting conversations on the service and staffing models required for this new provision, while providing 'critical friend' support on areas including, capacity modelling data collection and third sector involvement.

133 people were discharged from Intermediate Care in 17/18 across Stirling localities.

The site consists of three main purpose-built new facilities – the **Bellfield Centre** which will provide intermediate bed based care; **GP/primary care**, with two Practices moving onto the site from older premises within Stirling; the **Scottish Ambulance** facility, which will replace the existing facility in Riverside; X-ray and Minor Injuries. The existing outpatient facilities will be retained within their current buildings on the wider Stirling Community Hospital site.

A community engagement event was held February 2018, to bring together the local community, third sector and staff across both NHS Forth Valley and the Health and Social Care Partnership and consult on the ways in which the public spaces can be used, the activities they might like to see, and the activities that local organisations might be able to offer.

Considerable work has been carried out in preparation for moving services into the Bellfield Centre to ensure the integration of the workforce for the maximum benefit of service users and their carers. **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**.

A work force group has been established for the Health & Care Village to focus on the development and implementation of the model of care.

Over the past 12 months, a series of workforce engagement events have taken place with a focus on the development of the identity of the Bellfield Centre in delivery of the strategic priorities of the Partnership.

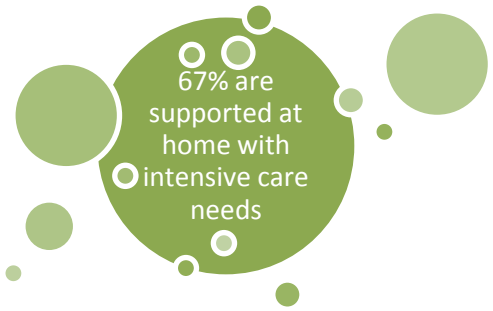
Day Support

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. It is also acknowledged that there is an inconsistent and potentially inequitable access to day supports across the Partnership.

A short life working group was established during 2017, to scope out existing service models and the outcomes being achieved within these services. It identified that there was an on-going need for 4 different types of service provision:

- Specialist Support
- Short Term service based upon rehabilitation and recovery
- Long-term day respite for users and unpaid carers
- Maintenance programmes to support benefits of rehabilitation programmes or to continue with long-term outcomes

Work commenced in February 2018 with Clackmannanshire Third Sector Interface to consider the range and types of services which could support place based, community supports, and a public engagement event took place in May 2018, to further identify how people wish to be supported in their communities. The consultation will carry on throughout summer 2018, to identify the most appropriate supports to reduce isolation and loneliness across Clackmannanshire's older population.



Care Homes

We are one of 8 Partnerships across Scotland who are currently engaged with the Care Inspectorate's improvement initiative, **Care About Physical Activity**. 10 care homes have been very active in adopting the improvement tools and resources promoted.

It was anticipated that participation in this programme would be a positive opportunity to promote transformational change in the way services are delivered to enable people to live successful lives in a care setting.

It is hoped that the programme will also **improve outcomes for people living in care homes** who may otherwise be excluded from community based opportunities.

The impacts noted by local care homes have been significant and incredibly positive. Locally, this has included:-

- Outdoor mobility & exercise groups
- Improved personal care skills
- Greater links with local community groups
- Inter-generational projects with local schools
- Improved communication and self-esteem of residents
- Improved sleeping patterns
- Improved mental health of residents who may have otherwise felt excluded
- Secondary impacts have also been noted such as improved physical activity within staff groups, and communication between care homes and their communities
- Links with Care at Home services

As part of Care About Physical Activity we are working together to develop services. For instance, the Partnership were able to resource Playlist for Life training for all local care homes over 2 learning events. This is an important initiative which **supports the therapeutic care of people living with dementia** through the use of music which is meaningful to them. There has been a commitment to develop a networking group for those services who wish to pursue this further. The Partnership has also sourced end of life care training via MacMillan for all local care homes.

It is hoped that this programme will become sustainable, with the Partnership committing to continuing to work closely with our care homes to build opportunities with groups and communities. This approach will also be rolled out to Care at Home services at a greater scale.

The community nursing support to care homes for two GP practices has already demonstrated significant benefits. This model will be scaled up over this year to provide support over the full week for all of the Clackmannanshire care homes and practices.

87% spend their last 6 months at home or community setting

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 reduction in the number of individuals in the Partnership who accounted for 50% of health expenditure. [1,077 Clackmannanshire and 1,783 in Stirling - 16/17].

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 focus over the last year was our innovation work **"Supporting full and independent lives through innovative technology approaches"**. We have worked with people to get access to equipment that meets their needs.

Within Clackmannanshire Locality, working with the GP practices, 4 new mental health primary care nurses have been recruited, as well as community nursing support to care homes and additional pharmacy sessions. [Baseline data has been collected with 10% of GP appointments found to be for mental health support alone. A further 10% of consultations include a mental health component presented alongside other complaints].

Exploring New Models for General Practice

We have three strands to our Primary Care Transformation Programme:

- Urgent Care GP Out of Hours Transformation. Introduction of 5 Advanced Nurse Practitioner training posts, Paramedic Specialists and improved integration with other over night supports.
- Primary Care Transformation: GPs in practices are working together in clusters, taking a multi-disciplinary approach to care within practice and the community.
- Mental Health in Primary Care: The investment for mental health services includes Mental Health Nurse Practitioner posts and aims to improve access for people with mental health needs to the most appropriate support as quickly as possible, in the most appropriate setting.

We are now working on a comprehensive Primary Care Implementation Plan to support services to deliver within local communities.

Enhanced Community Team

The Enhanced Community Team covers 'Closer To Home' (C2H) and GP Fellows. It aims to support people at home, avoiding preventable hospital attendance and/or admission. The Team provides an urgent response 24 hours a day, 7 days a week, using a dedicated enhanced nursing, Allied Health Professional and carer workforce support people to remain at home during the day and overnight.

At the moment, the team's work falls mainly into these categories:

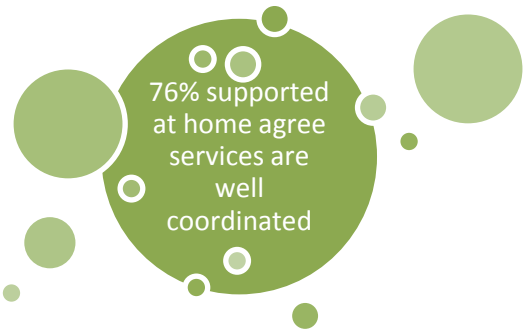
- Assessment of unwell patient (diagnosis has been made but the patient has additional needs or is deteriorating and is at risk of hospital admission)
- Rapid assessment of an uninjured faller
- Discharge facilitation
- Working on "acutely unwell adult" pathway where there is no diagnosis, using the GP fellows to provide the medical input.

Since February 2018, phone referrals to the team have been picked up by Advice Line For You (ALFY). It is very early days but initial improvements are that a **broader range of options are available to the referrer**.

Work with night nursing is ongoing to ensure a more equitable response both in and out of hours.

Social Care within the Partnership have facilitated **direct access to bed based intermediate care 24/7** and Closer To Home have continued to support some patients in this service.

The Closer to Home Team continue to take referrals from Scottish Ambulance Service for unwell, uninjured falls patients as part of a national initiative to **reduce the number of falls patients being conveyed to hospital following a fall**. This is being rolled out further across the Partnership.



Margaret's Story - Closer To Home

Margaret had recently been in hospital following treatment for an infection. She had a number of other conditions which left her vulnerable to further admission, but had expressed a wish to avoid a return to hospital. When she developed a cough and further signs of infection, she was visited by the Closer To Home Team who were able to provide her with appropriate medication as well as an oxygen concentrator.

Heath Care Support Workers visited Margaret for a short period and a Telecare [MECS] alarm was installed. Margaret was discharged from the Closer to Home service after 7 days.

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

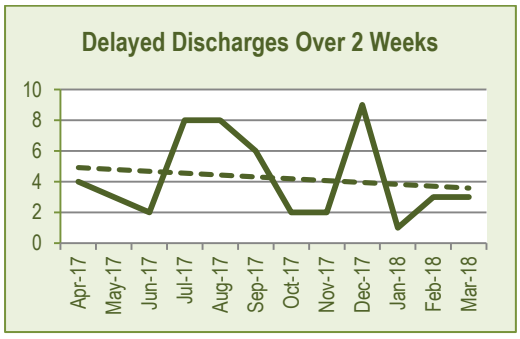
In 17/18 we spent 22% of our budget on emergency hospital stays

Delayed Discharge

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

This work is supported by the Unscheduled Care Programme Board and Delayed Discharge Steering Group, regular performance management reports, and a discharge improvement plan.

'Daily Dynamic Discharge' is a 'Test of Change' ongoing within Stirling Community Hospital where there are daily and weekly meetings between Health and Social Care staff. It is early days but staff feel that patient flow and discharge appears to have been quicker since implementation.



Source: FV NHS 17/18

At the end of 2017/18 our performance for all delayed discharges continues to be in the second highest quartile nationally. Our performance in the graph shows some peaks and troughs but there continues to be a positive general downward trend for 17/18.

The Partnership is well below comparators and national average when looking at all delays in the table below.

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

Source: ISD 17/18

Trends are also improving for:

- Patients are spending less time in hospital waiting to move back to community.
- The number of days is reducing for patients who are admitted to hospital as an emergency. Especially for those who are older or frail.

These indicators form part of the key targets agreed with Ministerial Strategic Group (MSG) for Health and Community Care.

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 Strategic Plan, and we are currently refreshing this information focussing on key priority areas.

- We know that the Partnership has an ageing population.

The number, and proportion, of older adults across Clackmannanshire and Stirling is projected to double, and our area will have growing numbers of individuals living with long term conditions, multiple conditions and complex needs.

We need to continue to work together to redesign our services to meet the needs of our population.

- We know that there are **inequalities**. There is a difference in life expectancy of men and women in the most and least deprived areas.
- Life expectancy in Stirling is higher than in Scotland in both the most and least deprived areas.
- There are a high proportion of women who face additional inequalities through disability and/or caring responsibilities in Clackmannanshire.

Technology Enabled Care

The Partnership secured grant funding from the Scottish Government's Technology Enabled Care (TEC) programme, and focussed on increasing users of telecare. The target of 500 more users over 16/17 and 17/18 was exceeded with a total of 1,226 new users by March 2018.

Increasing the use of technology has played a key role in supporting people with more complex needs to remain safely at home:

- Technology such as Just Checking is now used regularly to support reablement and home care assessment.
- Technology supports have also been central to reshaping overnight care and enabling independence.
- Improved relationships with other partners such as Scottish Fire and Rescue Service and Scottish Ambulance Service have been developed

Frank's Story - Technology Enabled Care TEC

Fraser lives with a significant brain injury following a serious fall, and had previously used our Reablement and TEC services when he was discharged from hospital to stay with his parents. However, Fraser had expressed a wish to return to his own home, and so the service worked with him and his family to identify the appropriate personal outcomes to make this happen.

The TEC service installed Just Checking as an environmental monitoring tool, following assessment and input from the Reablement team. This helped to build a picture of Fraser's daily routine, and reduced concerns raised by his family.

By working together, the service was able to support Fraser to improve his confidence, reduce his risks and build his self esteem and relationships with care providers. This also supported his family to make this transition for his future.

Housing and Social Care Contribution

The population projections raise questions about current local housing provision and the capacity of housing support services to ensure effective delivery for older people and other vulnerable groups. The multi-agency Housing and Social Care Group ensures joint working around key areas such as housing with care.

Older people living in the community who are vulnerable, often with complex medical conditions are a priority area for Local Housing Strategies.

The Alcohol and Drug Partnership has widened services involved in reviews of all local drug related deaths, including Social Care and Housing. Recent reviews have resulted in changes to Housing Policy in relation to identifying vulnerable people at an earlier stage and linking them with support as appropriate.

Adult addiction services continue to exceed the Scottish Government LDP standard in relation to waiting times

Data Sharing & Shared Assessments

We work within the Forth Valley Data Sharing Partnership to take forward the following priorities:

- Single Shared Assessment
- Information Sharing Portal
- File Sharing

Data sharing and shared assessment processes have the potential to reduce duplication and improve service user and carer experience.

Key integration staff are now able to work in a range of venues across the Partnership using host wifi on mobile devices.

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 used the Action Learning Set method facilitated by the Improvement Hub. Working with a range of staff and a local provider, to provide a shared understanding, greater ownership, and more joined up processes around overnight care.

Commissioning plans are now in place for Learning Disability and Mental Health Services. Joint Provider Forums are also in place to ensure dialogue and information sharing.

Workforce

Our workforce plays a key role in the delivery of our priorities. We have agreed and developed:

- Integrated Workforce Plan (2016-19)
- Partnership Development and Training
- Communication and Engagement Protocol & Engagement Strategy

Our Workforce Plan shapes the approach to planning for capacity and skills and is key to the delivery and re design of services. Work is ongoing to refresh the Workforce Plan to reflect the changing patterns, needs, and skills.

A Transforming Nursing Group has been established to future proof community nursing in the Partnership.

During 17/18 staff engagement events have begun to focus more on the detail of the operational delivery of some of the key elements of the Transforming Care Programme reflecting the current stage of our journey – this has included sessions relating to:

- Clackmannanshire Locality Service Planning
- Neighbourhood Care Team
- Health & Care Village – Bellfield Centre
- Innovation events.

We carried out a survey of social care staff using an adapted form of iMatter with a view to full roll out of iMatter across health and social care services next year. The response to the survey was encouraging with most responses indicating a positive level of commitment from the workforce.

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. Health and Social Care Partnerships have been identified as having the lead role in the effective implementation of new legislation to support this group which came into effect on 1st April 2018. Leading up to this date we worked together with Carers Centres to prepare for implementation of the Act, and will continue this work over the next year.

The Clackmannanshire and Stirling Carers Centres play an essential role in implementing the Act. Over the next year we will commission a review of the services within the Partnership.

- Identification of carers and awareness of supports remains a challenge particularly with some groups of carers.
- Further work is required to scope the elements required in acute NHS services including the duty to involve carers in discharge planning.

Carer Centres working in partnership:

The Care with Confidence programme was developed in partnership with carers and local health and social care professionals (ICF funding)

Carer Support Workers now attend multi-disciplinary team meetings at CCHC

Welfare Benefits Clinics developed for carers in partnership with local CAB

184 unpaid carers were supported with health assessments through the NHS Keepwell Service

Kevin's Story - Carer Support

Kevin cares for his adult son who has learning difficulties and is on the autism spectrum. The transition to adulthood increased pressures on Kevin and he was referred to a Carers Centre for support and was seen by an ICF funded Carer Support Worker. He was supported to:

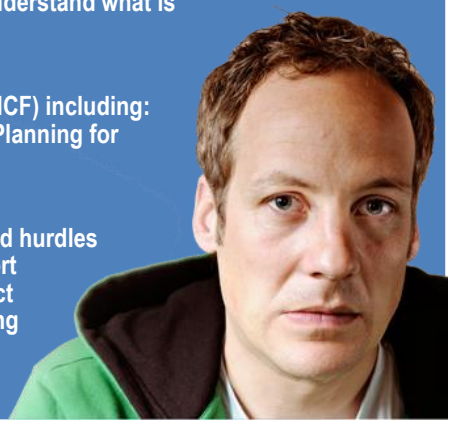
Access funds to improve quality time spent with his son, and to take driving lessons

Access financial advice and support to address benefit issues

Be accompained at transition planning meetings and help understand what is discussed

Attend activities where he could meet other carers

Benefit from Care with Confidence sessions (funded by the ICF) including: Handling Anxiety and Agitation, Understanding Stress, and Planning for the Future



Kevin's carer journey continues with constant challenges and hurdles to overcome and carer stress is a ongoing issue. The support provided by the Carers Centre will reduce the negative impact on Kevin's own health affecting the sustainability of his caring relationship with his son.

Financial Plan

We will continue to utilise current Partnership funding plans, including the Integrated Care Fund (ICF), Delayed Discharge Funds, Technology Enabled Care, Out of Hours and the Primary Care and Mental Health Transformation Funds to support our Transforming Care Programme, aligned to the Strategic Plan priorities.

The Partnership has been working with a Glasgow Caledonian University research programme funded by the Chief Scientists Office of the Scottish Government Health and Social Care Directorate to develop the first framework for making difficult social and healthcare decisions which integrates economics, decision-analysis, ethics and law to be applied in this new context of shifting the balance of care.

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 partnership funding allocated 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 it's behalf to deliver the priorities of the Strategic Plan.

For the financial year ended 31 March 2018 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 £1.145m of reserves of the Integration Joint Board and additional non-recurrent contributions for 2017/18 only from the constituent authorities on an agreed risk share basis. The Partnership's underlying financial position is a net deficit of £2.746m which requires to be addressed, along with other pressures in 2018/19 to achieve financial balance.

The expenditure of the Integration Joint Board for year ended 31 March 2018 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)	19,985
Adult Social Care: Clackmannanshire Locality	16,539
Adult Social Care: Urban and Rural Stirling Localities	32,383
Health Services under Operational Responsibility of Integration Joint Board	33,543
Universal Family Health Services including Primary Care Prescribing	67,034
Integration (Social) Care Fund	8,860
Shared Partnership Posts	262
Transformation	3,086
TOTAL EXPENDITURE	**181,692**

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 and 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.

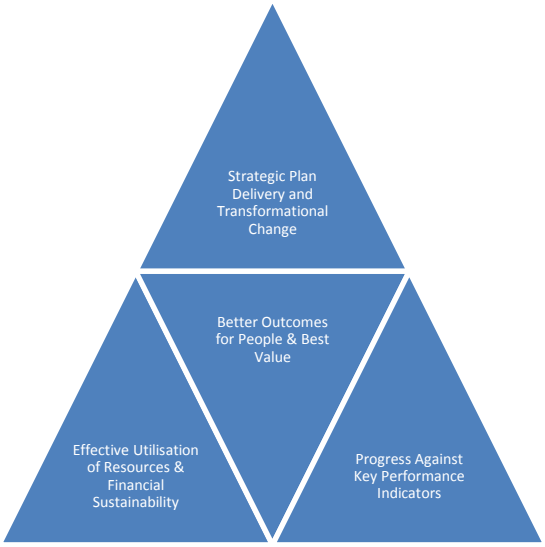
We are working to improve our evidence based approach to decision making in relation to investment and disinvestment priorities and have been working alongside the Scottish Government lead on commissioning as part of a national research programme led by Glasgow Caledonian University on the impact of a decision making framework in health and social care services.

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.

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

The Integration Joint Board has also reviewed its committee structure in 2017/18. It has an established Audit Committee and has approved the establishment of a Finance Committee to improve scrutiny and financial governance.

As part of governance arrangements to oversee the change programme the Chief Officer chairs both a Senior Leadership Group and Joint Management Team to oversee 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
- Reporting on Strategic Plan through both the Chief Officer's reports to the Integration Joint Board and topic specific reports.

This approach is visually represented in the Best Value Diagram above.

"All performance reports clearly state that, in order to ensure a sound basis for decision making and prioritisation, performance information should be read alongside financial reports to give a rounded view of the overall performance, best value and financial sustainability of the Partnership."

Internal Audit Review - Performance Management and Reporting

Financial Reporting on Localities

The 2017/18 financial information is not yet split into localities. Locality level financial reporting will be a focus for development in 2018/19.

Integrated Care Fund

The Partnership received £2,480,000 from the Integrated Care Fund (ICF) from Scottish Government during 2017/18. The spending priority was to support our strategic priorities.

Funding was allocated under the following areas:

- Test and Deliver action to ensure a responsive 24/7 Health & Social Care Model
- Develop and Extend intermediate care model to all adults – particularly implement a dementia intermediate care pathway
- Embedding a range of person centred anticipatory and prevention planning – across areas of poverty and high multi morbidity
- Extending Community Based Supports
- Direct Support to Carers
- Communications, Navigation/Way Finding
- Targeted Resource to Support Lifestyle Change
- Enablers for Transformational Change
- Bridging to Stirling Care Village

To ensure Partnership investment is providing good value, and that projects are sustainable, further reviews have been carried out and will continue to be revisited regularly throughout the duration of the programme. Work is ongoing to identify linkages and collaborative working in order to improve service delivery and ensure financial efficiencies.

We are working with Glasgow Caledonian University as part of a national programme to develop ways funded projects and services are monitored and reviewed. We will continue to develop this approach during 18/19.

This change funding compliments the developing plans for Primary Care and Adult Mental Health, which also have change fund support.

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:

Performance Measures & Improvement Objectives

- Accident & Emergency Performance
- Unplanned Admissions
- Bed Days Unscheduled Care
- Delayed Discharges
- Care In Community For Age 75+

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

We have developed a Strategy Map which helps us to clearly link the outcomes to the Strategic Plan, and will review this map over the 18/19 period.

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. The unique nature of our Partnership means that sometimes our data may be provided at local authority level only. However there has been progress over the last year in receiving national data at a Partnership level, and performance reporting to the Integration Joint Board is now provided from this perspective.

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

Some local data is now being extracted at locality level and this will increase over the 18/19 period, to inform the work of the Strategic Planning Group (who oversee Locality Planning within the Partnership).

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

The Local Outcomes come directly from the Strategic Plan and were created to address the key challenges highlighted in the Strategic Needs Assessment to ensure that the outcomes are consistent with the views of people who use services, their unpaid carers and communities.

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 June 18)

	Indicator	Title	Partnership	Comparator Average	Scotland
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	94%	94%	93%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	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	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	76%	74%	74%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	78%	80%	80%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	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	79%	79%	80%
	NI - 8	Total combined % carers who feel supported to continue in their caring role	38%	37%	37%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	86%	83%	83%
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA

Core Suite of Integration Indicators - Annual Performance (as at June 18)

	Indicator	Title	Partnership			Comparator Average	Scotland
			Baseline 15/16	Current 16/17	Current 17/18		
Data indicators	NI - 11	Premature mortality rate per 100,000 persons aged under 75 years	425	389	NA	401	440
	NI - 12	Emergency admission rate (per 100,000 adult population)	10,367	10,010	10,699	11,762	11,959
	NI - 13	Emergency bed day rate (per 100,000 population)	118,775	111,969	109,934	118,993	115,518
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	103	105	104	103	97
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%	87%	88%	88%
	NI - 16	Falls rate per 1,000 population aged 65+	18	16	20	20	22
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	82%	86%	94%	86%	83%
	NI - 18	Percentage of adults with intensive care needs receiving care at home	69%	67%	NA	62%	62%
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	640	723	516	793	772
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23%	22%	22%	25%	23%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	NA
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	NA
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	NA

Source: ISD are still developing these indicators and NA defines where no data is available yet. Comparators: South Ayrshire, East Lothian, Angus, Moray, Perth & Kinross, Falkirk. Figures as at May 2018

Our Performance : In Detail

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

Table Symbols			
	Benchmark		Survey
	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	17/18
Partnership	94%	94%
Comparators	95%	94%
Scotland	94%	93%

Source ISD 17/18

The 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 (including those with disabilities, long term conditions, or who are frail) are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

NI 2	% of adults supported at home who agree that they are supported to live as independently as possible	
	15/16	17/18
Partnership	82%	82%
Comparators	82%	80%
Scotland	83%	81%

Source ISD 17/18

This 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 Integrated Care Fund 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
Partnership	69%	67%
Comparators	62%	62%
Scotland	62%	62%

Source ISD 16/17

The 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 rising trend of care at home hours is similar to national trends, and the number of clients is similar to our peers. However the number of actual hours is much higher than similar Partnerships. 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	
	16/17	17/18
Partnership	87%	87%
Comparators	87%	88%
Scotland	87%	88%

Source ISD 17/18

The 17/18 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 2019.

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 is exploring the need for redesign of this patient pathway, workforce and communication.

The development of the Health & Care Village may impact this figure when it moves to a full community based model. 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	17/18
Partnership	76%	74%
Comparators	79%	74%
Scotland	79%	76%

Source ISD 17/18

The 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 18/19.

Outcome 3 cont'd

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	17/18
Partnership	87%	87%
Comparators	86%	82%
Scotland	85%	83%

Source ISD 17/18

The 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	17/18
Partnership	78%	78%
Comparators	82%	80%
Scotland	81%	80%

Source ISD 17/18

The 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	17/18
Partnership	77%	79%
Comparators	84%	79%
Scotland	83%	80%

Source ISD 17/18


The 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	
	16/17	17/18
Partnership	10,005	10,699
Comparators	11,456	11,762
Scotland	12,294	11,959

Source ISD 17/18


The NI 12 rate is a positive position in comparison to national and comparator figures. Although the rate of admissions in 17/18 has risen on the previous year, along with other similar Partnerships, this may reflect the rise in emergency admissions around the winter months (Nov-Jan) when Flu admissions were challenging.

It is important to note, that **although more people were admitted in 17/18 the length of time they are staying in hospital is reducing** [NI13].

The Partnership is aiming to achieve a 5% baseline reduction on admissions by 2019.

NI 13	Emergency bed day rate per 100,000 adult persons	
	16/17	17/18
Partnership	111,969	109,934
Comparators	128,090	118,993
Scotland	125,634	115,518

Source ISD 17/18


The NI 13 figure is less than the previous year and lower than national and comparator average. **This means that people are not staying as long when they are admitted to hospital in an emergency.**

Bed usage is monitored in hospitals through the Day of Care Audit, and the community hospital audit is showing a reduction for those who are still in hospital but do not require medical care. Pilot work such as 'daily dynamic discharge' continues in the 2 community hospital wards.

NI 14	Readmission to hospital rate within 28 days per 1,000 persons	
	16/17	17/18
Partnership	105	104
Comparators	106	103
Scotland	100	97

Source ISD 17/18


The NI 14 rate has improved on the previous year and similar to our comparators. 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 for the Partnership.

NI 16	Falls rate per 1,000 population aged 65+ who were admitted to hospital as an emergency	
	16/17	17/18
Partnership	16	20
Comparators	23	20
Scotland	22	22

Source ISD 17/18

The 17/18 figure for the Partnership reflects a positive position. Although higher than the previous year it is better than the national average. 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	
	16/17	17/18
Partnership	86%	94%
Comparators	80%	86%
Scotland	84%	83%

Source Care Inspectorate/ISD 17/18

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.

Partnership commissioners work closely with the Care Inspectorate. Quarterly liaison meetings take place to share local knowledge and best practice as an early intervention mechanism to identify and act upon any intelligence gathered.

Outcome 5

Health &social care services contribute to reducing health inequalities

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.

NI 11	Premature mortality rate per 100,000 persons aged under 75 years old	
	15/16	16/17
Partnership	425	389
Comparators	387	401
Scotland	441	440

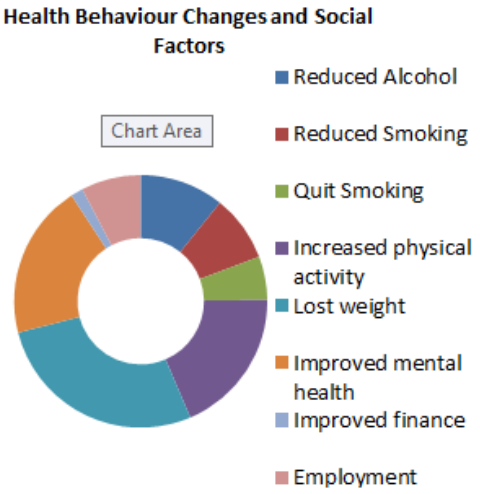
Source ISD 2016

The Partnership figure is lower than our comparators and national average. This is a positive figure. The refresh of the Partnership Strategic Needs Analysis will give further insight in 18/19.

In the meantime, 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.

In a key area, our Health Promotion services continue to provide **overdose awareness training** which included 80 participants from the Partnership.

Most of the people who attended the Keep Well Service for health assessments and support **live in areas of relative poverty or were identified as being at risk of preventable ill-health due to social or cultural inequalities**. People contacted reported the following improvements:



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	17/18
Partnership	32%	38%
Comparators	41%	37%
Scotland	40%	37%

Source ISD 17/18

This 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.

Unpaid carers reported feeling better supported in their role following participation in the NHS Keepwell Service.

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	17/18
Partnership	82%	86%
Comparators	83%	83%
Scotland	83%	83%

Source ISD 17/18

The figure has improved on the last survey and is positive for the Partnership. It reflects the joint work **with the Adult Support and Protection Committee and the Lead Officer to improve our responses**.

The Social Care staff survey reported that over 80% of staff within the Partnership agreed that the service their team provides is successful in helping people to remain safe from harm.

Adult Support and Protection activity has increased throughout the year. With 806 referrals, 147 investigations, and 22 case conferences.

Local Substance Misuse Services now have Naloxone available on their premises and on the mobile Harm Reduction vehicle. The corporate Naloxone policy is being rolled out across the Partnership.

The NHS Keepwell service identified and tested 65 people who were at risk of Blood Born Virus.

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	N/A
Comparators	N/A
Scotland	N/A

Source ISD 15/16

Although there is no national data available. In a Social Care staff survey across the Partnership in 2017, **just over half of the staff said they would recommend their organisation as a good place to work.**

There are a number of pieces of work carried out locally that support this outcome; iMatters is the continuous improvement tool designed with NHS Scotland to help individuals, teams and Partnerships understand and improve staff experience. It is hoped that by 2019 we will be able to use this tool across all of the health and social care Partnership.

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	17/18
Partnership	73%	76%
Comparators	76%	74%
Scotland	75%	74%

Source ISD 17/18

This 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	
	16/17	17/18
Partnership	723	516
Comparators	964	793
Scotland	842	772

Source ISD 17/18

The 17/18 Partnership figure reflects a positive position and is much lower than last year. A considerable amount of positive work is being done in this area as described in the Delayed Discharge section of this report [page 18].

NI 20	% of Health & Social Care spend on hospital stays where the patient was admitted in an emergency	
	16/17	17/18
Partnership	22%	22%
Comparators	26%	25%
Scotland	25%	23%

Source ISD 17/18

The 17/18 Partnership figure reflects a positive position and the rate is lower than comparator average. It reflects the reduction in delayed discharges, admissions, and the 'shift' to receiving support within the community.

The time spent in hospital wards following emergency admission has reduced in 17/18

The time delays for those clincally ready to leave hospital has reduced in 17/18

Inspections

- The Partnership underwent a strategic inspection in early 2018 and the outcome will be published late 2018.

The Care Inspectorate undertook both scheduled and unscheduled inspections across 9 services during 2017/18. The quality of care and support was assessed as 'good' or 'better' in 89% of these inspections. This is a reduction in performance from last year and is due to an 'adequate' environmental rating in Menstrie House. There were 3 mandatory requirements and a number of recommendations made by inspectors, which have all been acted upon by staff. Additional information and full detail on inspections can be found at the Care Inspectorates website www.careinspectorate.com.

Unit	Date Inspection Completed	Quality Theme Care Grades (out of 6)				Number of recommendations	Number of requirements
		Care and Support	Environment	Staffing	Management & Leadership		
Allan Lodge	02/06/17	5	N/A	N/A	5	1	1
Beech Gardens	09/01/18	5	N/A	N/A	5	0	0
Clacks Reablement and TEC Service	19/01/18	5	N/A	5	N/A	0	0
Stirling Reablement and TEC Service	20/11/17	5	N/A	4	N/A	2	0
Ludgate House Resource Centre	16/01/18	6	5	N/A	N/A	0	0
Menstrie House	25/10/17	4	3	N/A	N/A	5	2
Strathendrick	19/02/18	5	N/A	5	N/A	0	0
Streets Ahead	02/05/17	5	N/A	5	N/A	1	0
Whins Resource Centre	26/01/18	5	N/A	5	N/A	0	0

Source Care Inspectorate

Key to grading:
1. Unsatifactory
2. Weak
3. Adequate
4. Good
5. Very Good
6. Excellent

NA -not applicable/not inspected

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 and Recommendations

Unit	Action
Allan Lodge	
Requirement - To ensure the safety and well-being of people the provider must ensure that the Care Inspectorate are notified within 24 hours of any unforeseen event including accidents and incidents resulting in harm or injury to a person using the service which results in: - a GP visit - a visit or referral to hospital - an injury reportable under Reporting of Injuries, Timescale: Immediate	Senior and Admin Staff to have training on the Care Inspectorate website/eforms. This will enable them to notify the Care Inspectorate of any events including accidents and incidents. Senior and Admin Staff will now notify Care Inspectorate as part of the Allan Lodge reporting accident incident procedure. **Action complete**
Recommendation - It is recommended that the manager works with staff to improve the quality of care planning evaluation to make sure known needs and risks are clearly identified with guidance on how they should be managed or minimised. Care plans should be subject to robust evaluation, to establish the effectiveness of the care being delivered for the benefits of those using the service.	Allan Lodge Care Plan Audit documentation to be reviewed. Audit documentation to be more meaningful and include an evaluation process which clearly establishes the effectiveness of the care being delivered to service users. **Action complete.**
Stirling Reablement and TEC Service	
Recommendation - Six-monthly reviews of people's support needs should be planned and consistent. Review visits should evidence discussion of service user's support, if it continued to meet their needs, future needs and include any points of discussion with service users or their representative. Timescale: March 2018	An alert will be added to our new schedule system to inform Care Coordinator a 6th monthly review is due. This involves approximately 8 people at this time. The Service will ensure discussions with the Service user and/or with their representative will be clearly recorded and will reflect any discussions and any changes to their care needs. The service will work alongside Adult assessment to ensure any changes to their care needs are updated on their support plan. **Action complete**
Recommendation - The service will ensure that supervision is a priority for all staff as a key aspect of their learning. Use of management practices such as supervision, appraisal, observed practice and care audits should be further developed to guide staff and support the services quality assurance practices. Timescale: June 2018	A rolling programme for one to one and group supervision is in place. Team leader and Care Co-ordinators will observe group supervisions to ensure these are around good reflective practice and sharing information. All Seniors and Care Co-ordinators have or are in the process of completing PDA in Supervision. Staff participation group will be further established to ensure all staff are involved in service development and learning. Team leader and Care Co-ordinators will ensure supervision is a priority for the team, this is non-noticeable. The Team Leader and Care Co-ordinators are aware of the importance one to one and group supervision and will strive to ensure they are maintained. Care audits and any other quality assurance audits will be continued to be developed and ensure recordings are appropriate and any actions are completed. **Actions complete**
Menstrie House	
Requirement - The provider must ensure that people who use the service have access to a reliable and efficient room alarm system. When a person cannot operate the room alarm system then a risk assessment should be completed and incorporated into the care plan. Timescale: 31st March 2018	Capital bid previously submitted to the senior management team for upgrade /replacement of existing call system prior to inspection. Meetings have already taken place with suppliers and costings being sought for the appropriate call system that will be in place by 31st March 18. In the event of the call system breaking down staff will provide regular checks to residents throughout the day and night. Where there is a risk of a resident being unable to operate the room alarm system there are risk assessments in each care plan to identify the risk and there are regular checks carried out throughout the day and night. **Action complete**

Unit	Action
Menstrie House	
Requirement - The home should be maintained and decorated to a good standard. Maintenance to bathrooms, bathing equipment and communal toilets should be rectified without unnecessary delays. Timescale: 31 March 2018.	Meetings have taken place with facilities management to identify work that needs carried out, costings sought and manager currently seeking to identify funding for maintenance required for upgrade of areas highlighted in this report. **Action complete**
Recommendation - Cleaning records should evidence the required frequency of cleaning in the specified areas has been carried out. Timescale: within 1 month / Dec 17	Facilities Management manage the domestic staff within Menstrie House. The manager of Menstrie House has arranged a monthly meeting between Facilities management and their staff to discuss cleaning schedule throughout the month. During the meeting the supervisor and manager of Menstrie House will check cleaning schedules to ensure all areas have been cleaned and signed by staff. **Actions complete**.
Recommendation - Regular maintenance checks should be evidenced and carried out for profiling beds and window restictors within the recommended frequencies. Timescale: March 2018	The property maintenance team have provided the service with a copy of all relevant paperwork regarding regular maintenance checks. A monthly check list for window restrictors was put in place by the end of October 17. The property maintenance team have been instructed to arrange a yearly contract with Arjo for testing of Profiling beds. **Action complete**
Recommendation - The recording of daily oral health for residents should be implemented and advice and support sought where necessary. Timescale: 3 months	Email sent to NHS re caring for smiles. Awaiting response. Staff are already reviewing caring for smiles and residents care plans are being developed to include good oral hygiene. **Actions complete**
Recommendation - The recording of cream applications for residents should improve so that it is evidenced the frequency of administering is in accordance with the prescribed instructions. Timescale: 3 months	All Mar charts to be checked at the change of each shift by seniors to ensure creams administered are signed in accordance with prescribed instructions. **Actions complete**
Recommendation - Care should be taken with the recording of medicated adhesive patches so that it is clear and legible when these have been applied, removed and observed to be in place and that guidance is followed as to where in the body these are applied. Timescale: 3 months	Small workshops will be arranged to discuss protocol and guidance for the recording of medicated adhesive patches. **Actions complete**
Streets Ahead	
Recommendation –The service provider should ensure that plans of support are signed by the person, or where appropriate, their representative. Timescale: 3 months	6 monthly care provider review will be recorded in new format that welcomes feedback from parents/carers and other provider's as well as service users. **Action complete**
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 second 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.

- We are currently working with iHub to develop our services further and support the step into the Health & Care Village late 2018, and further works in Clackmannanshire. The work will feed into the refresh of our Older People's Commissioning Strategy and inform our organisational development plans.

- Work has been taking place to delegate further services from NHS Forth Valley and Stirling Council over 2018.

- We will continue to work with others including housing services to develop opportunities for co-location of services by better use of our joint estate and alternatives to long term care 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 Falls Pathway and Frailty review 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.

- In Clackmannanshire we are reviewing our day support services for all care groups with a view to establishing integrated day assessment services and are working closely with Primary Care to support new ways of working. Initial work has also taken place to consider options for an integrated front door approach for health and social care services.

- Over the next year we will develop our the next Strategic Plan 2019 – 2022 which will include updating the Strategic Needs Assessment and horizon scanning to assess the impact of key developments such as the Carers Act, the national Mental Health and Dementia strategies.

- We will continue to develop the areas identified within our Delivery Plan and work together across all service areas to ensure greater understanding of the impact of our services on individual patients/ service users and their unpaid carers.

- We will review or develop the following key strategic plans:
  - Partnership Carers Strategy
  - Participation & Engagement Strategy
  - Older People's Commissioning Strategy
  - Primary Care Improvement Plan
  - Inspection Improvement Plan
  - Mental Health Plan
  - Mid-term Financial Plan
  - Workforce Plan
  - Local Dementia Strategy Implementation Plan
  - Intermediate Care Strategy

- Implement new national Health and Social Care standards. These Standards set out what we should expect when using health, social care or social work services in Scotland. The objectives of the Standards are to drive improvement, promote flexibility and encourage innovation in how people are cared for and supported.

- We will pilot a multi-disciplinary specialist team with clear locality links. This work will be overseen by the Forth Valley Dementia group and is in line with the National Dementia Strategy. There are clear links with locality approaches, the neighbourhood models of care and greater emphasis on the needs of unpaid carers.

- Develop our approach to digital health and care services in response to Scotland's Digital Health & Care Strategy.

- Complete a review of commissioned services to support unpaid carers.

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).
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.
ALFY	A service, supported by NHS Forth Valley and Health & Social Care Partnerships, introduced across Forth Valley to help support older people to remain well at home. The round-the-clock advice line known as ALFY (Advice Line For You), is available to everyone aged 65 or over as well as family members and other people who may care for them. The dedicated advice line 01324 567247 is operated by experienced nurses.
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 Healthcarel 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.
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://nhsforthvalley.com/about-us/health-and-social-care-integration/clackmannanshire-and-stirling/

If you would like this information in another language, braille, large print or audio tape please call 01786 454524 or email cs.integration@nhs.net .

Clackmannanshire Council

Stirling Council

NHS Forth Valley