Clackmannanshire & Stirling Health & Social Care Partnership

Annual Performance Report

2016 – 2017




Clackmannanshire Council

Stirling Council

NHS Forth Valley

Contents

Our First Year

The Integration Authority was fully established on 1 April 2016, supported by a governing Integration Joint Board. This is our first Annual Performance Report and it provides us with an opportunity to reflect on our progress together as a Partnership. This is the only Health and Social Care Partnership in Scotland incorporating two Local Authorities and one Health Board – and it provides us with some unique opportunities to work together to improve our services and the outcomes for the citizens and communities across Clackmannanshire and Stirling.

Our vision for the Partnership 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 and the underpinning Delivery Plan set out how we plan to work together to achieve this vision. Over this first year Clackmannanshire Council, NHS Forth Valley, Stirling Council, the independent and third sector providers for care homes, care at home and day care, our local Hospice and people using services and their family, friends, unpaid carers and communities have worked together to prioritise the areas where we would like to transform our services. In common with other Health and Social Care Partnerships across Scotland, we are working together to meet the challenge of growing levels of demand across services and a challenging financial environment. We have also initiated 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 much to be proud of in this Partnership. This year has seen the further development of a range of services to support people to return home from hospital with care and support, including the further development of our reablement care at home and a 'quick step', fast response care at home service in Clackmannanshire."

We have worked together and with other organisations, such as the Scottish Social Services Council, to explore and develop the opportunities for a new model of providing integrated care in our emerging localities based around Buurtzorg care at home.

The building work on the £35m Care Village in Stirling commenced in January 2017 and the majority of the new facilities are expected to be operational by autumn 2018. The Care Village will provide modern, purpose built facilities for a range of local services including GP services, 100 short stay beds for older people, including those with dementia, and the new Scottish Ambulance Service station. The Care Village design has recently featured at an international masterclass on design for dementia and ageing.

We have worked with our providers to develop a Market Position Statement and to deliver the Living Wage. Our services across the Partnership continue to perform well and this is reflected in the inspection reports.

Finally, I would like to take the opportunity to thank the Chair of the Integration Joint Board during 2016/2017, Councillor Les Sharp, the Vice Chair John Ford and the members of the Integration Joint Board for their work and support over this first year. Further thanks also go to the members of the Strategic Planning Group and to our partners and their staff, and not least to the many service users, patients and their unpaid carers, family and friends and local communities for their willing engagement, ideas and energy. The foundation laid in this first year will continue to serve the Partnership well in the coming year.

Shiona Strachan

Chief Officer

1. About Us

Background

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 Members 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 services. These include 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 [now being used as the basis for the developing performance framework], a high level approach to locality planning and the eight local priorities.

The eight priorities and the actions were developed following a period of extensive consultation and engagement across all services, partners and communities.

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 Care Village
- Develop seven day access to appropriate services
- Take further steps to reduce the number of unplanned admissions to hospital and acute services

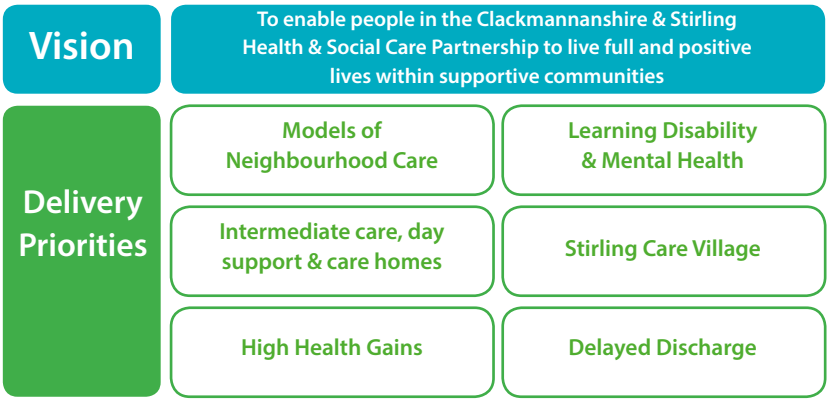
The ***'we will'*** high level priorities are statements of how the Partnership intends to develop services to deliver the vision. They have been further developed, again using a consultation and engagement approach, into core delivery priorities. These bring together the health and social care services along with the commissioned services and partners, to redesign and focus activity onto integrated service delivery models, which will significantly strengthen community and place based services.

207 staff across Health, Local Authorities (Social Services & Housing), Third & Independent Sectors, Primary Care and Fire & Ambulance Services participated in 7 multi-disciplinary and multi-agency staff engagement events held in June 2016. The purpose of these events was to work collaboratively to identify and shape core priorities that will deliver the outcomes in the Partnership Strategic Plan and ensure staff are well-informed of strategic Partnership activity and progress.

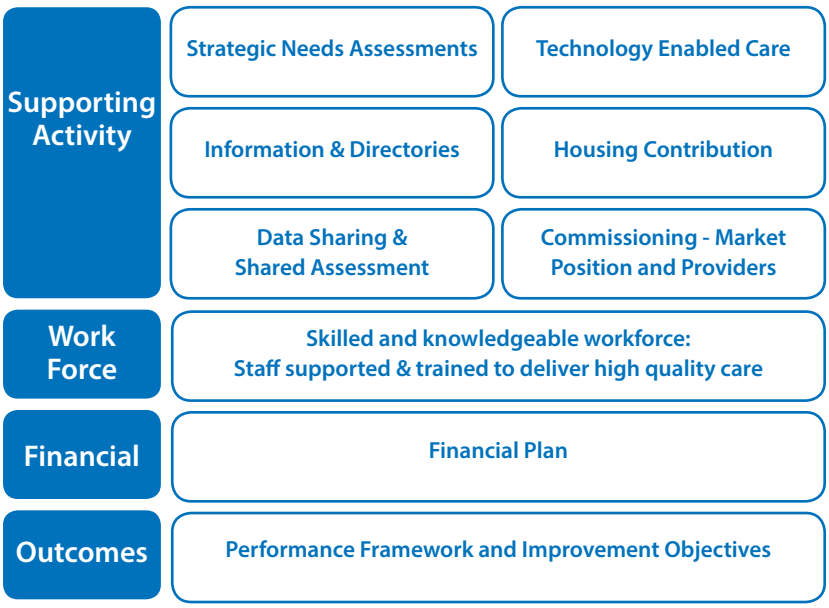
The following diagrams represent the core Partnership delivery priorities for 2017-2019 and the underpinning enablers, which also involve redesign activity. Together they make up the Partnership's Transforming Care Programme.

These delivery priorities do not cover the entire activity taking place within and between services and partners but focus on the actions the Partnership can take together to strengthen and develop the building blocks for community based services.

Transforming Care: Core Delivery Priorities 2017/19



Transforming Care: The Enablers



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

Work is now underway in each of these areas, with workstreams established to support implementation of the core delivery priorities and the required progress and performance reporting to the Integration Joint Board over 2017-19.

Localities

The Strategic Plan identified the planning Localities for the Health and Social Care Partnership, which were agreed in October 2015.

Geographic spread of the population varies across the Partnership, with Clackmannanshire the most densely populated and Stirling Rural the least.

Over the course of this first year work has been carried out to complete the Locality profiles and to ensure alignment with the developing GP clusters and the evolving local authority and Community Planning Partnership/ Alliance community based approaches.

To support this we held a Whole Systems Working event in November 2016. This was to get wide discussion across the whole system on Locality Plans and gather multi-partner feedback to inform the next steps in Locality development and agree local priorities.

The work on the Models of Neighbourhood Care will also provide a strong foundation for the development of place based services and will support Locality planning. However, our development of Locality planning requires further work and emphasis over 2017/18.

64 multi-disciplinary staff from GP Practices and Services in the community participated in a Locality Planning event in November 2016

Clackmannanshire

15.5% People Income deprived compared to 13.1% for the whole of Scotland

Telecare rate per 1,000 Clackmannanshire - 42.1 compared to the whole of Scotland - 23.0

334 per 100k Psychiatric hospitalisations compared to the whole of Scotland - 286

Rural Stirling

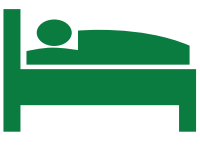
22.2% of population are aged 65+ compared to the whole of Scotland - 18.0%

Cancer rate per 1,000 population - 29.4 compared to the whole of Scotland - 23

5,729 Emergency hospitalisations per 100k compared to the whole of Scotland - 7,473

Stirling City with the Eastern Villages of Bridge Of Allan and Dunblane

Coronary Heart Disease rate per 1,000 population - 35.9 compared to the whole of Scotland - 41.4



5,015 delayed discharge bed days occupied in 2015

536 people recorded on Dementia GP register

Source: Locality Profiles

2. Transforming Care: Core Delivery Priorities 2017/19

To support the delivery of our Transforming Care Programme we have established a series of work streams reporting to the Joint Management Team of the Partnership and to the Strategic Planning Group. We have agreed a supporting Delivery Plan and progress against the national and local outcomes will be reviewed by the Strategic Planning Group in autumn 2017.

This section highlights some of the work taking place.

Models of Neighbourhood Care

The community of the rural south west of Stirling has collectively identified the care of older people as a priority for them. Over this first year we have been working together to develop a new and innovative Model of Neighbourhood Care that will use the foundation principles of the successful Dutch programme of care in local communities called Buurtzorg. That is:

Person at the centre – promotion of supported self management; independence; active involvement of family, friends and the community

Autonomy for staff – streamlined administration; use of technology for care assessment, support and for record keeping and sharing

Hospital Admission – avoidance of unnecessary admission and support timely discharge

The multi disciplinary, place based services are scheduled to commence in 2017/18.

Learning Disability & Mental Health

The Learning Disability Service and community adult Mental Health Services have been integrated for some time. These services offer a range of assessment, support and intervention services. Work in the first year of the Partnership has established some priorities for review and development during 2017/18, including the redesign 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.

Current published baseline data tells us that the majority of Guardianship Orders granted for adult residents in the Partnership area were private and the primary cause for nearly half of those was Dementia/Alzheimer's disease.

Private & Local Authority	Rate per 100,000 population for Guardianship Orders granted for adults aged 16 and over.	
Partnership	54	
Comparators	64	
Scotland	60	

Source: Mental Welfare Commission 2015/16

Table Symbols

Throughout this report we have information tables.

Some are sourced through surveys or benchmarking. We have indicated if we have achieved our targets or if further work is required.

Benchmark

Survey

Achieved

More work required

Intermediate Care, Day Support & Care Homes

This Partnership has developed a range of intermediate care services for older people all operating within the national framework – Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland [Scottish Government, 2012].

Streams of Intermediate Care Services

- Intermediate Care at Home
- Bed Based Intermediate Care
- Hospital at Home

We know that older people and their unpaid carers are concerned about the increasing likelihood of unplanned or emergency hospital admissions as they develop more long term conditions and complex needs - and about having to stay there for longer periods of time. This concern is reflected in the Partnership's Strategic Plan as part of Sam's journey. We also know from our own service developments and the wider research and evidence base that, while many admissions to hospital are necessary, some can be avoided if we take the right anticipatory care action and we have developed appropriate and effective alternatives in the community.

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, for example occupational therapists and physiotherapists, home carers, and community support teams. This model is also often referred to as reablement.

Help will usually be provided within 24 hours, normally lasting for a period of no more than 6 weeks, and offers a safe alternative to admission to hospital, or short term support following discharge from hospital.

An average of 548 hours of reablement support per week was arranged in 2016/17 by Social Care for people living in the community in Clackmannanshire and Stirling.

Case Study

Paul is recently discharged from hospital

- He remains weak and is very anxious
- Has very limited mobility
- Remained in bed most of the day

Paul is supported on his return home

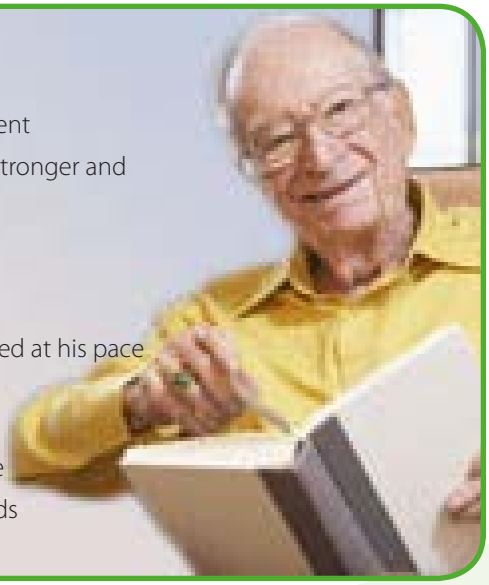
- Reablement support worker
- Occupational therapist
- His family help with meals and medication

The Reablement Team

- Provide specialist equipment
- Help Paul exercise to get stronger and moving again
- Help with personal care

The Service

- Listened to Paul and worked at his pace
- Helped foster a sense of achievement
- Improved his quality of life
- Helped make steps towards achieving his goals



Bed Based Intermediate Care

Similar to Intermediate Care at Home, this is a time limited episode of care provided in dedicated care homes, housing with care or community hospitals. It can be provided as an alternative to admission to hospital (step-up) or to provide further assessment and rehabilitation, following discharge from hospital (step-down).

Bed based intermediate care services have been established within the residential care homes owned by the Local Authorities - we have a total of 37 beds. Care homes provide a more homely environment where people can be assessed, while giving them the opportunity to make informed decisions about their longer term care and support needs. Within this bed based provision, care and support is available 24 hours a day.

On average, 70% of service users access the service from a hospital setting (step down) and 30% of service users access the service from the community (step up).

2016-2017	Total Discharged from Intermediate Care Service	Home with package of care	Care home admission	Hospital re-admission	Death
Clackmannanshire	26 people	27%	46%	23%	4%
Stirling	97 people	55%	25%	17%	3%
Partnership	123 people				

Hospital at Home – Enhanced Community Team

The Enhanced Community Team (ECT) 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, AHP and carer workforce to 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 an unwell patient (where a diagnosis has already been made e.g. by GP or frailty clinic but the patient has additional needs or is deteriorating and is at risk of hospital admission)
- Rapid assessment of an uninjured faller
- Discharge facilitation
- We are working on the "acutely unwell adult" pathway where there is no diagnosis, using the GP fellows to provide the medical input.

In 2016/17, 321 referrals were received. 289 of the people referred were accepted into the service, 238 (74%) of which were deemed urgent. Improvement measures indicated that all but 14 (9%) people supported by the service were enabled to stay at home. Assessment outcomes show that 124 (78%) of these people would otherwise have been admitted to hospital.

The Fellowship Programme developed by NHS Education for Scotland includes a one-year post-qualification GP Fellowship (GP Fellows employed by NES) followed by a two-year Health Board funded post as a ***"community physician"*** in newly developed community hubs.

During 2016 five Forth Valley located GP Fellows undertook training and were supported to develop and test a model of working to augment Closer to Home pathways and bridge gaps between acute and primary care in the Falkirk Partnership. From March 2016 the scope of the GP Fellows was widened to include the City of Stirling as a first step.

Care Homes

Currently, there are 18 care homes across the Clackmannanshire and Stirling Health and Social Care Partnership area providing 779 long term placements. There is also one very sheltered housing complex, as well as 4 Local Authority owned and operated care homes providing intermediate care services to older people.

- The Partnership has a low rate of registered Care Home beds for older people (aged 65 and over) for the size of its population. In 2016, the rate per 1,000 population was 29 compared to a national average of 38.
- There were 616 Care Home residents at the 2016 March 'census' who had stayed for an average of 2 years.
- Care Home residents in the March 2016 census made up approximately 0.6% of the population living in the Partnership area.
- Most residents live at home without support (97%), with just over 1% living at home with support.

The Partnership is working to enhance the care provided through Care Homes for older people. Research has shown that, in some cases, older people living in care homes can spend 80% of their time sitting, which can have a negative effective on both their physical and mental health.

The Care Inspectorate published guidance to support the promotion of physical activity, called "Care About Physical Activity" in 2014. This included a pack of resources which care homes could use to improve the assessment of activity in their setting, and a range of opportunities which they could work towards to improve activity levels for their residents. The Partnership was invited to join the national programme which includes access to programme advisers, an evaluation process and opportunities for learning and development for the workforce.

Stirling Care Village

Building work commenced in January 2017 on the £35 million Care Village. This is a joint venture by NHS Forth Valley, Stirling Council, the Scottish Ambulance service and the Health & Social Care Partnership. Forth Valley College is also a partner in the project, looking with Health and Social Services at the education and training needs of the workforce of the future.

Stirling Care Village - The Care Hub

The purpose built Care Hub is designed to be dementia friendly and will have more than 100 short stay beds to support rehabilitation, prevention of unnecessary admission to hospital, support timely discharge from hospital, palliative and end of life care. It is a key element of the Partnership's Intermediate Care services.

Stirling Care Village - The Primary and Urgent Care Centre

A new Primary and Urgent Care Centre will also see the location of a minor injuries service, X-ray facilities, GP out of hours and GP practices. In addition, the Scottish Ambulance Service plans to relocate their existing base to this new facility.

High Health Gains

A small number of people, with complex and intensive needs, account for half the total health expenditure in their local area. It is 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.

For 2015/16, there were 1,134 individuals in Clackmannanshire (2.6% of service users) and 1,770 in Stirling (2.4% of service users) who accounted for 50% of health expenditure in their areas. The management of High Health Gain individuals is one of the key quality improvement areas which our new GP clusters will focus on. This work sits within a framework of change for General Practice, including a new quality focussed approach to contractual arrangements and a transformation of the way Primary Care is delivered in the future.

Exploring New Models for General Practice

Sustainable Primary and Community Care models, both in and out of working hours, are at the centre of our strategic vision and Delivery Plan. Across Forth Valley we have already seen successful models of transformation within Primary Care in practices such as Bannockburn and Kersiebank Health centres which, in May 2015, became '2c' practices (Health Board managed). These practices have developed an innovative, multi-disciplinary approach to delivering General Medical Services.

As a result:

- General Medical Services have been maintained for 20,000 patients
- Direct access to a new multi-disciplinary team model means most people now see the right person first time including; Advanced Nurse Practitioners, Extended Scope Physiotherapists and Mental Health Nurses
- This model delivers accessible medical services with around 50% less GP sessions per week and longer GP appointments for complex patients
- Referral rates to the Community Mental Health Team and to Orthopaedics have been significantly reduced (around 50%)
- User experience feedback is very positive.

We held an Innovation Session to identify how we can use technology to work together and support self management and people with high health gains

These challenges are not limited to these two practices, and Forth Valley wide Primary Care, Urgent Out of Hours Care and Mental Health Transformation plans were agreed in 2016. The plans are being implemented to:

- Encourage GP practices to work together and take a multi-disciplinary approach to patient care within the community, freeing up GPs to focus on more complex cases and provide clinical leadership
- Develop new models of Primary Care support for people with mental health problems
- Enable the conditions for practical change through:
  - Educational support for pharmacy, nursing and AHP advanced practice
  - Promoting the use of outcome focussed conversations within Primary Care to support shared decision making
  - Supporting accelerated quality improvement within GP clusters
  - Promoting innovation and technology.

Case Study

Jim values his independence and enjoys socialising.

He said "I have some great days and some not so great ones. I know I have a lot going on, I just wish I could get on with my life so all these health issues aren't the only thing in my life!"

Recently

- Emergency hospital admission due to UTI
- Being assessed by Social Work for Care at Home

Jim has multiple issues including

- Diabetes
- Waiting for a wheelchair assessment - uses a walking stick to walk short distances
- Continence problems & frequent UTI
- Pressure Ulcers

Services used by Jim

- District Nurse
- GP visits at least every month
- Physiotherapy
- Day Centre twice a week
- Diabetes Clinic
- Neurology Service
- Mecs Alarm

Delayed Discharge

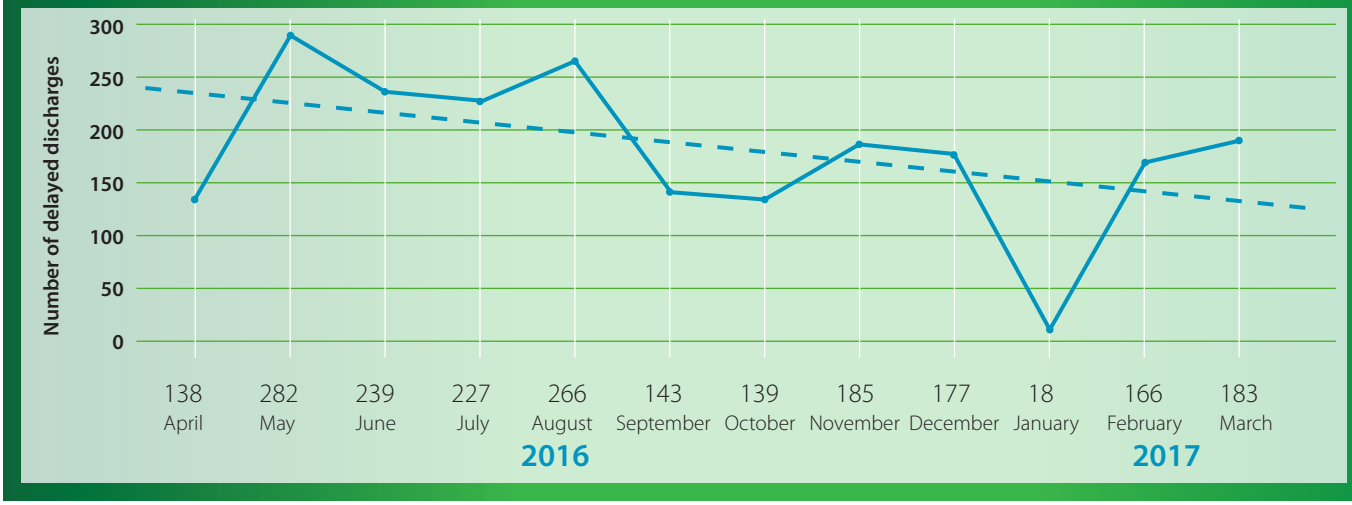
Although our performance shows some peaks and troughs there is a positive general downward trend for 2016/17. We continue to work together to reduce delays to discharge and to redesign services to support avoidance of unnecessary admission.

At the end of 2016/17 our performance for all delayed discharges is in the second quartile nationally.

As at March 17	Number of all delayed discharges
Partnership	23
Comparator Average	34
Scotland Average	41

Source: ISD 2016/17

Delayed Discharge Occupied Bed days over 2 weeks



Source: FV NHS 2016/17

3. Transforming Care: The Enablers

This section of the Annual Performance Report outlines the supporting activities (the underpinning Enablers) which also involve redesign activity but are often more about information and research or planning work that helps us to understand our population and services.

Strategic Needs Assessment

We based our Strategic Plan on a needs assessment and have continued to develop our understanding of our Partnership area and population over 2016/17. From this work we know that both Clackmannanshire and Stirling have 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.

	65-74 yrs	75-84 yrs	85-90 yrs	Total 18+ population
2014	13%	7%	2%	113,517
2039	16%	12%	3%	120,040

Source: National Records of Scotland

Technology Enabled Care

The Partnership secured grant funding of £162,000 from the Scottish Government's Technology Enabled Care programme. The project will concentrate on promoting a net increase in users of telecare by 15% across the Partnership area – 500 more users over the 2 year period of the project.

We set a target for 2016/17 to increase our numbers of service users across the Partnership area by 250 and exceeded this with our total additional users at 392.

In addition, by streamlining our processes and up-skilling staff, we have provided advanced technology to an increasing number of existing service users.

Housing Contribution

The population projections raise questions about the suitability of current local housing provision and the capacity of housing support services to ensure effective delivery for older people.

The multi-agency Housing and Social Care Group has been set up to look at this. A significant piece of research was carried out in 2016 to find out more about the housing needs of two priority groups; older people and homelessness.

Homelessness applications in the Partnership area have been reducing in the last 15 years but there is an upward trend over the last couple of years, with applications rising from 819 in 2013/14 to 1,045 in 2015/16. Homelessness affects a small proportion, around 1%, of households in the Partnership area, but the impact on lives and on services can be high and is often caused by health and support issues rather than housing.

Workshops have been held to focus on housing and social care for mental health, older people and homelessness.

The findings of this research are now informing the two Councils' Local Housing Strategies.

Data Sharing & Shared Assessment

The Partnership has defined its key strategic service requirements covering; operational logistics, information management and governance. We are working within the Forth Valley Data Sharing Partnership to take forward the following priorities:

- **Delayed Discharge**
- **Single Shared Assessment**
- **Information Sharing Portal**
- **File Sharing Across Health and Social Care**

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

Commissioning: Market Position and Providers

We have established provider fora and during the later part of 2016/17 have begun to jointly scope out the review our commissioning arrangements for the Partnership.

We developed a Market Position Statement for older people, learning disability and mental health. The Statement has been informed by consultation with our providers through a series of events and a survey.

Further work is required over the coming year to further develop our approach but development of our first Market Position Statement is a significant step forward.

We held 2 Market Position consultation events in 2016/17.

We held a focus group with providers in April 2017 to receive feedback on the draft Market Position Statement.

Workforce

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

- ***'Caring Together'***, our Integrated Workforce Plan (2016/19) - how we will support and develop staff across our Partners
- Partnership Workforce Development and Training – a framework for our joint approach
- Communication and Engagement Protocol on staff integration – delivering effective communication and a Partnership Participation & Engagement Strategy, to make sure any initiatives are aligned to our strategic priorities.

Promoting Excellence - Dementia programme highlighted as good practice by SSSC & NES

Some of the things we have carried out during the year include:

- Staff were involved in developing and informing the Strategic Plan and again in the setting of the Partnership core delivery priorities.
- During 2016/17 the two Health and Social Care Partnerships in Forth Valley issued newsletters to support information sharing.
- Further analysis of our work force is currently taking place with support from the Information Services Division. This is helping us to better understand our total staff group and identify where our resources are currently deployed, where we have pressures and skill gaps. This work will report during 2017/18.
- During this first year work has commenced on identifying and agreeing the best staff engagement and experience measurement tool.

207 staff across Health, Local Authorities (Social Services and Housing), Third and Independent Sectors, Primary Care and Fire and Ambulance Services took part in 7 mixed Staff Engagement events held in June 2016.

- We have engaged with the Collaborative Leadership in Practice [CLiP] national programme to support the development of the Joint Management Team
- The Scottish Social Services Council [SSSC] has been involved in the development of the Models of Neighbourhood Care pilot work and supported two sessions with senior managers using a collaborative enquiry process to build knowledge, understanding and commitment. They will continue to be involved as the work develops further
- The Partnership's work in using the Promoting Excellence framework to deliver training to improve skills and experience in relation to dementia was highlighted as good practice by the Scottish Social Services Council (SSSC) and NHS Education for Scotland (NES). The Programme is interactive and was initially piloted in a care home before being rolled out to a group of 250 staff. There is also a plan to create a local network of Dementia Ambassadors across all services
- We have established a Joint Staff Forum for the two Health and Social Care Partnerships which brings together the staff side and trade union representatives from NHS Forth Valley and the three Councils – Clackmannanshire, Falkirk and Stirling.

'Not only has the Skilled Practice Programme affected how people communicate and support people with dementia, it has also led to staff taking the initiative to review and improve a number of service areas, including the review of care paperwork to make it even more outcome focussed, person-centred and service user friendly.'

Hazel Chalk, Registered Manager, Allan Lodge Short Term Assessment Care Home, Stirling

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.

Financial Performance

The funding available to the Integration Joint Board to support the delivery of the Strategic Plan comes from contributions from the constituent authorities (Clackmannanshire and Stirling Councils and NHS Forth Valley) and 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 its behalf to deliver the priorities of the Strategic Plan.

For the financial year ended 31 March 2017 the Partnership's underlying financial position was a net underspend of £0.003m. However, by utilising the terms of the Integration Scheme, the Reserves Policy and Strategy and to manage the difference in timing between allocation of funding and investing for optimal benefit the Integration Joint Board will carry forward funding totalling £3.412m into 2017/18, through a combination of general and earmarked reserves.

The expenditure of the Integration Joint Board for the year ending 31 March 2017 is detailed below. These figures are subject to audit.

Service Area	£'000
Set Aside Budget for Large Hospital Services*	19,816
Community Learning Disability Services	1,294
Community Mental Health and Addictions Services	6,846
Older People, Reablement, Physical and Sensory Impairments	4,348
Other Social Care Services	1,108
Care at Home	11,886
Residential and Respite Care	17,084
Day Care	3,052
MECS and Telecare	1,091
Housing & Equipment and Adaptations	7,299
Other Community Health Services	28,333
General Pharmaceutical Services and Primary Care Prescribing	31,930
Other Primary Care Services	33,453
Shared Partnership Posts	235
Integration (Social) Care Fund	5,733
Transformation	2,951
TOTAL EXPENDITURE	**176,459**

**Relates to Large Hospital Services delivered in the Acute Sector for which the IJB is responsible for Strategic Planning but not Operational Delivery. This is a notional budget.*

Best Value

The constituent authorities, Clackmannanshire and Stirling Councils and NHS Forth Valley, delegate budgets 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.

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

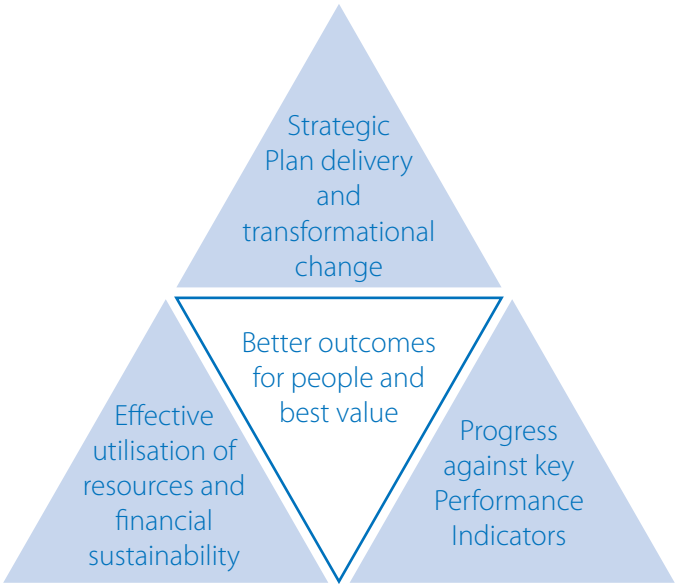
The Integration Joint Board ensures proper administration of its financial affairs by having a Chief Financial Officer (section 95 of the Local Government (Scotland) Act 1973).

As part of governance arrangements to oversee the change programme, the Chief Officer chairs both a Senior Leadership Group and Joint Management Team.

The Partnership views the triangulation of key Performance Indicators, measurable progress in delivering the priorities of the Strategic Plan, and financial performance as the cornerstone of demonstrating Best Value. Therefore the evidence of Best Value can be seen through:

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

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



Financial Reporting on Localities

The 2016/17 financial information is not split into Localities, as this level of financial reporting will be developed during 2017/18. This will be based on Locality Planning arrangements that the Integration Joint Board approved during 2016/17.

Integrated Care Fund

The Partnership received £2,480,000 from the Integrated Care Fund (ICF) from the Scottish Government during 2016/17. 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 the intermediate care model to all adults, particularly 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 and 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, reviews have been carried out. Further work is also planned to identify linkages and collaborative working in order to improve service delivery and ensure financial efficiencies.

We are also developing the way that funded projects will be monitored and reviewed in the future, ensuring close links with the performance framework, Strategic and Delivery Plan priorities, and National Outcomes. This approach will be more fully developed for 2018/19.

4. Outcomes: Our Performance

National Outcomes and our Local Framework

Integration Joint Boards are responsible for effective monitoring and reporting on the delivery of services and 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 understand how well services are meeting the individual outcomes for people using services and for communities.

The national outcomes are currently subject to review, with a view to more closely aligning to the national Health and Social Care Delivery Plan, published by the Scottish Government in December 2016.

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

Performance Under Integration

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

Performance Framework & Improvement Objectives

Improvement Objectives			
	Unplanned Admissions	Occupied Bed Days for Unscheduled Care	A & E Performance
	Delayed Discharges	End of Life Care	Balance of Spend across Institutional & Community Services

Work is ongoing to develop these and we have developed a Strategy Map which helps us to clearly link the Outcomes to the Strategic Plan.

The Outcomes are supported by a Core Suite of Integration Indicators. This data is provided to each Partnership by Information Services Division. The unique nature of our Partnership means that sometimes our data is provided at Local Authority level only, and existing formal Local Authority comparator or family groupings are not relevant. It is not always possible to provide a figure for the Partnership from the Local Authority based data, and it may at times be an average of the two figures. Work is ongoing to develop reporting processes at local and national level that provides data in the format that we require for the Partnership. For example, receiving Partnership only data would mean that we would lose the historical trend information for the two areas and this is very useful to help inform locality planning. In an effort to give a fuller understanding of our performance, the Partnership has identified a range of comparator Partnerships. Work is ongoing to develop collaborative working with our comparators and learn from good practice.

Our Performance: A Summary

Indicators 1-9 of the core indicators draw on questions from the Health & Care Experience Survey. The results from the 2015/16 survey will form part of the baseline from which improvements in people's experience of care can be monitored.

The Partnership has set baseline data for this first annual report (the most current data available at the time of publication).

Core Suite of Integration Indicators - Annual Performance (as at June 2017)

	Indicator	Title	Partnership	Comparator Average	Clacks	Stirling	Scotland
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	94%	95%	94%	94%	94%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	85%	83%	89%	82%	84%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	79%	79%	82%	78%	79%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	74%	78%	71%	76%	75%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	80%	82%	87%	76%	81%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	87%	87%	89%	86%	87%
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	77%	85%	78%	77%	84%
	NI - 8	Total combined % carers who feel supported to continue in their caring role	34%	43%	31%	35%	41%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	82%	85%	84%	80%	84%
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	N/A	N/A	N/A	N/A	N/A

Source: ISD is still developing these indicators and N/A defines where no data is available yet.

Comparators: South Ayrshire, East Lothian, Angus, Moray, Perth & Kinross, Falkirk. Figures as at June 2017

Core Suite of Integration Indicators - Annual Performance (as at June 2017)

	Indicator	Title	Partnership	Comparator Average	Clacks	Stirling	Scotland
Data indicators	NI - 11	Premature mortality rate per 100,000 persons aged under 75 years	425	387	481	393	441
	NI - 12	Emergency admission rate (per 100,000 adult population)	9,874	11,346	10,854	9,344	12,037
	NI - 13	Emergency bed day rate (per 100,000 population)	107,243	123,028	116,845	102,050	119,649
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	101	103	108	96	95
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	87%	88%	86%	86%	87%
	NI - 16	Falls rate per 1,000 population aged 65+	16	20	14	17	21
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	83%	84%	91%	78%	83%
	NI - 18	Percentage of adults with intensive care needs receiving care at home	69%	62%	70%	68%	62%
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	723	964	641	764	842
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	20%	25%	22%	20%	23%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	N/A	N/A	N/A	N/A	N/A
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	N/A	N/A	N/A	N/A	N/A
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	N/A	N/A	N/A	N/A	N/A

Source: ISD is still developing these indicators and N/A defines where no data is available yet.

Comparators: South Ayrshire, East Lothian, Angus, Moray, Perth & Kinross, Falkirk. Figures as at June 2017

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.

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
Partnership	94%
Comparators	95%
Scotland	94%

Source ISD 2015/16

The percentage reported for both Clackmannanshire and Stirling reflects a positive position comparable with the national and comparator average. **The vast majority of those surveyed reported 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 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
Partnership	85%
Comparators	83%
Scotland	84%

Source ISD 2015/16

This indicator reflects whether people who need support feel that it helps them maintain their independence as much as possible. The Partnership figure shows a positive position and is above national and comparator average. 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.

Table Symbols

Benchmark
Survey
Achieved
More work required

Outcome 2 cont'd

NI 18	% of adults aged 18+ with intensive care needs receiving care at home
Partnership	69%
Comparators	62%
Scotland	62%

Source ISD 2015/16

The figure for the Partnership is a positive position and is above both national and comparator averages. **This indicator reflects the work of the Partnership to shift care from hospitals and care homes to the community.**

NI 15	Proportion of last 6 months of life spent at home or in a community setting
Partnership	87%
Comparators	88%
Scotland	87%

Source ISD 2016/17

The figure for the Partnership reflects a positive position and is the same as the national average and just below the comparator average. One reason for this may be that the Partnership has traditionally used local community hospitals more than other Partnerships. **The development of the Care Village will change this type of hospital based support in the future 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 and 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.
Partnership	79%
Comparators	79%
Scotland	79%

Source ISD 2015/16

The figure for the Partnership reflects a positive position and is in line with both national and comparator averages. **Most people receiving care and support feel that 'having a say' over the way their services are provided is very important. However, we do know that 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
Partnership	87%
Comparators	87%
Scotland	87%

Source ISD 2015/16

The figure for the Partnership reflects a positive position and is in line with both the national and comparator averages. **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.
Partnership	80%
Comparators	82%
Scotland	81%

Source ISD 2015/16

The figure for the Partnership reflects a positive position and is only slightly less than both national and comparator averages.

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
Partnership	77%
Comparators	85%
Scotland	84%

Source ISD 2015/16

The figure for the Partnership is lower than both the national and comparator average. A considerable amount of work is already carried out within and between services to gather and analyse feedback and impact. **The Partnership will review this work and identify any areas for further development.**

Outcome 4 cont'd

NI 12	Emergency Hospital Admission Rate per 100,000 adult persons
Partnership	9,874
Comparators	11,346
Scotland	12,037


Source ISD 2016/17

The figure for the Partnership reflects a positive position and is lower than both the national and comparator averages. Just under half of the emergency adult admissions in 2016/17 were for those aged 65 and over.

NI 13	Emergency bed day rate per 100,000 adult persons
Partnership	107,243
Comparators	123,028
Scotland	119,649


Source ISD 2016/17

The figure for the Partnership reflects a positive position and is lower than the national and comparator averages.

NI 14	Readmission to hospital within 28 days rate per 1,000 persons
Partnership	101
Comparators	103
Scotland	95


Source ISD 2016/17

This rate reflects several aspects of integrated health and care service, including discharge arrangements and co-ordination of follow up care. Although the figure for the Partnership is higher the national average it is lower than other similar Partnerships.

NI 16	Falls rate per 1,000 population aged 65+ who were admitted to hospital as an emergency
Partnership	16
Comparators	20
Scotland	21


Source ISD 16/17

The figure for the Partnership reflects a positive position and is lower than both national and comparator averages. **Examples of work in this area are 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
Partnership	83%
Comparators	84%
Scotland	83%


Source Care Inspectorate/ISD 2015/16

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

Forth Valley Royal Hospital received an unannounced inspection in November 2016. The inspection focussed on care of the older people in the hospital. The inspection team found that there was very good feedback and evidence that older people were treated with dignity and respect.

Outcome 5

Health & social care services contribute to reducing health inequalities

NI 11	Premature mortality rate per 100,000 persons under 75 years	
Partnership Av	425	
Comparators Av	387	
Scotland Av	441	

Source ISD 2015

The Partnership figure is higher than our comparators but lower than the national average. This is an area that the Partnership will investigate, with a particular focus on Localities and communities to identify any areas for further development.

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	
Partnership	34%	
Comparators	43%	
Scotland	41%	

Source ISD 2015/16

The Partnership is lower than the national and comparator average. **As noted above 80% of adults receiving any care rate it as excellent or good.** 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.

Outcome 7

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

NI 9	% of adults supported at home who feel safe	
Partnership	82%	
Comparators	85%	
Scotland	84%	

Source ISD 2015/16

The figure for the Partnership is lower than both the national and comparator averages. **The Partnership is working with the Adult Support and Protection Committee to develop our responses.**

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. No published data available.

There are a number of pieces of work being carried out locally that support this outcome: iMatter is the staff experience continuous improvement tool designed with NHS Scotland to help individuals, teams and Health Boards understand and improve staff experience; a similar survey of Local Authority staff is planned for 2017/18. We have also established a Joint Staff Forum to support engagement.

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	
Partnership	74%	
Comparators	78%	
Scotland	75%	

Source ISD 2015/16

The figure for the Partnership is in line with the national average, but is slightly lower than our comparator Partnerships. **In terms of service examples, a considerable amount of work has been carried out in relation to the use of Single Shared Assessment and 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	
Partnership	723	
Comparators	964	
Scotland	842	

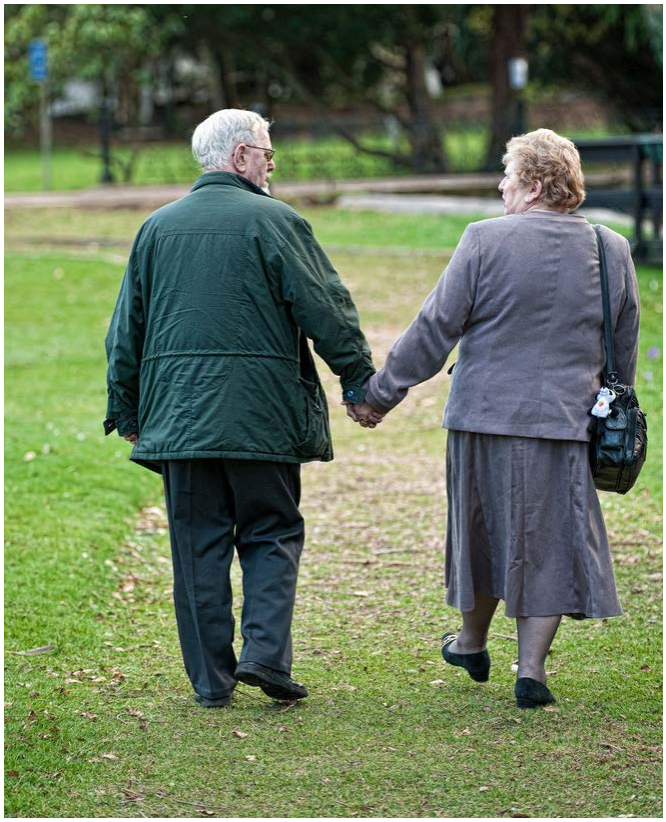
Source ISD 2016/17

The Partnership figure reflects a positive position with the rate much lower than both the national and comparator averages. The combined total of Standard and Code 9 delays is used for this indicator.

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

Source ISD 2016/17

The Partnership figure reflects a positive position and the rate is lower than both the national and comparator averages.



Inspections

The Care Inspectorate undertook both scheduled and unscheduled inspections across 9 services during 2016/17. The quality of care and support was assessed as 'good' or better in 100% of these inspections. There were no mandatory requirements and a number of recommendations made by inspectors, which have or are being acted upon by staff. Additional information and full detail on inspections can be found at the Care Inspectorate's website at www.careinspectorate.com/

Unit	Date Inspection completed	Quality Theme Care Grades (out of 6)				No. of recs	No. of requs
		Care and Support	Environment	Staffing	Management & Leadership		
Care Inspectorate							
Allan Lodge	24/06/16	5	N/A	5	N/A	0	0
Beech Gardens	05/12/16	5	5	5	5	7	0
Clacks Reablement & TEC Service	16/12/16	5	N/A	N/A	5	1	0
Stirling Reablement & TEC Service	29/09/16	5	N/A	N/A	5	0	0
Ludgate House Resource Centre	04/11/16	6	5	6	6	4	0
Menstrie House	25/07/16	4	4	4	4	7	0
Stirling Council Community Services Home Support	29/09/16	5	N/A	N/A	5	0	0
Strathendrick Care Home	04/07/16	5	N/A	N/A	5	0	0
Riverbank Day Centre	29/04/16	5	N/A	6	N/A	0	0
Customer Service Excellence							
Integrated Mental Health Service	Overall Self assessment	Satisfactory					
	Overall outcome	Successful					

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

N/A Not Assessed

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.

Requ 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 Recommendations

Unit	Action
Beech Gardens	
The service is currently gathering information about local community resources with the Carers Centre to help people reintegrate into their communities on their return home. We suggested this include services/ resources for people with dementia.	The service has developed an action plan to include development of dementia resources.
Some service users are in the service for an extended period of time awaiting packages of care. Consider providing activities for these people to provide social/ mental stimulation while they are waiting to move on.	The service has introduced activity plans for service users with a focus on improving access to community resources and benefiting from physical activity. The service is participating in the national CAPA programme.
The communal toilet in the unit is being used for storage. It should either be cleared, or taken out of use.	This has been actioned.
Hoists and turning equipment should be appropriately stored.	This has been actioned.
Staff should have one-to-one supervision meetings, giving them opportunities to discuss their work,development and give views on aspects of the service.	Supervision schedules have been devised to ensure discussion of service improvements/ development of Stirling Care Village.
Identified some poor recording on MAR sheets and some medication errors. The service should address this via refresher training, observation of practice and group supervision.	The Registered Manager has carried out weekly audits of all medication activity and improved access to training opportunities for all staff who administer medicines.
We found from the issues around medication that the service is under reporting to the Care Inspectorate. The service should ensure they are familiar with the guidance for reporting notifiable events. This will be observed by us and checked at the next inspection.	The Registered Manager is adhering to guidance on reporting notifiable events.
Clacks Reablement & TEC Service	
The service should review their medication policy and procedure to take account of the increased range of medications they now support people with. Warfarin and Controlled Drugs should be referred to specifically.	The internal policy has been amended, while the service is supporting the testing of a Community Medicines Management Policy with Pharmacy Service.
Ludgate House Resource Centre	
The service should ensure that wall switches are in a contrasting colour from the walls for ease of orientation for people with dementia.	This has been actioned.
The service should ensure that toilet seats are in a contrasting colour to aid ease of orientation.	This has been actioned.

The service has an easily accessible enclosed garden which could be developed further for residents with dementia e.g. using different colours or developing a sensory garden.	Improvements to the courtyard garden were made for Summer 2017 with use of flower beds to provide colour. Service engaging with Community Growing Group to develop this further.
The service could ensure they have small activities to hand for residents with dementia, such as rummage boxes and comfort blankets.	This has been actioned.
Menstrie House	
The provider should ensure that residents' personal plans set out how the health, welfare and safety needs of the individual are to be met.	Service personal plans have been improved to identify greater information relating to healthcare needs and personal outcomes. Wider service engaging with the national Anticipatory Care Planning work and will develop this further over next year.
The provider should review the provision of meaningful activities for residents.	Service has an Activities Co-ordinator who is supporting further development of meaningful activities. Service is engaged with national CAPA programme.
The provider should consider best practice guidance to improve the signage in the home to guide and orientate people who use the service.	Signage has been improved along with environmental improvements to support effective wayfinding.
The provider should ensure that the use of equipment that may restrain, such as bedrails, is fully assessed and monitored in line with the Mental Welfare Commission for Scotland's best practice guidance Rights, risks and limits to freedom.	The Registered Manager has improved assessment tools for assessing risk for bedrail management.
The provider should access the Promoting Excellence Framework for dementia learning and development for all staff working in the home.	Staff are working towards or have achieved the Dementia Skilled level of practice under the Promoting Excellence Framework.
The provider should utilise the outcome of risk assessments to inform an overview of risk within the service and monitor the management of risk for residents.	The Registered Manager has introduced an audit to be used monthly for the analysis of a range of tools including risk, nutrition and skin integrity. Further work required on falls risk tools/approach.
The provider should implement a system to ensure that six monthly care reviews are scheduled and undertaken within timescales.	The Registered Manager has introduced an audit tool to ensure compliance with 6 monthly reviews.

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 first year has been to jointly identify and work on the actions the Partnership can take together to strengthen and develop the building blocks for community based services.

The performance information helps us to:

- understand the impact of the services we provide
- identify the areas where outcomes are positive
- identify the areas where we need to work to improve services and impact for individuals.

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.

6. Glossary And Abbreviations

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. In medical terms, it is the opposite of chronic or longer term care.

AHP

Allied Health Professionals (such as Physiotherapists, Occupational Therapists, Speech and Language Therapists, Podiatrists) provide treatment and help rehabilitate people who are ill, have disabilities or special needs, to live life as fully as possible.

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.

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. This enables the Partnership to find out how well it is doing compared to others and can help to highlight areas to focus activity on.

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.

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.

Collaborative Leadership in Practice Programme (CLiP)

Part of the Leadership for Integration development programme offered in joint partnership by NES, the Royal College of General Practitioners Scotland and SSSC.

Comparator

A selected grouping of other Partnerships who share agreed similarities e.g. population size. The group is then used to compare performance against.

'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.

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

The Public Bodies (Joint Working) (Scotland) Act 2014 sets the legal framework for health and social care services in Scotland to be integrated. With a greater emphasis on community-based and more joined-up, anticipatory and preventative care, integration aims to improve care and support for those who use health and social care services.

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.

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

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.

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.

Locality Planning

A locality is defined in the Public Bodies (Joint Working) (Scotland) Act 2014 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.

NES

NHS Education for Scotland (NES) is an education and training body with responsibility for developing and delivering education and training for the healthcare workforce in Scotland.

NI

National Indicator. In this case, the National Core Integration Indicators set by the Scottish Government to help measure performance.

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.

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.

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.

SSSC

The Scottish Social Services Council (SSSC) is the regulator for the social service workforce in Scotland.

Technology Enabled Care

Technologies such as telehealth, telecare, telemedicine, telecoaching and self-care apps 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. There have been many developments in technology to increase the options to help people, such as automatically alerting staff at a response centre or a carer if help is needed.

Third Sector

An umbrella term for a range of organisations with different structures and purposes belonging to neither the public nor private sectors (e.g. voluntary sector or non-profit organisations).

Whole Systems Working

An approach to change that helps people make connections, with both people and ideas, to enable them to find local solutions to local concerns.

Publications in Alternative Formats

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