Clackmannanshire & Stirling
Health & Social Care Partnership

Annual Performance Report

2019 – 2020

Clackmannanshire Council

Stirling Council

NHS Forth Valley

Contents

Our Fourth Year

Message from the Chair

Welcome to our Annual Performance Report which reflects on our progress together as a Health and Social Care Partnership from 1 April 2019 to 31 March 2020.

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

Progress on our key priorities made throughout 2019/2020 is set out in further detail within this report.

We must recognise the COVID-19 pandemic which was declared by the World Health Organisation on the 11 March 2020.

Staff within the Health and Social Care Partnership alongside colleagues in our Partner organisations across the statutory, third and independent sector worked tirelessly to ensure the safe and effective provision of health and social care across the Partnership area to support people in communities.

This report will not reflect the significant work and efforts of all people who supported the communities of Clackmannanshire & Stirling throughout the Pandemic. This will be reflected in more details in next year's annual performance report 2020 - 2021.

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

I hope you enjoy reading about our progress.

Cllr Les Sharp
Chair Clackmannanshire &Stirling

Vision	Priorities	Enabling Activities				Strategies and Initiatives to deliver change
...to enable people in the Clackmannanshire and Stirling Health & Social Care Partnership area to live full and positive lives within supportive communities	Care Closer to Home	Technology Enabled Care	Workforce Planning and Development	Housing / Adaptations	Infrastructure	Intermediate Care Strategy
	Primary Care Transformation					Primary Care Improvement Plan
	Caring, Connected Communities					Carers (Scotland) Act 2016 Community Empowerment (Scotland) Act 2015 Free Personal Care for under 65's 'A Connected Scotland: our strategy for tackling isolation and loneliness and building stronger social connections' Public Health Priorities for Scotland
	Mental Health					Mental Health Strategy
	Supporting people living with Dementia					Dementia Strategy
	Alcohol and drugs					Forth Valley ADP Strategy

The Year In Figures 2019-2020

37.5% of reablement clients reduced their care hours because they were more independent at the end of the intervention.

2019-2020
66 referrals to Adult Social Care for those in carer care group.

436 Adult Support Plans for carers completed in Adult social Care.

Clients seen within 5 weeks

19/20 Average

97.5%
Clackmannanshire & Stirling ADPs

Target 90%

Alcohol & Drug Treatment Wait Times

1,002 clients received a Reablement Service, re-learning daily skills to help them be more independent.

Number of Adults at Risk of Harm subject to an Adult Support and Protection Investigation:

148

91% of Care services graded good, or better by Care Inspectorate Inspections

4,493 Adult Care Referrals

Section 1 - Introduction

Purpose of the Annual Performance Report

The Clackmannanshire and Stirling Integration Joint Board (IJB) was established on 1 April 2016 and is responsible for planning and setting direction for the majority of integrated health and social care services for adults in the area.

The Integration Joint Board assesses how it has delivered services and improved outcomes for the people of Clackmannanshire and Stirling in the previous year through an annual performance report.

This report is an assessment of progress towards "enabling people in Clackmannanshire and Stirling to live full and positive lives within supportive communities".

Information and data we use to measure our performance

To compile this report, we have used a mixture of nationally and locally available information. This will set out how the Health and Social Care Partnership is delivering services and improving outcomes for the people of Clackmannanshire & Stirling.

Appendix 1 demonstrates how our Strategic Plan 2019-2022 priorities link with the National Health and Wellbeing Outcomes and the National Health and Care Standards.

Due to local data delays in SMR01 returns the Core Suite of Integration Indicators, to measure progress against the National Health and Wellbeing Outcomes, has been estimated and therefore not comparable to other Partnerships.

The estimated National Health & Wellbeing indicators are included for reference in Appendix 2. An improvement plan is in place to ensure SMR01 returns are completed.

Our Strategic Commissioning Plan and Partnership Priorities 2019-2022

HSCP PRIORITIES:

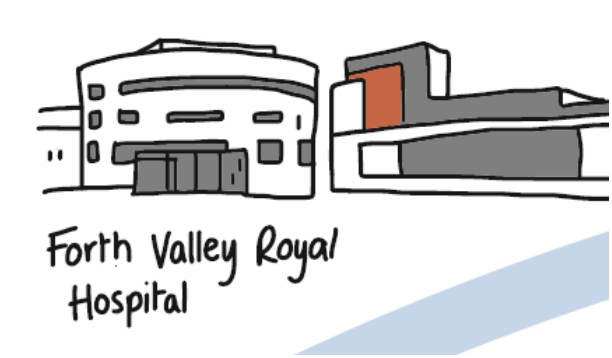
- Care Closer To Home
- Primary Care Transformation
- Caring, Connected Communities
- Mental Health
- Supporting People Living With Dementia
- Alcohol And Drugs

Section 2 - Care Closer To Home

> *"We will work to reduce people going to hospital, support more people to stay well at home, improve timely access to community services, and build enablement approaches across the Partnership."*
>
> *Strategic Plan 2019-2022*

Community health and social care integration creates the conditions to shift the balance of care from acute hospital to community settings to ensure that **'people live independently and at home or in a homely setting in their community'**.

People also have the right to make **personal choices at the end of life, to** be supported in their home or within the community in a care home or communityhospice.



Improving emergency or unscheduled care within hospitals across Scotland is a key priority for the Scottish Government.

The aim is to delivering reductions in:

- Delays in hospital discharge planning
- Unnecessary hospital admissions
- Attendances at accident and emergency (ED)

Meeting our targets for emergency or unscheduled hospital admissions has proved challenging during 2019/20.

People can arrive at Emergency Departments through different ways, the most commonly identified were[1]:

Individuals	Self Referral	Ambulance	GP Referral
Attended	18,706	6,209	755
Admitted	1,653	3,887	171
%	9%	63%	23%

These hospital attendances were not planned and have a big impact on health and social care resources where they become emergency admissions to hospital.

The cost to the NHS for emergency admissions was £1,156,648.

Where people received no social care support or a little support before admission to hospital, this is often increased after they leave hospital. As their ability to remain independent may have reduced, regardless of their health condition.

1 This relates to 17/18 data which is the most up to date national data available for this type of analysis.

Locality Data 2016-2018

Source: Scotpho

Clackmannanshire

Highest rate of emergency patient hospitilisations amongst localities but lower than Sotland average
Highest rate of psychiatric hospitilisations amongst localities and higher than Scotland

Stirling City & Eastern Villages

Highest rate of multiple hospital emergency admissions for those aged 65+ amongst localities but less than Scotland average 2016-2018
Rate of psychiatric hospitalisations higher than Scotland

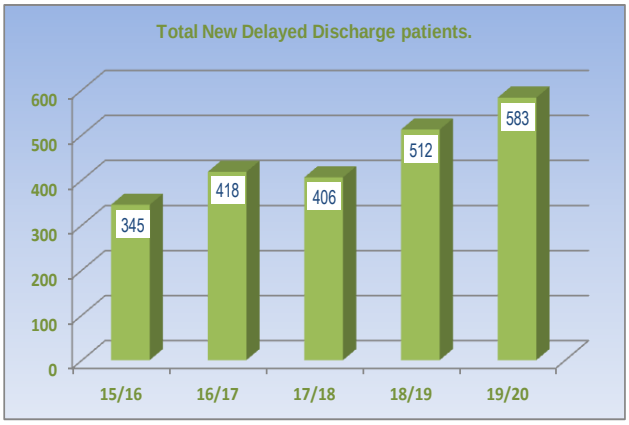
Stirling Rural

Rate of psychiatric hospitalisations lower than Scotland average

Avoid unnecessary delays in hospital discharge

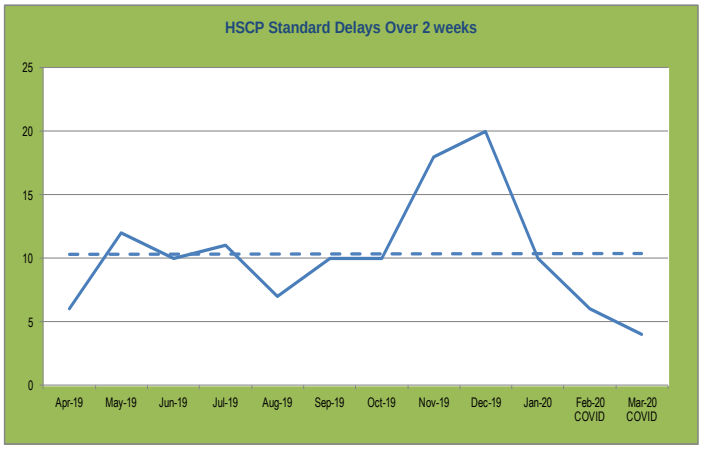
We continue to work to minimise any delays to discharge, and redesign services to support avoidance of unnecessary admission.

The graph below shows a rise in new patients who were delayed in their discharge from hospital compared to the previous year[2].



Meeting our targets for delayed discharges last year proved challenging.

Our performance for those patients waiting 2 weeks or more to go home shows a variable trend for 19/20 with the drop in the spring attributable to the COVID-19 pandemic where patients were moved quickly from hospital into the community to provide capacity within acute services.



Source: FV NHS

[2] The number reduced significantly in the last quarter of the year during the Pandemic.

The Health and Social Care Partnership strives to help people remain independent and safe within their own home or a homely setting for as long as they are able to: maintaining their connections with their communities and their quality of life.

An increasing number of older people and those with complex health conditions were delayed in hospital last year, resulting in pressures within the management of unscheduled care and delays for people being discharged from hospital.

Community health and social care prevention and interventions

Many adults can be supported at home, even when unwell, and that to stay unnecessarily in hospital can be detrimental to people's ability to manage their own care, leading to a loss of function.

This has led to a strong focus on working to improve pathways to reduce delays in discharge planning for those receiving care and their families and carers.

Along with our focus on prevention, effective discharge from hospital is also important in reducing the risk of re-admission.

District Nursing, NHS Enhanced Community Team, and Adult Social Care work together to support people in their own homes and prevent the need for uneccessary hospital admissions.

Some community health services were transferred to the Health and Social Care Partnership at the end of January 2020.

The community nursing team is available 24 hours a day, 365 days a year, and provides planned and unplanned care.

Activity over January to March included 23,526 contacts with people:

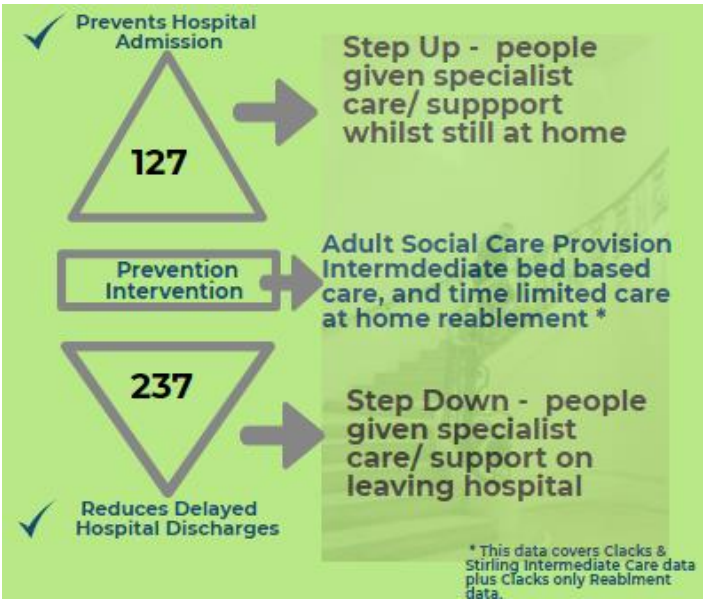
- Home visits 17,201
- Treatment room appointments 6,325

In addition, 408 telephone calls provided advice to people or redirected to another service and 94 people were supported to die at home.

The Health and Social Care Partnership also helps people to regain or maximise their independence by offering Social Care services such as Reablement or Intermediate Care.

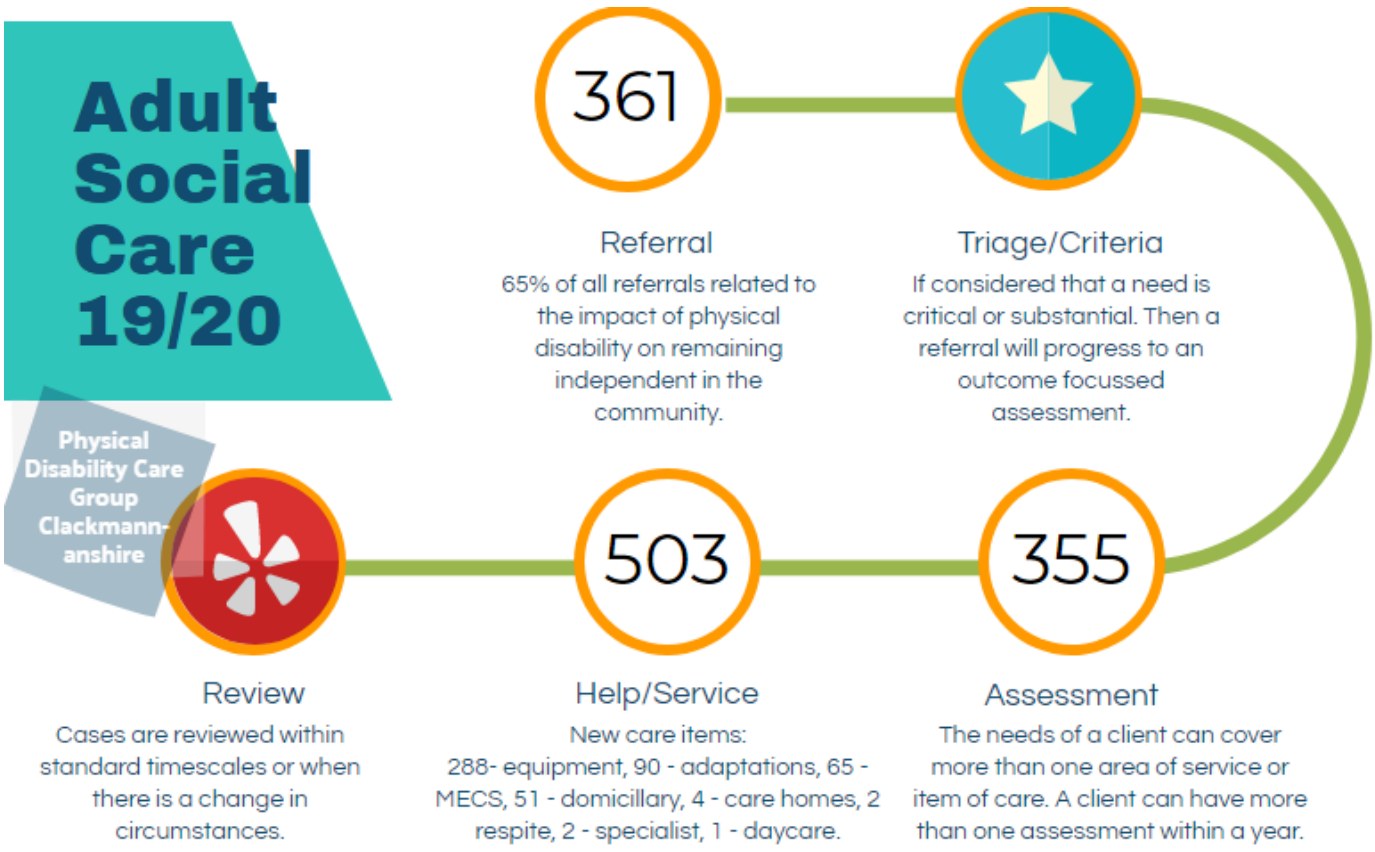
This can be offered to prevent someone going into hospital or when someone is leaving hospital.

40% of service users aged 65+ receive over 10 hours care a week.



Intermediate Care, Reablement Services, and Care at Home support people to achieve their agreed personal outcomes such as preparing their own meals, resuming their personal care, being able to access community resources they previously enjoyed.

Adult Social Care Reablement services focus on helping people to relearn daily skills they may have lost due to a deterioration, crisis or hospital admission. Allowing people to regain confidence, independence, potentially avoid a hospital admission or re-admission and to live safely at home for as long as possible.



Section 3 - Primary Care Transformation

> ***"Work together and take a multi-disciplinary approach to improving primary care. Scale up the support to all GP practices."***
>
> *Strategic Plan 2019-2022*

We know that access to GPs and primary care support matters greatly to people and to the wider health and care system[3].

The Primary Care Improvement Plan 2018-2021 encourages GP practices to work together and take a multi-disciplinary approach to improving primary care.

By developing the role of health professionals such as pharmacists, physiotherapists, mental health professionals and advanced nurse practitioner, we are able to free up precious GPs time to focus on those with complex needs.

24 of the 28 GP practices in Clackmannanshire & Stirling have direct access to dedicated Primary Care Mental Health Nurses.

Therefore, supporting the delivery of a seamless pathway for patients to care and support from mental health services timeously. We will scale up the support to all GP practices.

Pharmacotherapy

With additional pharmacists and pharmacy technicians supporting GP practices in North West Stirling, the Pharmacy Team have transferred significant levels of acute and repeat prescribing and medication management activities from GPs and supporting people with medication needs on a daily basis.

This model will be spread to all GP practices by April 2021.

Additional Professional Roles

Across Clackmannanshire and Stirling GP practices we now have advanced practice physiotherapists, mental health nurses, advanced nurse practitioners, and health care support workers'

These additional roles act as a first point of contact to assess and direct care for urgent health issues, muscle and joint problems, mental health issues, provide additional access for blood tests and support residents living in care homes.

[3] We asked the public at two public partnership forums, in September 2018, 'what matters when seeking healthcare advice or support'.

Your practice team is changing[4]

Accessing the right community support at the right time is vital for those in all our communities, the table below describes how the GP practice team is changing to ensure that all patients know who to contact for their specific issue.

GP Receptionists

Trained to ask a few questions so they can direct you to the right member of the Practice team. GPs in each Practice advise the receptionists on which questions to ask and which healthcare issues can be directed to other colleagues.

Mental Health Nurses

Able to provide support, advice and for many common mental health issues including anxiety, stress and low mood. They can offer guidance, support and a range of treatment options or refer you to specialist mental health services, if appropriate.

Advanced Physiotherapy Practitioners (APPs)

Provide highly skilled assessment, diagnosis and management for muscle, joint and soft tissue problems. They can also provide a wide range of self care options and advice to help manage these problems and refer for further tests and investigations, if required.

Advanced Nurse Practitioners (ANPs)

Highly skilled professionals who have undertaken additional training to assess, diagnose and treat a wide range of conditions which you may have seen a GP for in the past. If required, they can prescribe medication and refer you to hospital services.

Practice Clinical Pharmacist

Work alongside GPs and can carry out a review of the medicines you are taking and answer any questions you have. If you feel your medication isn't working or you are concerned about side effects they may be able to suggest alternatives.

General Practice Nurses

See people of all ages and have a varied role. They support patients in managing a range of long term conditions such as asthma, diabetes and high blood pressure. They also carry out cervical screening, give advice on sexual health, contraception and hormone replacement therapy.

GPs

Doctors who support and treat people with more complex or serious health conditions. Many people won't need to see a doctor as you can now be assessed and treated by one of the other experienced healthcare professionals based at the Practice, however, you will always be able to see a doctor, if required.

Phlebotomists

Phlebotomists are trained in the process of taking samples of blood. This is normally requested by another member of the Clinical Team and can be quicker than waiting for a nurse or GP appointment for blood samples.

[4] https://nhsforthvalley.com/health-services/know-who-to-turn-to-when-you-are-ill/your-gp-practice/

Section 4 - Caring Connected Communities

> *"Work with unpaid carers to support them in their role. Work with the Third Sector to reduce isolation and loneliness of older adults. Expand the neighbourhood care model to other localities. Expand housing with care opportunities across all localities. "*

The Health and Social Care Partnership has three distinct localities Clackmannanshire, Stirling Rural and Stirling Urban.

Each of these areas is sufficiently large enough to support area-based service planning and development, whilst also providing scope for local involvement.

We know that population changes mean a changing demand and use of services, particularly for older people and people with multiple and complex health conditions.

However, there are some significant variances in terms of socio-economic opportunity across the Localities. This has an impact on health and wellbeing within our communities, as demonstrated within the locality profiles which are published on our website.

In early 2020, as part of the development of the new Health and Social Care Partnership Management Team, dedicated resource was allocated to support the development of our Localities to ensure community participation and co-produced local services models.

Some preparatory work has been undertaken during spring; however, this had to be paused due to the Covid-19 pandemic.

During 2020-2021 this work will recommence, with the development of an approach to supporting localities which is inclusive and addresses disparity.

Planned activity includes:

- A refresh of Locality Profiles
- A refresh of the Participation & Engagement Strategy
- Test of concept of a community hub model
- Establishment of local task groups to address locally identified priorities
- Establishment of a virtual network
- Explore establishment of Community Link Workers (linked to Primary Care Improvement)

In October 2019 Stirling Health and Care Village opened, which **has transformed the way we provide bed based short stay assessment** and Primary Care services and facilities in Stirling.

This coupled with the development of our first Neighbourhood Care Team is **beginning to create a locality model which will support service change further**.

The Neighbourhood Care Project brought together existing community nurses, adult social care workers, and re-ablement/rehabilitation services to become a **co-located, integrated Neighbourhood Care Team** (NCT) working from Buchlyvie Medical Centre.

A Resource Worker was also recruited into the Health and Social Care Partnership in 2018.

The Resource Worker identifies and fills gaps in informal community supports by working closely with local community groups, forums, Health and Social Care Partnership practitioners and 3rd sector and community organisations.

Some of the supports developed in response to community ideas include

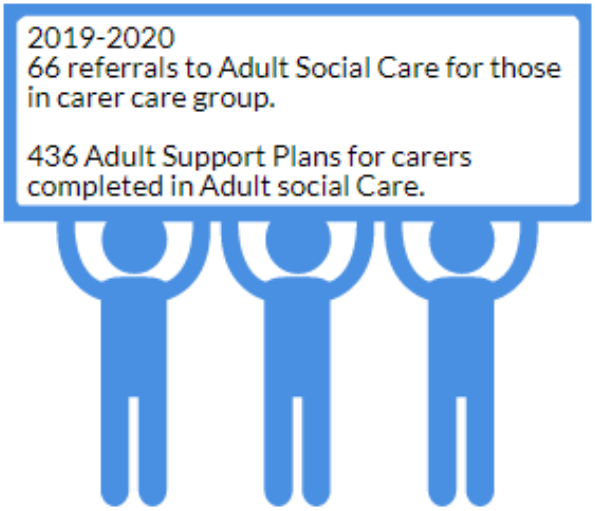
- Tea & Tunes in Balfron & Drymen)
- Trossachs Search and Rescue Volunteer Responder partnership with Stirling Council Telecare
- Alzheimer Scotland Drop-Ins
- Otago and Wellbeing drop-in sessions
- Volunteer Handyperson Service (in partnership with Volunteering Matters)
- Solicitors for Older People in Partnership with Age UK
- Local PA Network Development

Unpaid Carers are a key group within the community who care for many of the most frail and vulnerable residents in our area.

The impact on carers' health and wellbeing can be considerable and we work closely with both Carers Centres to support carers locally.

The HSCP Carers Strategy outlines how we will support unpaid carers as well as meets our statutory requirements.

This strategy dovetails with the HSCP Short Break Services Statement.



Support more people at end of life

Palliative and/or end of life care is provided by community health and social care services across our communities. There are also specialist services for those with more complex health needs.

The number of people with complex long-term conditions and palliative care needs are increasing. We seek to offer a choice of support in the place most appropriate to them when it comes to the end of their life.

We aim is to ensure everyone who has palliative/end of life needs is identified and their needs are met.

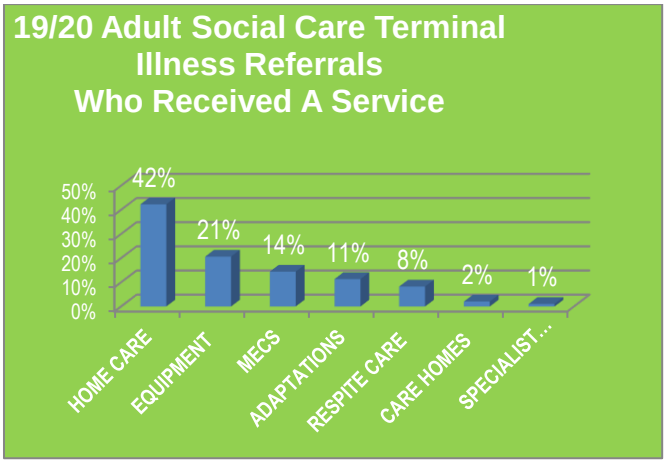
An electronic palliative care summary is shared with hospital acute services and the Scottish Ambulance Service to ensure a person's wishes are communicated.

94 referrals to Adult Social Care for those in Terminal Illness care group over 19/20

69 referrals assessed

65 clients received a care package

Palliative care services also provide support to care homes to manage patients with complex needs during an end of life.



Learning Disabilities

Our commitment to improving outcomes for people with learning disabilities reflects the national strategy, and our outcome focussed approach promotes person centred assessment and planning.

Health and social care staff have been integrated to ensure a consistency of service, and this includes the re design of day services. The wider use of self directed support allows service users and their unpaid carers to exercise choice and control over their care.

In 2019/20 there were approximately 509 people with a learning disability known to Adult Social Care. 81%[5] were receiving home care which is support in clients own home or family home. 15%[6] were living in long term care which can include care homes and supported accommodation.

136 referrals to Adult Social Care for those in Learning Disability/Autism care group over 19/20

40 referrals were assessed

12 clients received a care package

5 Stir (243) Clacks (170)

6 Stir (44) clacks (31)

Section 5 - Mental Health

Scotland's Mental Health Strategy emphasises the need to prevent and treat mental health problems with the same commitment as physical health problems.

In line with the national strategy the HSCP aims to support prevention and early intervention.

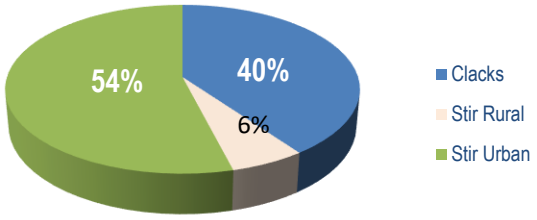
For people affected by mental health issues there are often also health inequalities.

Life expectancy for people with serious mental health problems is 15 to 20 years lower than the general population in Scotland.

It is estimated that only a third of people in Scotland who would benefit from treatment for a mental illness actually receive it.

There were 457 admissions to hospital over 19/20, and the chart below shows the proportion by locality area.

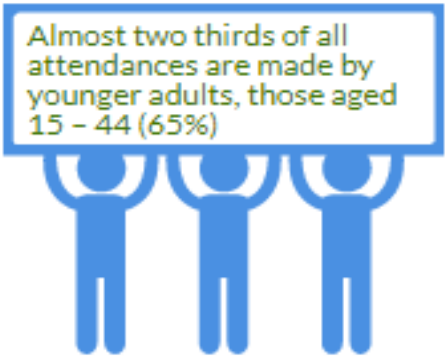
Admission to Hospital 19/20



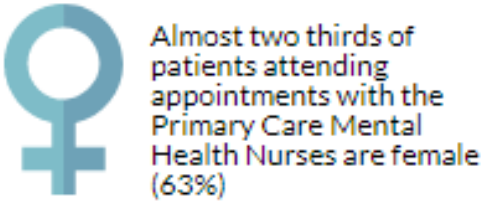
Community Support

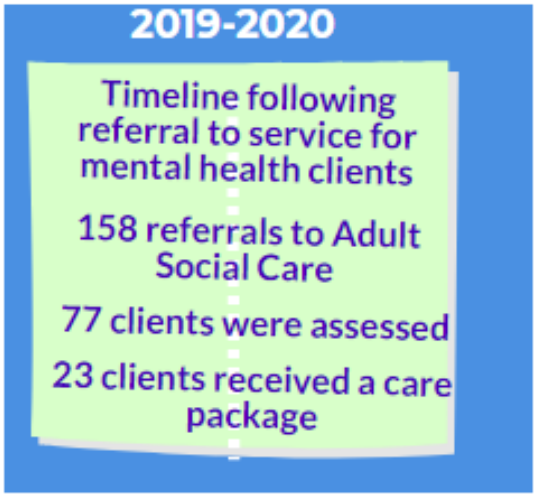
52% of people are seen by a Community Mental Health Team (CMHT) within 5 weeks; rising to 82% seen within 11 weeks.

Caseload analysis of the community (primary care) mental health nursing team highlighted the following[7]



Low mood is the issue that is most widely mentioned (33%), followed by anxiety (26%), other stress (11%) and situational crisis (5%).





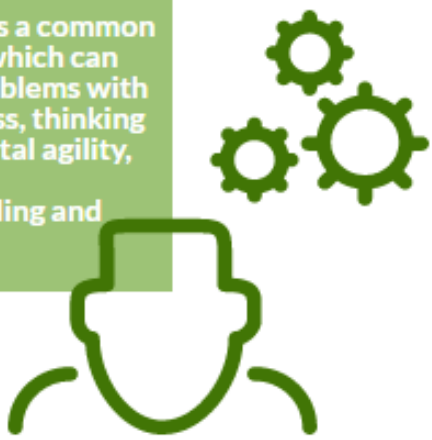
[7] A Forth Valley audit of 37 practices and 1800 appointments over a 2-week period. It should be noted that the overall percentages relate to all Forth Valley but that 50% of appointments studied were in Clacks and Stirling practices. 900 appointments were from 20 Clacks and Stirling practices.

Section 6 - Supporting People With Dementia

"Progress the redesign of services in order to provide support to people with a diagnosis of dementia in a multi-professional way which meets the individual needs of the person and their carers. Spread dementia friendly community work to all areas within the partnership with the Third Sector."

Every person with a new diagnosis of dementia in Scotland is entitled to a minimum of one year of Post Diagnostic Support (PDS) from a named person who will work alongside the person and those close to them.

Dementia is a common condition which can include problems with memory loss, thinking speed, mental agility, language, understanding and judgement.



The 5 Pillars Model provides a framework for people living with dementia, their families and carers with the tools, connections, resources and plans to allow them to live as well as possible with dementia and prepare for the future.

A total of 220 people living in the HSCP area received 1 year post diagnostic support via Alzheimer Scotland.

Post diagnostic support is also delivered by NHS Forth Valley – activity for 2019/2020:

- Referrals received – 180
- Closing caseload as at 31/03/20 – 164
- Waiting list 52 people
- Discharged – 228

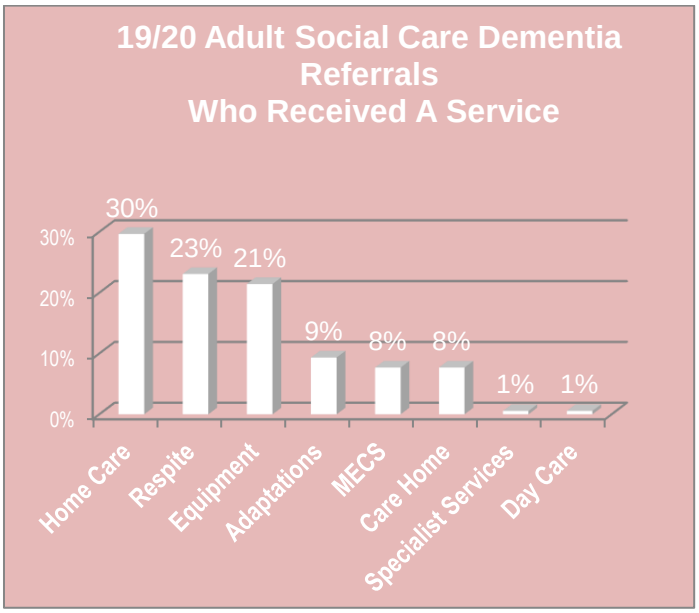
Of the 228 people who were discharged from the service, 120 had completed the Post Diagnostic Support.

Social Care also works to ensure that those clients with dementia and their unpaid carers are supported to remain living at home and with their family for as long as possible.

301 referrals to Adult Social Care for those in Dementia care group over 19/20

137 referrals were assessed

134 clients received a care package

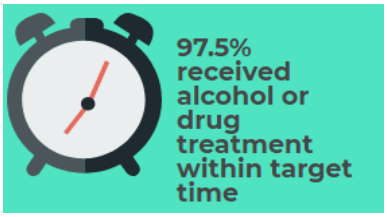


Section 7 - Alcohol & Drugs

Community addiction services support people to participate in meaningful activities within their communities.

> *"Work jointly with the Clackmannanshire and Stirling ADP to deliver outcomes for our community and relieve the burden of alcohol and drugs related harm, together, across the partnership."*
>
> *Strategic Plan 2019-2022*

The Scottish Government's National Quality Principles underpin the development of Addiction Services, supported by The Road to Recovery Strategy.



Waiting Times 2019/2020

The national waiting times target for accessing Drug & Alcohol treatment is; 90% of people should wait no longer than 3 weeks.

- Clackmannanshire 96.2%
- Stirling 95.9%
- Scotland 94.4%

Alcohol related hospital admissions in 18/19 for Partnership residents was well below the national average. But the deprived areas have 92% more admissions than the overall area. Amongst the localities Clackmannanshire has the highest rate of admissions.

The most deprived areas of the HSCP have 114% more alcohol specific deaths than the overall average.

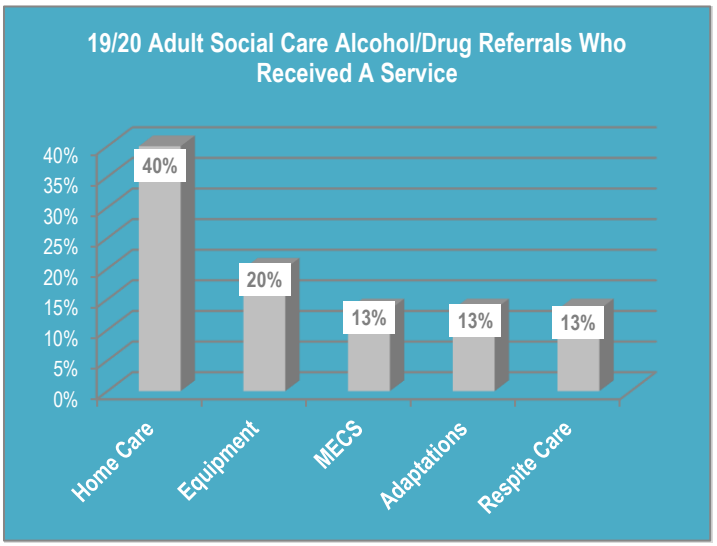
The performance reports for the Alcohol and Drug Partnership can be accessed here.

Social Care provides support and care to enable those in this care group to remain at home or a homely setting.

35 referrals to Adult Social Care for those in Alcohol or Drugs care group over 19/20

14 referrals assessed

10 clients received a care package



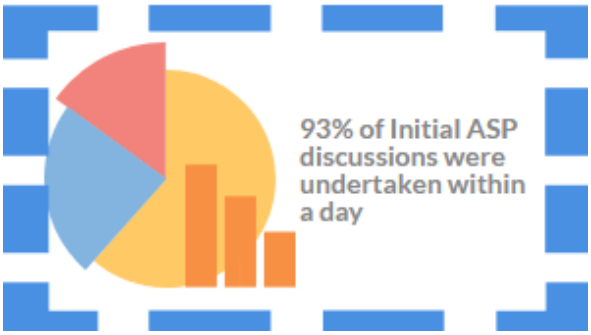
Section 8 - Adult Protection

Adult Protection (ASP) offers support and protection to adults who may be at risk of harm or neglect. It aims to balance people's rights and taking action, where necessary, to support and protect them.

An 'adult at risk' of harm is defined as a person aged 16 years or over, who may be unable to protect themselves from harm, exploitation or neglect, because of a disability, mental disorder or mental Illness, physical or mental infirmity.

Clackmannanshire and Stirling Adult Support and Protection Committee assures that each of the community services in place for adult protection are performing well and keeping the residents of the HSCP area safe.

When a concern is reported (called a referral), initial inquiries/discussions are made before taking action. This information helps make the best decision with the involvement of the adult concerned. It may lead to immediate action or a more planned response. In 19/20 there were 900 initial discussions undertaken in Adult Social Care.



The volume of ASP Referrals received in the year ending 31 March 2020, increased across the Partnership. The increase was most significant in the Clackmannanshire locality and was attributable to changes in the recording process.

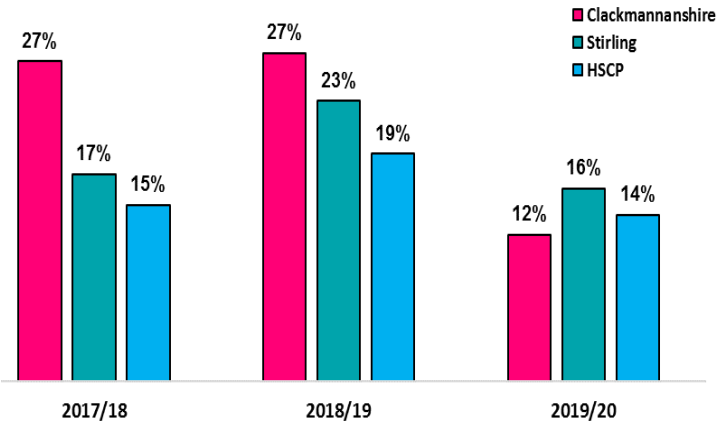
	HSCP	Clackmannanshire	Stirling
ASP Referrals 2017/18	805	94	711
Change 2017/18 > 2018/19	↓ 8%	↑ 52%	↓ 15%
ASP Referrals 2018/19	744	143	601
Change 2018/19 > 2019/20	↑ 34%	↑ 107%	↑ 16%
ASP Referrals 2019/20	994	296	698

The number of referrals increased on the previous year with a rising trend over the last 5 years. However, the proportion of ASP referrals leading to an investigation has decreased across both localities.

The term “no further action” means that it did not lead to a formal ASP investigation.

In the majority of all referrals, work has been done by Social Care to support the adult and manage risks proportionate to the circumstances.

Proportion of ASP referrals leading to an Investigation

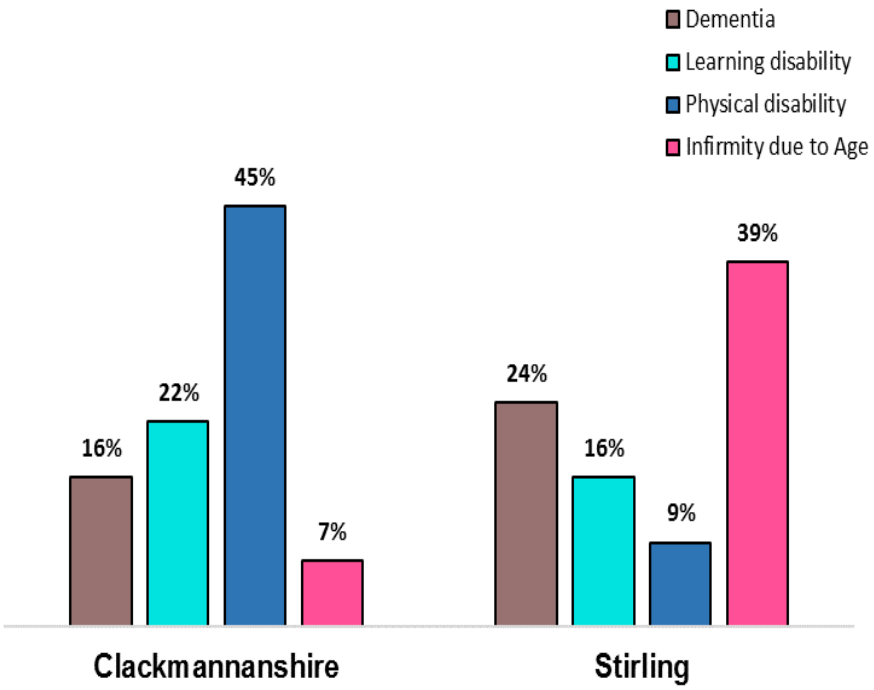


Number of Adults at Risk of Harm subject to an Adult Support and Protection Investigation:

148

The chart below illustrates the four main client groups for ASP Investigations over the 3-year period.

The two main groups varied across the Partnership. In Clackmannanshire it was adults with a physical or a learning disability. In Stirling it is adults categorised as being infirm due to age or diagnosed with dementia.



Number of investigations which resulted in an Adult Support and Protection case conference:

40

Section 9 - Finance & Governance

Annual Financial Statement

We will continue to use the funding available to the Partnership to improve services for people and pursue our Strategic Plan priorities.

Financial Performance

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

The Integration Joint Board then directs partners to deliver and/or commission services across the Partnership on its behalf.

For the financial year ended 31 March 2020 a balanced financial position is reported. However, it is important to understand that this position has been achieved through a combination of transforming care, budget recovery actions, utilisation of earmarked reserves and additional payments from the constituent authorities on an agreed risk share basis. The Partnership requires to address the recurrent deficit along with other financial pressures to allow service delivery to be sustainable.

The expenditure of the Integration Joint Board for year ended 31 March 2020 is detailed in the table below. These figures are subject to statutory audit and approval of the audited 2019/20 accounts.

Further detail is available within the Integration Joint Board accounts which will be published here: https://clacksandstirlinghscp.org/about-us/finance/

Service Area	2017/18	2018/19	2019/20
	£'000	£'000	£'000
Set Aside Budget for Large Hospital Services	19,985	20,633	22,006
Adult Social Care: Clackmannanshire Locality	16,539	17,136	16,130
Adult Social Care: Urban and Rural Stirling Localities	32,383	34,889	37,733
Health Services under Operational Responsibility of Integration Joint Board	33,543	36,039	36,129
Universal Family Health Services including Primary Care Prescribing	67,034	70,365	76,594
Integration (Social) Care Fund	8,860	8,808	8,838
Shared Partnership Posts & Statutory Costs of Integration Joint Board	262	292	284
Transformation	3,086	2,734	2,202
TOTAL EXPENDITURE	**181,692**	**190,897**	**199,916**

Best Value

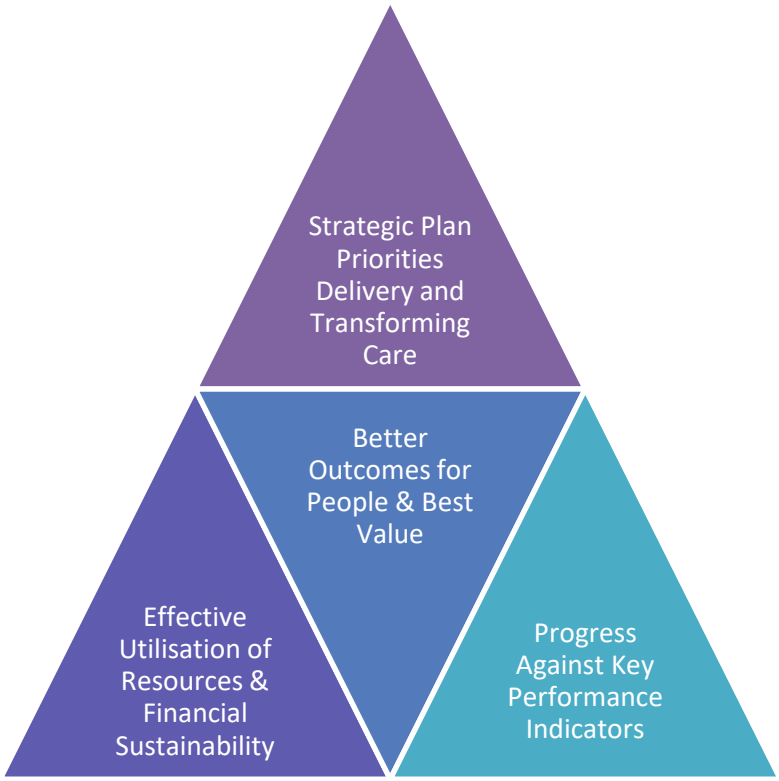
Clackmannanshire Council, Stirling Council and NHS Forth Valley (the constituent authorities) delegate budgets, referred to as payments and Set Aside budget for Large Hospital Services, to the Integration Joint Board which decides how to use these resources to pursue the priorities of the Strategic Plan and progress on performance against the national health and wellbeing indicators. The Board then directs the partnership through the constituent authorities to deliver services in line with this plan.

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

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

As part of governance arrangements, the Chief Officer leads the Senior Partnership Team (SLT) and chairs the Partnership 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 forming the cornerstone of demonstrating best value. This is set out graphically below.



Therefore, the evidence of best value can be observed through:

- The Performance Management Framework and Performance Reports
- Development and Approval of the Annual Operational Budget and Medium-Term Financial Plan
- Development of the Transforming Care Programme
- Financial Reports
- Topic Specific Progress Reporting e.g. Primary Care Improvement Plan
- Reporting on Strategic Plan to the Integration Joint Board and topic specific reports.

There is, however, appreciation that the approach to Best Value in Health and Social Care Partnerships requires to further evolve. This will be further examined during 2020/21 examining best existing best practice and examples from elsewhere in the public sector.

Financial Reporting on Localities

The 2019/20 financial information is not yet fully split into localities. The Partnership has approved and established a locality management structure linked to GP clusters. Developing locality plans aligned to the Strategic Commissioning Plan priorities and developing locality level reporting will be further considered as localities develop. Further development of locality reporting will be considered as part of this.

Good Governance

The Integration Joint Board is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively. The Integration Joint Boards accounts contain an Annual Governance Statement which reports progress on the review and improvement of governance arrangements, identifies any weaknesses apparent during the year and sets out a governance action plan for the coming year to continually improve governance arrangements.

The Integration Joint Board is supported by two committees – Audit and Risk Committee and Finance and Performance Committee which report to the Integration Joint Board through committee chairs who are voting members of the Integration Joint Board. The terms of reference of the committees were reviewed and revised in March 2019 and with clear executive officer support to each committee identified.

Appendix 1 – Strategy Map

	Strategic Plan Priorities					
National Health & Wellbeing Outcomes	**Care closer to home**	**Primary Care Transformation**	**Caring, connected communities**	**Mental Health**	**Supporting people living with Dementia**	**Alcohol and Drugs**
People are able to look after and improve their own health and wellbeing and live in good health for longer.					✓	
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 in their community.	✓					
People who use health and social care services have positive experiences of those services, and have their dignity respected.	✓	✓	✓	✓	✓	✓
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	✓	✓	✓	✓	✓	✓
Health and social care services contribute to reducing health inequalities.	✓	✓	✓	✓	✓	✓
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.	✓	✓		✓	✓	
People who use health and social care services are safe from harm.	✓	✓	✓	✓	✓	✓
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.		✓		✓		
Resources are used effectively and efficiently in the provision of health and social care services.	✓	✓	✓	✓	✓	✓

National Health & Care Standards	Strategic Plan Priorities					
	Care closer to home	Primary Care Transformation	Caring, connected communities	Mental Health	Supporting people living with Dementia	Alcohol and Drugs
I experience high quality care and support that is right for me	✓	✓	✓	✓	✓	✓
I am fully involved in all decisions about my care and support	✓	✓	✓	✓	✓	✓
I have confidence in the people who support and care for me	✓	✓	✓	✓	✓	✓
I have confidence in the organisation providing my care and support	✓	✓	✓	✓	✓	✓
I experience a high-quality environment if the organisation provides the premises	✓	✓	✓	✓	✓	✓

Vision	Priorities	Enabling Activities				Strategies and Initiatives to deliver change
...to enable people in the Clackmannanshire and Stirling Health & Social Care Partnership area to live full and positive lives within supportive communities	Care Closer to Home	Technology Enabled Care	Workforce Planning and Development	Housing / Adaptations	Infrastructure	Intermediate Care Strategy
	Primary Care Transformation					Primary Care Improvement Plan
	Caring, Connected Communities					Carers (Scotland) Act 2016 Community Empowerment (Scotland) Act 2015 Free Personal Care for under 65's 'A Connected Scotland: our strategy for tackling isolation and loneliness and building stronger social connections' Public Health Priorities for Scotland
	Mental Health					Mental Health Strategy
	Supporting people living with Dementia					Dementia Strategy
	Alcohol and drugs					Forth Valley ADP Strategy

Appendix 2 - Core Indicators

These indicators are normally reported in the Scottish Health and Care Experience Survey commissioned by the Scottish Government. Data relating to these indicators for 2019/20 was originally due to be published in April 2020 but, due to staff redeployment during the COVID-19 pandemic, the publication was delayed and so the most recent survey results were not available for inclusion within this report. The survey results will be published later in 2020.

	Indicator	Title	Partnership		
			15/16	17/18	19/20
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	95%	94%	No Data
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	82%	82%	No Data
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	76%	74%	No Data
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	73%	76%	No Data
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	78%	78%	No Data
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	87%	87%	No Data
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	77%	79%	No Data
	NI - 8	Total combined % carers who feel supported to continue in their caring role	32%	38%	No Data
	NI - 9	Percentage of adults supported at home who agreed they felt safe	82%	86%	No Data
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	no data	no data	No Data

Core Suite of Integration Indicators

The Core Suite of Integration Indicators are based on Standardised Mortality Ratio (SMR) returns from the Health Board. In July 2019 SMR01 completeness fell to almost 0% due to resource issues and Trakcare transition. PHS have therefore estimated the indicators for Clackmannanshire & Stirling HSCP based on previous years. The means the Partnership cannot utilise the Core Suite of Integration Indicators to measure progress against the National Health and Wellbeing Outcomes, compare against other Partnerships or Nationally.

NHS Forth Valley have devised and implemented an action plan to address SMR completeness; significant improvement has been achieved in recent months and coding throughput has now increased to more than 3000 episodes per week and this will be followed up by two bulk correction/submission proposals that if approved will result in a significant reduction in the backlog.

			Partnership				
			Baseline	Current			
	Indicator	Title	15/16	16 / 17	17 / 18	18 / 19	2019[8]
Data indicators	NI - 11	Premature mortality rate per 100,000 persons aged under 75 years	425	389	379	371	429
	NI - 12	Emergency admission rate (per 100,000 adult population)	10,373	10,011	10,685	10,447	10,881
	NI - 13	Emergency bed day rate (per 100,000 population)	118,800	112,450	111,813	113,106	113,106
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	104	105	107	108e	108
	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	21	21
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	82%	88%	96%	93%	91%[9]
	NI - 18	Percentage of adults with intensive care needs receiving care at home	68%	68%	67%	67%	No Data[10]
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	640	723	503	579	686
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	21%	21%	23%	24%	24%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	No Data	No Data	No Data	No Data	No Data
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	No Data	No Data	No Data	No Data	No Data
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	No Data	No Data	No Data	No Data	No Data

[8] Estimated for calendar year 2019
[9] This is a figure for 2019 / 2020
[10] Will be published later in 2020

Appendix 3 - Inspections

The Partnership underwent a strategic inspection in 2018 which examined the effectiveness of strategic planning in the Partnership and details were explored in the 18/19 Annual Performance Report.

Registered services owned by the Partnership are inspected annually by the Care Inspectorate, there were 4 services inspected during 2019/20. Additional information and full detail on inspections can be found at the Care Inspectorates website https://www.careinspectorate.com/.

The Care Inspectorate introduced a new approach to inspecting the quality of care and support in care homes for older people in July 2018. However, some services were inspected using the previous approach against the four Quality Themes. Since 1 April 2018, the new Health and Social Care Standards have been used across Scotland. In response to these new standards, the Care Inspectorate introduced a new framework for inspections of care homes for older people.

Unit	Date Inspection Completed	Quality Theme Care Grades (out of 6)				Number of recommendations	Number of requirements	Areas for Improvement
		Care and Support	Environment	Staffing	Management & Leadership			
OLD FRAMEWORK								
Stirling Reablement and TEC service	13/12/19	Very Good	N/A	Very Good	N/A	0	0	0
NEW FRAMEWORK								
Unit	Date Inspection Completed	How well do we support people's wellbeing?	How well is our care and support planned?	How good is our leadership?	How good is our staff team?	How good is our setting?	Recommendations	Requirements	Areas for improvement
Ludgate House Resource Centre	8/11/19	Very Good	Very Good	N/A	N/A	N/A	0	0	0
Bellfield Centre Care Home	20/6/19	Good	Good	Good	Good	Good	0	0	4
Strathendrick Care Home	16/12/19	Very Good	Good	N/A	N/A	N/A	0	0	0

Source Care Inspectorate

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

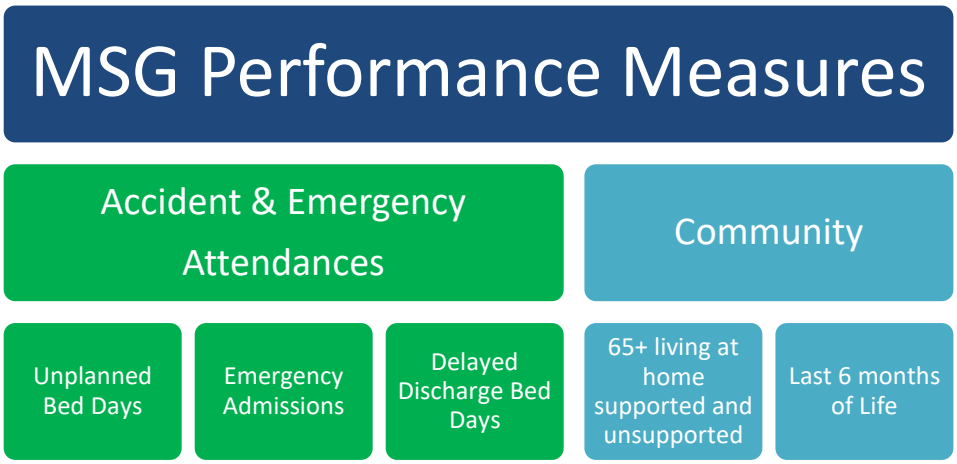
Req - A requirement sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in statutory requirements. Requirements are enforceable in law.

Inspection Requirements, Recommendations, and Areas For Improvement

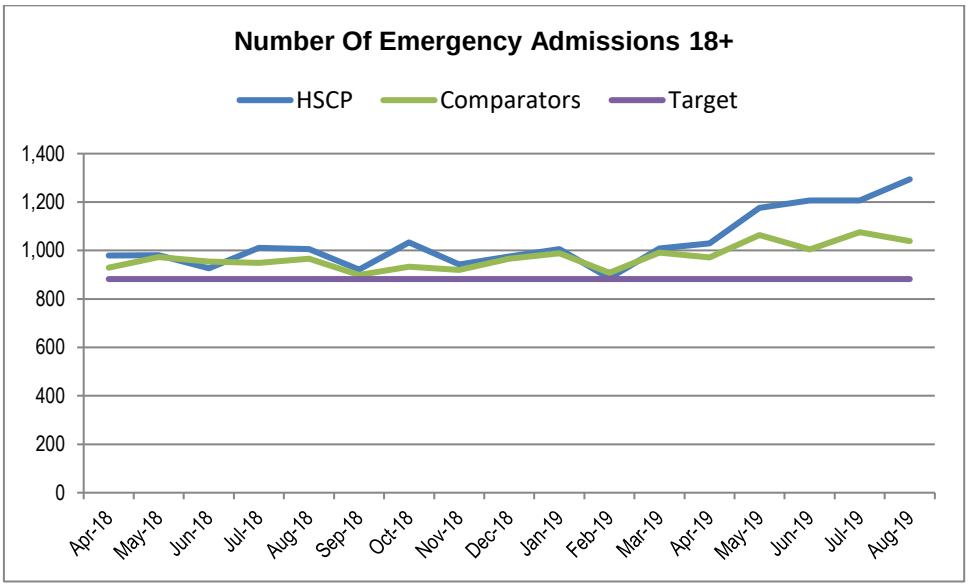
Unit	Action
Bellfield Centre Care Home	
1. The service should increase the number of people who can notify the Care Inspectorate within 24 hours of any unforeseen event including accidents and incidents resulting in harm or injury to a person. They must also ensure that staff have the competence to do so.	Areas of Improvement Action Planned: 3 x Senior Social care workers have been trained and log in details to access the eforms and carry out notification etc, Completed Aug 2019. This has worked well, therefore plan to train and obtain log in details for other Senior social care workers to carry out this task by the end of Oct 2019. Areas of Improvement Timescale: Aug 2019 Update / Current position Work ongoing to train and obtain log in's for remaining Seniors Social Care Workers, this was due to long term sickness / maternity leave x2 and newly recruited seniors. x3 seniors' access and training complete Aug 2019, other seniors have gained experience in completing notifications through Bellfield log in for e-forms. All remaining seniors to obtain log in's by June 2020
2. The service must now put in place their planned supervision and appraisal schedule.	Areas of Improvement Action Planned: Seniors meeting arranged, and supervision matrix now devised all staff have supervisors and dates scheduled over the next coming months. Areas of Improvement Timescale: Sept 2019 Update / Current position Improvement complete Sept 2019, all seniors now Staff groups that they supervise, supervisions and appraisal is an ongoing function that continues, supporting a continuous improvement approach. Seniors are also receiving supervision; all staff groups identify training and development needs ad these are actioned through organisational development and access to learning through mylo.
3. To ensure that the Certificate of Registration for the Bellfield Centre reflects service provision, the service should submit a variation request to the Care Inspectorate so that conditions 1 and 4 can be reviewed	Areas of Improvement Action Planned: Information to be submitted on the balconies and the 5 service users that are under the age of 65 years old. Areas of Improvement Timescale: Aug 2019 Update / Current position Complete/ Ongoing, Risk assessment and information relating to access of balcony space submitted August 2019. 5 Service users under age 65 - notifications submitted after each under 65 discharge, only one person under 65 remains in the service.
4. Assessment and support planning should consistently inform all aspects of the care and support people experience. Strong leadership, staff competency, meaningful involvement and embedded quality assurance and improvement processes support this happening	Areas of Improvement Action Planned: Audit tools have been devised, and senior social care workers allocated to individual suites to carry out audits. Management to report outcome of audits and improvements/actions plans to bimonthly clinical care and governance group. Areas of Improvement Timescale: Oct 2019 Update / Current position Action complete Oct 2019 continuous improvement work ongoing to improve service user experience, recording Information and representing service users' journey, service continually exploring ways to improve support plans to reflect service users voice, wishes and needs. Weekly multi-disciplinary team meetings have been set up in individual suites to support better information sharing and better outcomes for people using the service, improving the wider assessment, future planning, and ensuring collaborative approach to meet needs, wishes and choices of service users.
Source Care Inspectorate	

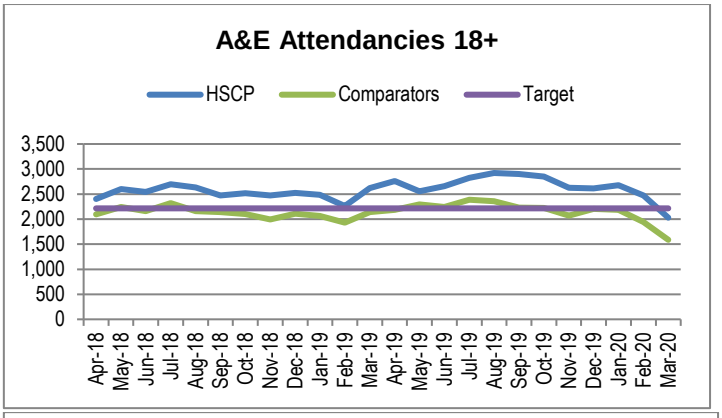
Appendix 4 – Unscheduled Care

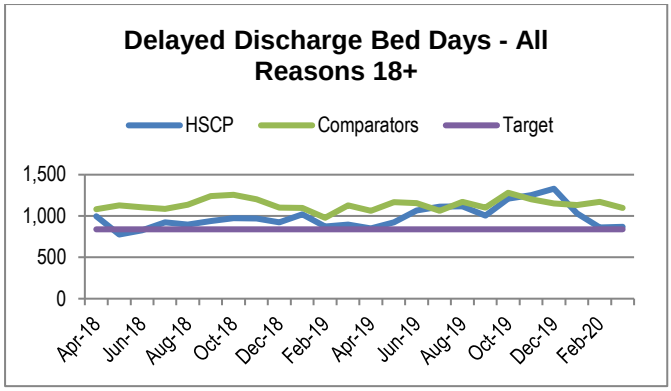
To support the delivery of the National Priorities Partnerships we completed a self assessment and improvement action plan as well as agreeing local targets for the following key areas: Nationally this is monitored by the Ministerial Strategic Group for Health and Community Care (MSG).

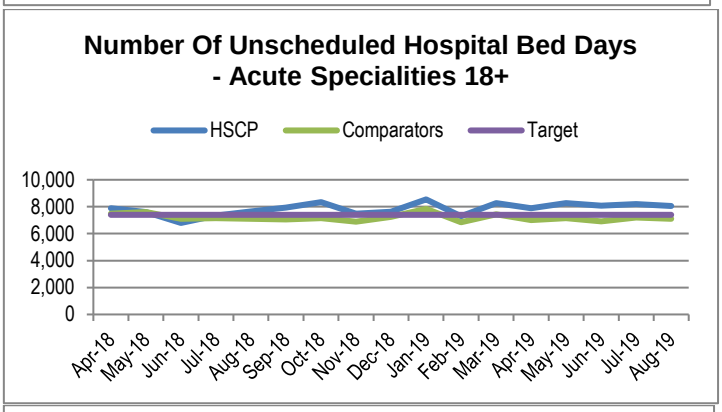


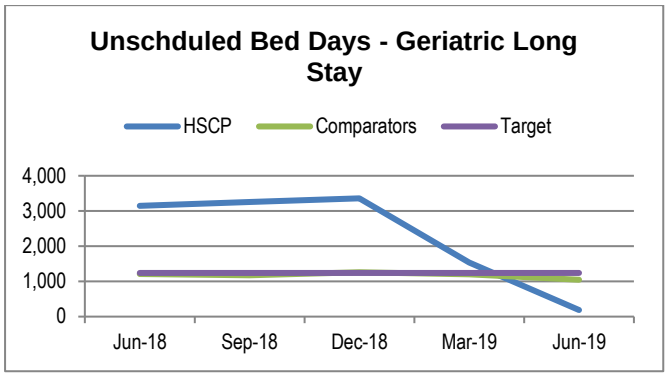
Due to the late submission of data by NHS Forth Valley it is not possible to report on the annual performance for 19/20. Monthly data has therefore been provided up to the point that we know is 100% complete and annual target has been divided by 12 to get an average monthly target.

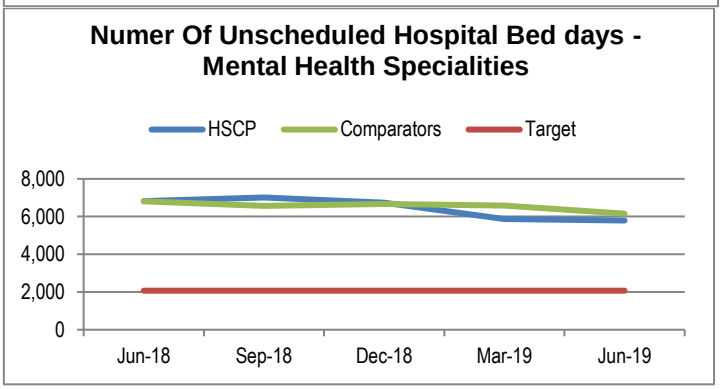


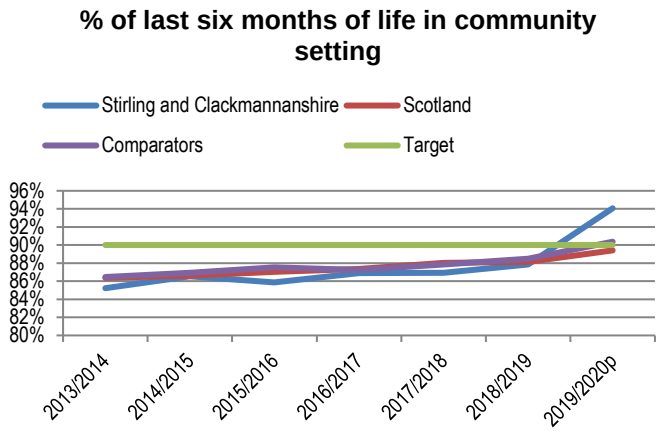

A&E Attendancies 18+
HSCP
Comparators
Target
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20

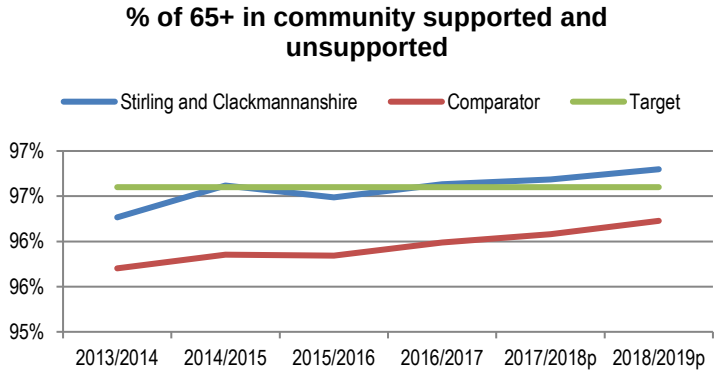

Delayed Discharge Bed Days - All Reasons 18+
HSCP
Comparators
Target
1,500
1,000
500
0
Apr-18
Jun-18
Aug-18
Oct-18
Dec-18
Feb-19
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20


Number Of Unscheduled Hospital Bed Days - Acute Specialities 18+
HSCP
Comparators
Target
10,000
8,000
6,000
4,000
2,000
0
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19


Unschduled Bed Days - Geriatric Long Stay
HSCP
Comparators
Target
4,000
3,000
2,000
1,000
0
Jun-18
Sep-18
Dec-18
Mar-19
Jun-19


Numer Of Unscheduled Hospital Bed days - Mental Health Specialities
HSCP
Comparators
Target
8,000
6,000
4,000
2,000
0
Jun-18
Sep-18
Dec-18
Mar-19
Jun-19


% of last six months of life in community setting
Stirling and Clackmannanshire
Scotland
Comparators
Target
96%
94%
92%
90%
88%
86%
84%
82%
80%
2013/2014
2014/2015
2015/2016
2016/2017
2017/2018
2018/2019
2019/2020p


% of 65+ in community supported and unsupported
Stirling and Clackmannanshire
Comparator
Target
97%
97%
96%
96%
95%
2013/2014
2014/2015
2015/2016
2016/2017
2017/2018p
2018/2019p

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

Web: clacksandstirlinghscp.org

Clackmannanshire & Stirling Health & Social Care Partnership

Clackmannanshire Council

Stirling Council

NHS Forth Valley

STIRLING COMMUNITY PLANNING PARTNERSHIP

Clackmannanshire Alliance
Clackmannanshire Alcohol & Drug Partnership

Forth Valley Alcohol & Drug Partnership