Clackmannanshire & Stirling
Health & Social Care Partnership

Annual Performance Report

2020 – 2021

Clackmannanshire Council

Stirling Council

NHS Forth Valley

Contents

Our Fifth Year

Message from the Chair

Welcome to our 5th Annual Performance Report, which reflects on our progress together as Clackmannanshire and Stirling Health and Social Care Partnership from 1st April 2020 to 31st March 2021.

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

This is a unique partnership in Scotland as there are two local authority areas and one health board all of whom have voting members on the Integrated Joint Board alongside representatives of the wider partnership including third sector, carers and community representatives.

Progress on our key priorities made throughout 2020/2021 is set out in further detail within this report.

> *"We found the performance of the service in relation to infection control practices to support a safe and clean environment to be very good"*
>
> Care Inspectorate feedback from an inspection at the Bellfield Centre

However we must recognise the impact of 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 third and independent sector partners have worked tirelessly to ensure the safe and effective provision of community health and social care across the HSCP area to support people in our communities.

This report will reflect some of the significant work and efforts of all people who supported the communities of Clackmannanshire & Stirling throughout the last year of the pandemic.

This 5th Annual Report evidences that there is much to be proud of but it also shows that the HSCP continues to meet the challenge of the growing older people's population and increasing levels of need in our population against a backdrop of financial challenge.

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 2020-2021

45% of reablement clients reduced their care hours because they were more independent at the end of the intervention.

2020-2021 Adult Support Plans

496 ASP's for Carers completed by local Carers Centres and 290 ASP's completed in Adult social Care.

729 clients received a Reablement Service, re-learning daily skills to help them be more independent. 2020/21

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

176

6 ESSENTIAL ACTIONS Unscheduled Care

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

3,827 Adult Care Referrals

Change Grow Live

Section 1 - Introduction

Introduction to the 5th Annual Performance Report

Clackmannanshire and Stirling Integration Joint Board is responsible for strategic planning and budget management of community health and social care services for adults.

This report is the Integration Joint Board's assessment of progress towards "enabling people in Clackmannanshire and Stirling to live full and positive lives within supportive communities".

Clackmannanshire and Stirling Health and Social Care Partnership is the delivery vehicle for all community health and care services delegated by the three constituent authorities of Clackmannanshire Council, Stirling Council and NHS Forth Valley.

The HSCP area is served by one acute hospital, Forth Valley Royal Hospital, and community hospitals based in Clackmannanshire and Stirling, which also incorporate a minor injuries unit.

The HSCP covers a large mixed urban and rural geographical area with some of the most stunning scenery in Scotland. The HSCP has a population of approximately 145,730 across three Localities: Rural Stirling (25,137); Stirling City (69,193) and, Clackmannanshire (51,400)[1], with 65% of the population residing in Stirling and 35% in Clackmannanshire.

Both Clackmannanshire and Stirling have ageing populations. The numbers and proportion of older adults is projected to double, evidence points to older people being more intensive users of health and social care services and this will impact significantly on demand in the years ahead.

There are close working relationships with supported people, people accessing services and unpaid carers, local communities, staff and professionals and key partners in the third and independent sectors to develop and deliver on an ambitious programme of transforming care and strategic improvement.

For more than eighteen months the Health and Social Care Partnership has been responding to the COVID-19 pandemic, and continues to be in an emergency response phase.

Initially all non-essential activity was stood down in line with Government restrictions, however mobilisation and recovery planning has been put in place across community health and social care services to reflect a community first approach and an outcomes based service model within communities.

It is projected that more people living in Clackmannanshire and Stirling will have long term conditions, multiple conditions and complex needs.

Transforming our current care pathways and guidelines away from current disease specific models towards a greater focus on the holistic needs of patients is required and is already underway within community health and care services.

[1] Available in Locality Profiles here https://clacksandstirlinghscp.org/about-us/strategic-plan/

Information and data we use to measure our performance

To compile this report, data has been accessed from a range of published national and local data sources.

The Annual Performance Report will set out how well the Health and Social Care Partnership is meeting the outcomes of local people. The Report will lay out, measure the impact of the changing model of care, and support being delivered for the people of Clackmannanshire & Stirling.

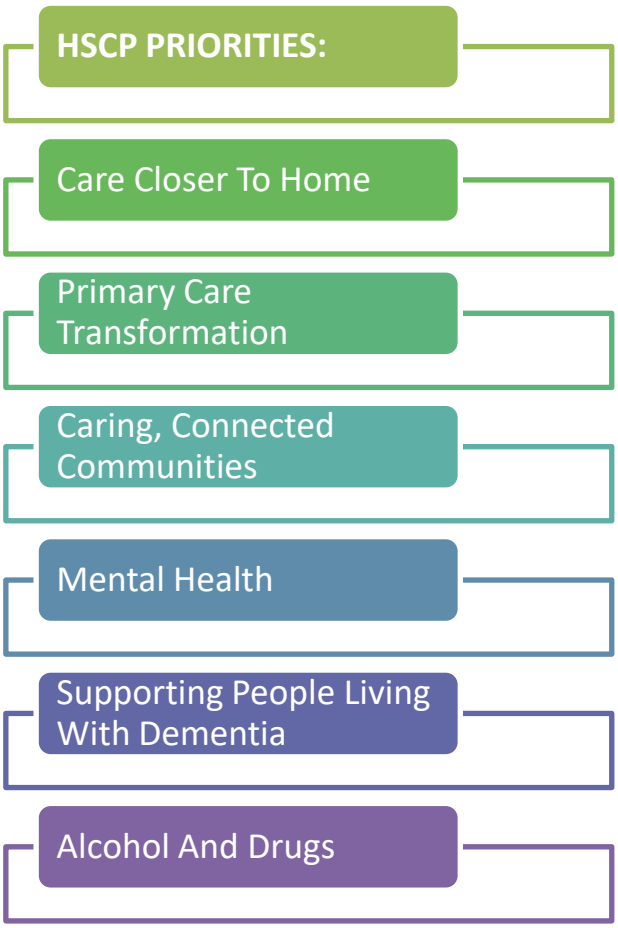
The Strategic Commissioning Priorities form the focus of this Annual Performance Report, drawing attention to day-to-day performance as well as to areas of good practice and plans for improvement.

To provide a wider context, appendix 1 lays out how the current Strategic Plan 2019-2022 priorities link with the National Health and Wellbeing Outcomes and the National Health and Care Standards.

Ongoing local data delays in SMR01 returns make reporting linked to the Core Suite of Integration Indicators more difficult however activity over the past few months has resulted in more up to date data. For the purpose of this report, measuring progress against the National Health and Wellbeing Outcomes has been estimated and therefore not comparable to other Health and Social Care Partnerships.

Appendix 2 provides the estimated National Health & Wellbeing indicators which are included for reference. An improvement plan is in place and being locally implemented to ensure SMR01 returns are completed timeously.

Our Strategic Commissioning Plan and Partnership Priorities 2019-2022



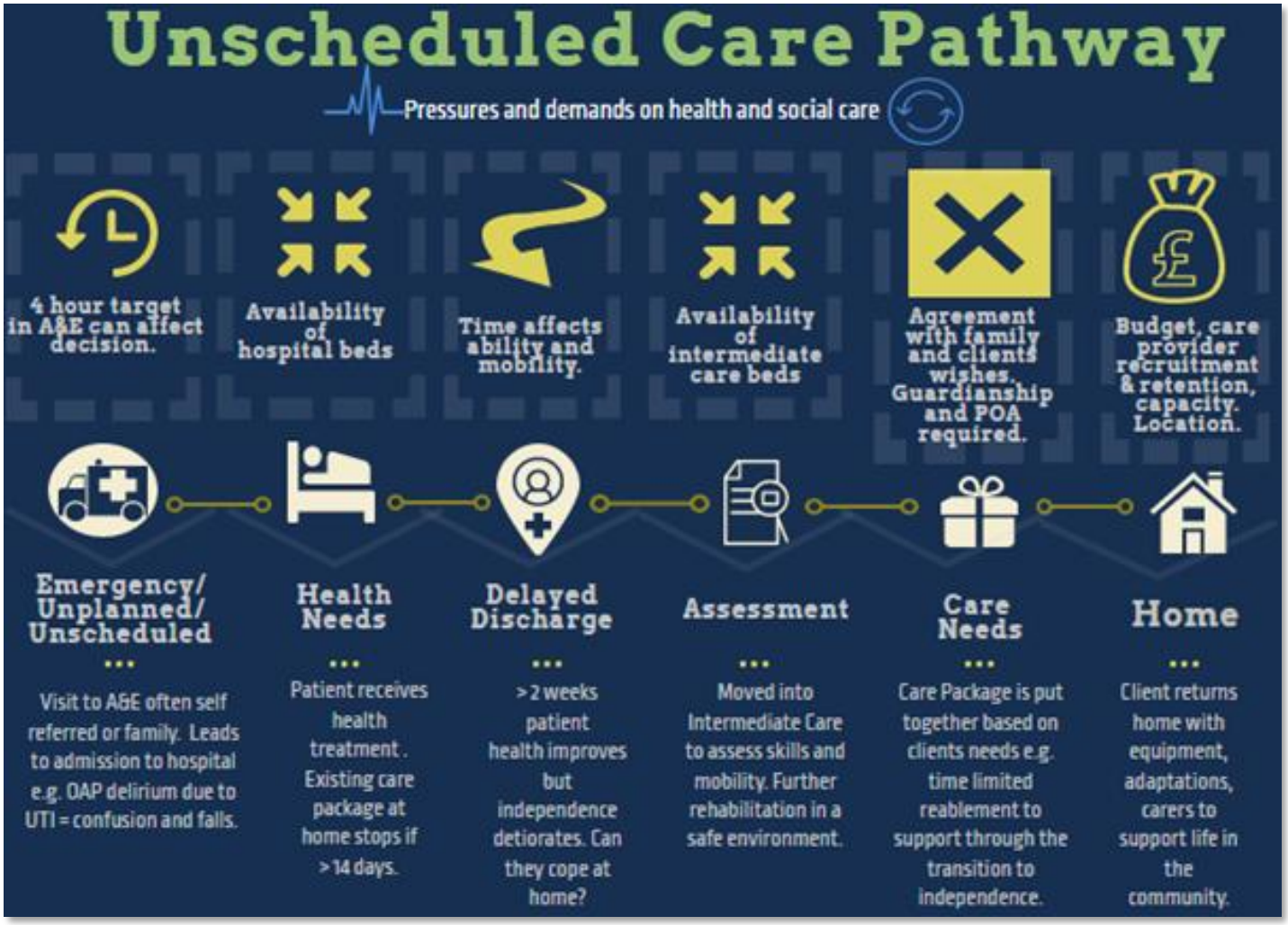
Section 2 - Care Closer To Home

"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 HSCP."

Strategic Plan 2019-2022

Integrated community health and social care creates the conditions to shift the balance of care away from acute hospital. To ensure that **'people live independently 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 community hospice.



Improving emergency or unscheduled care within hospitals is a key priority for the Scottish Government and locally for the HSCP.

The National Unscheduled Care – 6 Essential Actions Improvement Programme aims to improve the timeliness and quality of patient care from arrival to discharge back into the community.

The common ways to arrive at Emergency Departments (ED) are[2]:

Number	Self Referral	Ambulance	GP Referral
Attended	15,963	8,341	981
Admitted	1,744	4,950	162
%	11%	59%	16%

Source: PHS Source

48% attend once, 44% between 2-4 times, and 8% over 5 times.

Operational services are working with individuals and their carers to ensure people are attending the right service at the right time. There is ongoing work with those who frequently attend hospital to be supported with community based interventions.

Cost per attendance:
FVRH - £151
SCH - £93
Hospital outside health board - £141.

Source: PHS Source

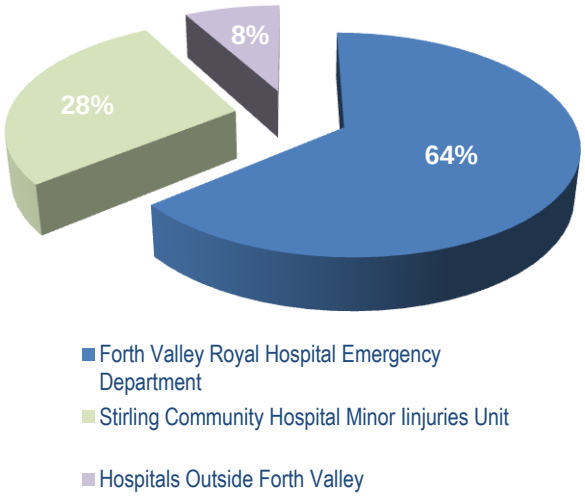
'Emergency Admission Rate'
Rank 10/31
More than Scottish average
National Indicator 12 - 2020/2021

Emergency attendances have a significant impact on both acute and community services. People who may have had no need for very little social care support before admission, often require increased support after leaving hospital. Often people's independence may have reduced following a hospital stay regardless of their presenting health condition.

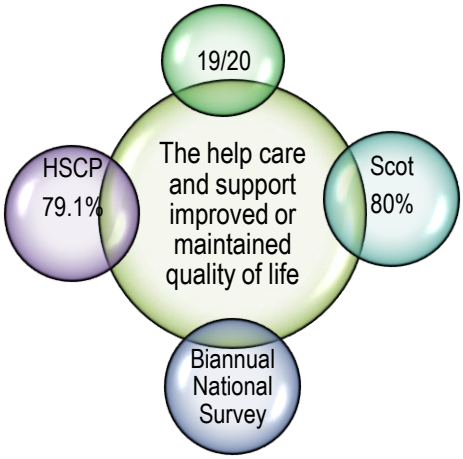
The ongoing programme of service re-design is focused on a home first ethos to minimise any delays to discharge, and access to care and support to avoidance of unnecessary admissions.

The graph opposite shows a drop in new patients who were delayed in their discharge from hospital, compared to the previous year. The COVID-19 pandemic had an impact on behaviours, with many people avoiding going to hospital especially during lockdowns restrictions.

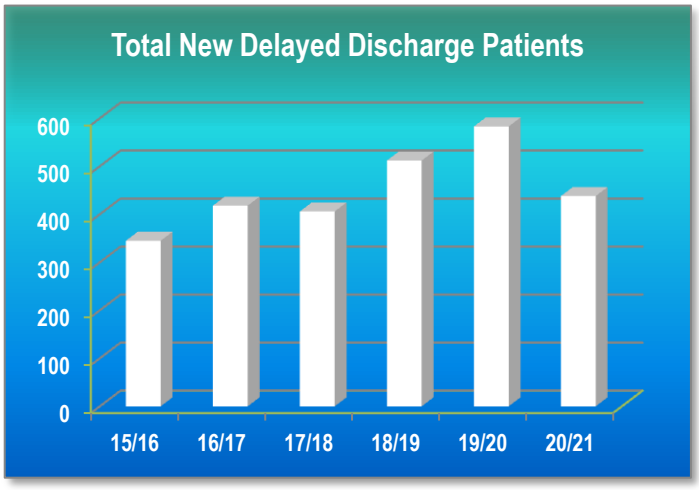
Where Do People Go?



Source: PHS Source

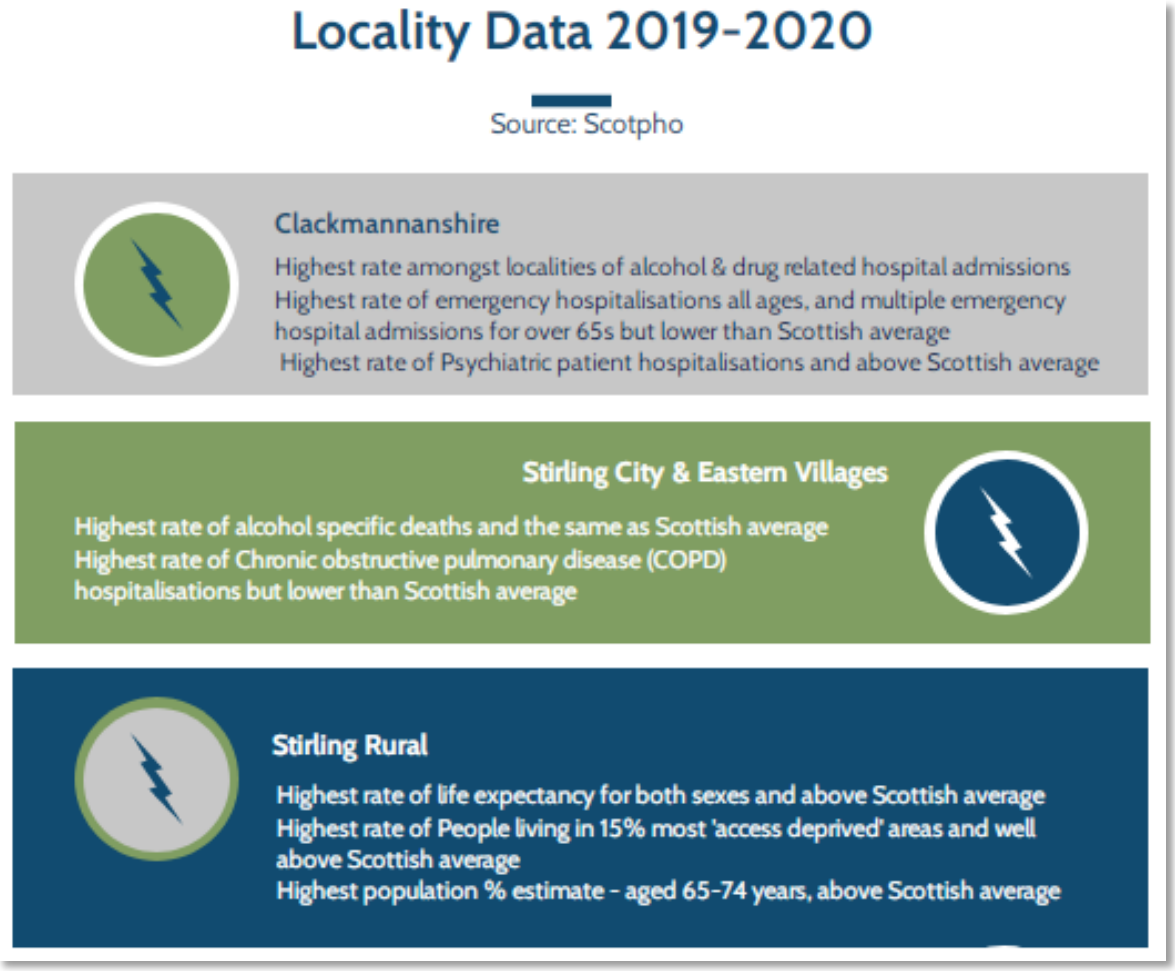


Source: National Core Indicators



Source: Local NHS FV

2 This relates to 19/20 data which is the most up to date national data available for this type of analysis and includes minor injuries unit.

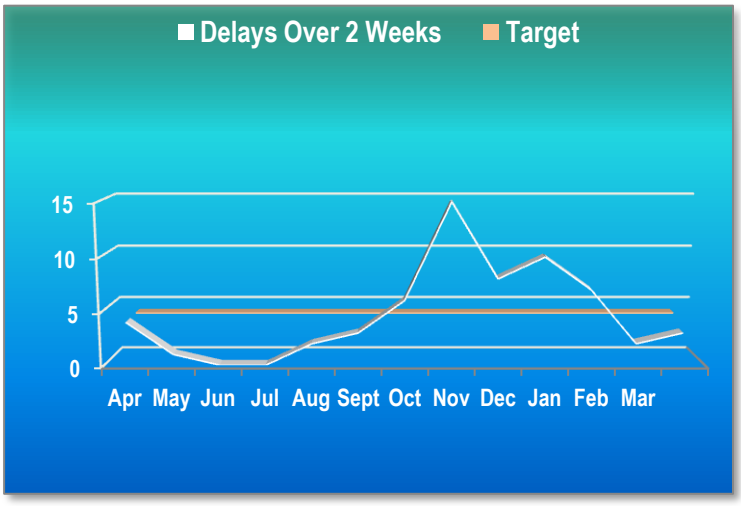


In line with other HSCPs, managing delayed discharges over the past year has proved challenging. In addition, capacity within care homes fluctuated due to ongoing COVID-19 outbreaks and staff sickness. Care at home services were also challenged by cyclical outbreaks and workers self-isolating.

These pressures had an ongoing impact on the level and type of care and support organisations were able to provide during the height of the pandemic.

'% Health Care Resources spent on hospital stays where patient was admitted in an emergency'
Rank 10/31
More than Scottish average
National Indicator 20- 20/21

Our performance for those patients waiting 2 weeks or more to go home shows a variable trend for 20/21 with the drops attributable to the COVID-19 pandemic.



Source: Local NHS FV

KEY ISSUES

Care Homes affected by COVID-19

Either closed to new residents, or require 2 negative covid tests

Covid- 19 staff self isolating or sick

Within Care @ Home sector

Higher Care Needs

More staff more often to enable someone to live independently at home

Alternatives To Admission And Supported Discharge

Many adults and older people can be supported at home, even when unwell, because it is well documented that staying unnecessarily in hospital can be detrimental to a person's ability to be re-abled or rehabilitated which may lead to a loss of function.

This has led to a strong focus on working to improve pathways to reduce delays in patient discharge planning. Planning for an effective discharge from hospital is vital in also reducing the risk of re-admission.

District Nursing

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

Activity over 20/21 included:

	Jan-Mar 20	20/21
Home Visits	17,201	77,066
Treatment Room	6,325	14,424
Telephone Calls	408	1,362

Source: Local Data – NHS FV

District Nurses supported 102 patients in the community who chose to die at home

Enhanced Community Team (ECT) provides support to frail, elderly patients and those with complex health problems.

The aim of the service is:

- A reduction in avoidable attendances, emergency hospital admissions and readmissions.
- A more coordinated community health and social care response to patient's need particularly during times of crisis.

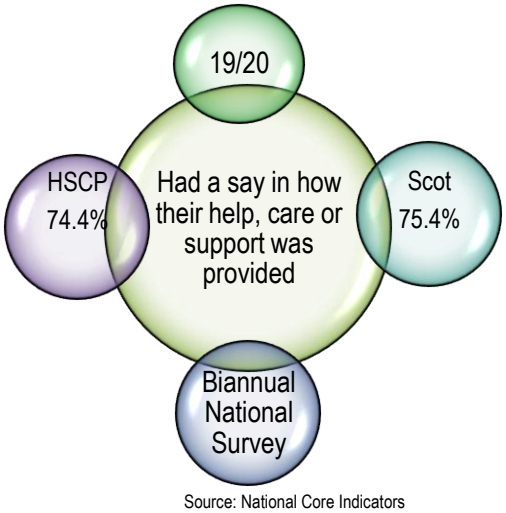
The main challenge faced over the last year has been the response to Covid 19.

This had a huge impact on the delivery of care and support. As such, an ambitious programme of change was undertaken:

- Geriatricians began working in the community team providing 7 day cover
- A change of working patterns for nurses who moved to 10 hour shifts.
- Increase in housebound COVID-19 assessments.
- Direct access into community based hospital beds.
- Access to specialist services via consultants in working in acute hospital.

In 20/21 the ECT service took on approximately 600 cases, preventing 450 admissions to hospital.

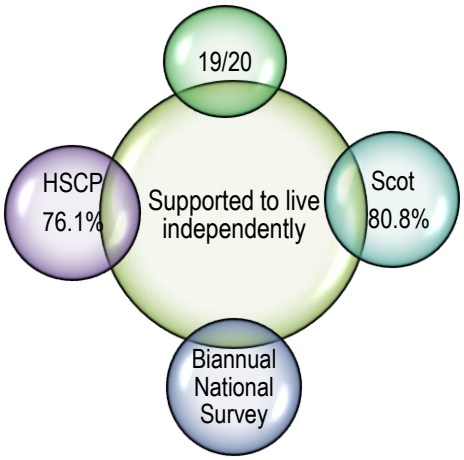
As a result, the Enhanced Community Team, and Adult Social Care worked together to offer support to people in their own homes and seek to prevent the need for uneccessary hospital admissions.



Source: National Core Indicators

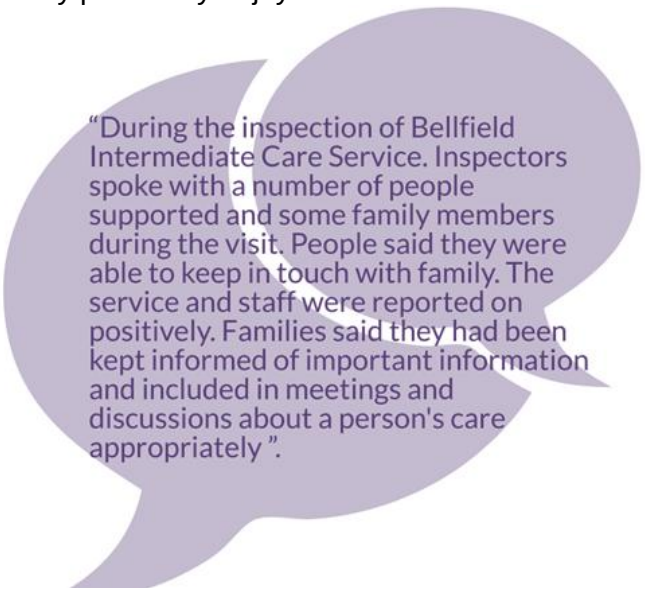
The prevention of unnecessary hospital admission can be achieved when people can

regain or maximise their independence by being offered reablement or access to intermediate care. This can be offered to prevent an individual from having to go into hospital or when someone is leaving hospital to go home.



Source: National Core Indicators

Adult Social Care services such as; Intermediate Care, Reablement Services, and Care at Home, support people to achieve their agreed personal outcomes. Such as preparing their own meals, accessing care and support, or being able to continue to access community resources they previously enjoyed.



Souce: Care Inspectorate

Source: Local Data – Adult Social Care

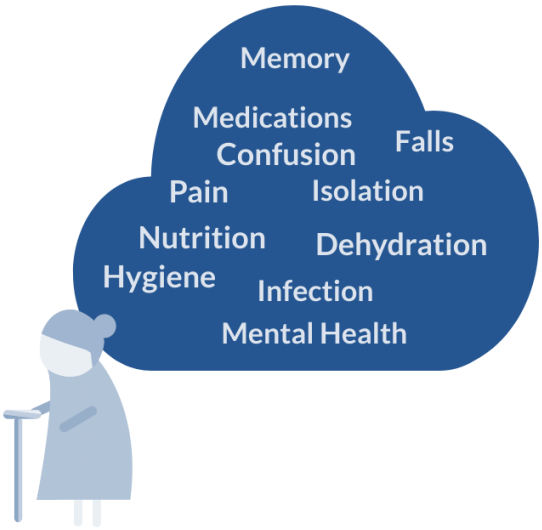
Reablement services focus on helping people to regain daily skills they may have lost due to a deterioration in their condition, a, crisis or as a result of hospital admission. Supporting people to regain confidence and their independence, can potentially avoid a hospital admission or readmission, and can support live safely at home for as long as possible.

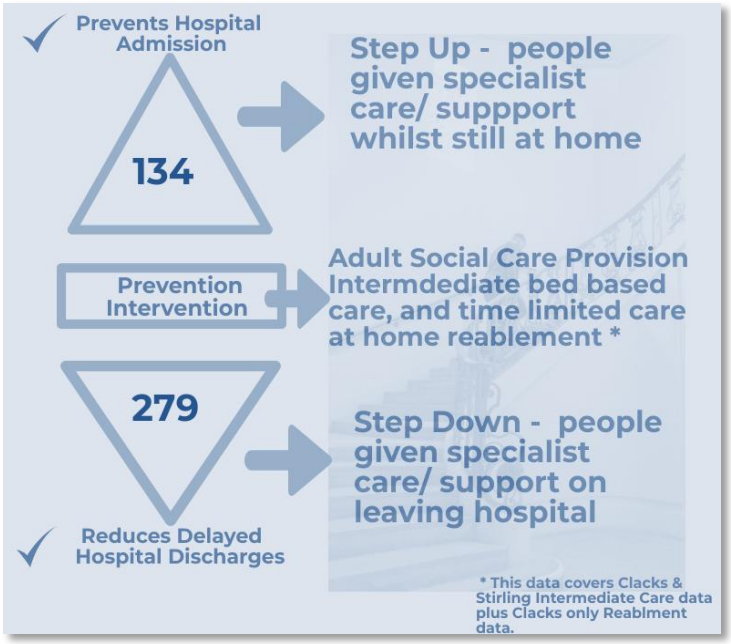
Review of adult social care

The HSCP Is taking forward a transformation programme of which the implementation of the Social Work Review is an important aspect. This work includes service modernisation across adult social work and also a refresh of how we are implementing Self-directed Support and how we deliver Adult Support and Protection.

Over the past year, work has begun on defining that in detail, and a local Steering Group has been established to plan the priority activities, to review the resource and governance implications, and to scrutinise the initial implementation in 2021.

The group has representation from stakeholders from across the Partnership, including our third sector partners, people with lived experience, unpaid carers and our frontline staff.





Source: Local Data – Adult Social Care

Care Home Assessment and Review Team (CHART)

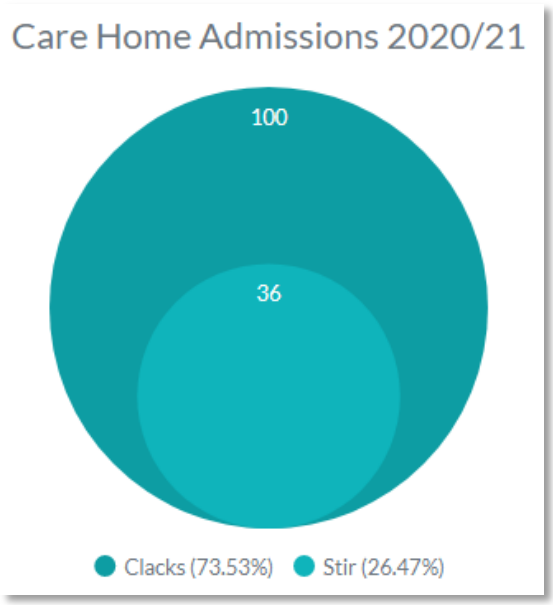
As part of the community health and care response to COVID-19, and in line with Scottish Government guidance, a new team was developed to support the care home sector across Forth Valley.

An integrated Care Home Assessment and Response Team (CHART) was established to work across the two HSCPs and independent sector and Council run care homes.

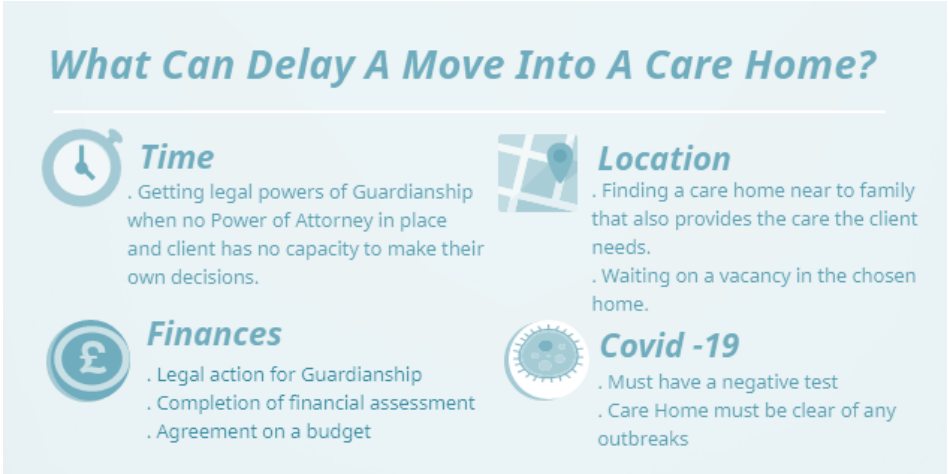
This innovative approach was nationally recognised and has developed to be mainstreamed across the whole care home sector to support consistency and assurance of quality of care as well as access to clinical care and support for local care homes.

'Proportion of care services graded good or better in care inspectorate inspections'
Rank 3/31
More than Scottish average

When people are no longer able to live at home independently they often move to a residential or nursing care home.



The high number of admissions needs to be balanced against the number of residents who also died during the period. With total resident numbers, especially in Clacks remaining the same or less.



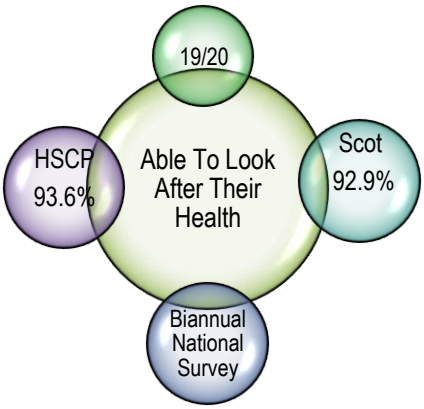
Section 3 – Primary Care Transformation

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

The Primary Care Improvement Plan 2018-2021 has been updated and encourages General Practices (GP) to work together and take a multi-disciplinary approach to improving primary care including working on a Locality based model.

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

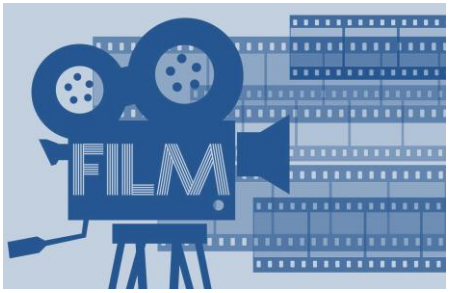
All practices now have a Primary Care Mental Health Nursing service.
Evaluation over three years, has noted that less than 3% of people required to go on to see a Doctor.



Source: National Core Indicators

The HSCP have recorded people's stories including the impact of the mental health nurses on people living in our communities. The stories were published to fall within mental health awareness week.

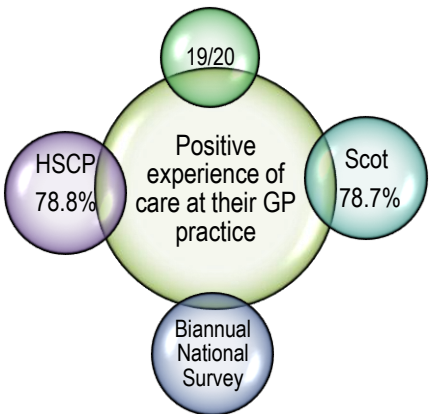
A positive patient story and short companion video about the mental health primary care model can be found below:



· Service User Experience Video Link
· Service Perspective Video Link

All practices now have a level of multidisciplinary support in place, and the model of care is now well embedded. Into 2021 – 2022 Locality based planning and delivery will be significantly developed.

Despite a challenging year, there continues to be a significant focus on service quality and evaluation.



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 strives to support people to 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.

The HSCP 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.

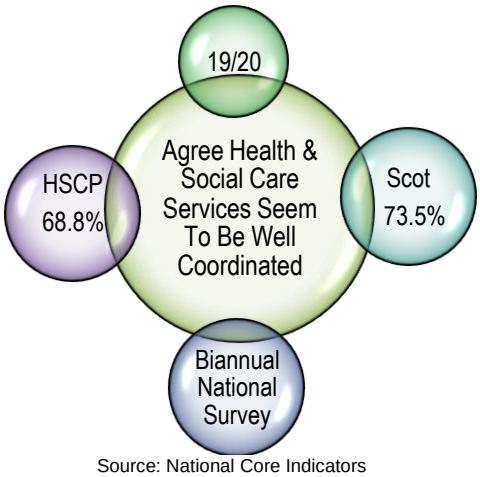
It is well documented that population changes mean a changing demand and use of services, particularly for older people and people with multiple and complex health conditions.

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 Senior Management Team, dedicated resource was allocated to support the development of 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 2021-2022 this work will recommence, with the development of an approach to supporting Localities which is inclusive and addresses disparity.



Source: National Core Indicators

Completed activities included:

- A refresh of Locality Planning arrangements
- A refresh of the Participation & Engagement Strategy
- Test of the concept of a community hub model
- Establishment of local task groups to address locally identified priorities
- Establishment of a Locality 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 ongoing review of the model of care ensures the delivery of an outcomes focused service that is in line with national policy; of effectively delivering care closer to home and the continuation of the shift away from institutional bed based care where possible towards flexible and person centred care and support in communities.

***'Emergency readmissions to hospital within 28 days of discharge** (rate per 1,000).'*
Rank 3/31
More than Scottish average
National Indicator 14 - 20/21

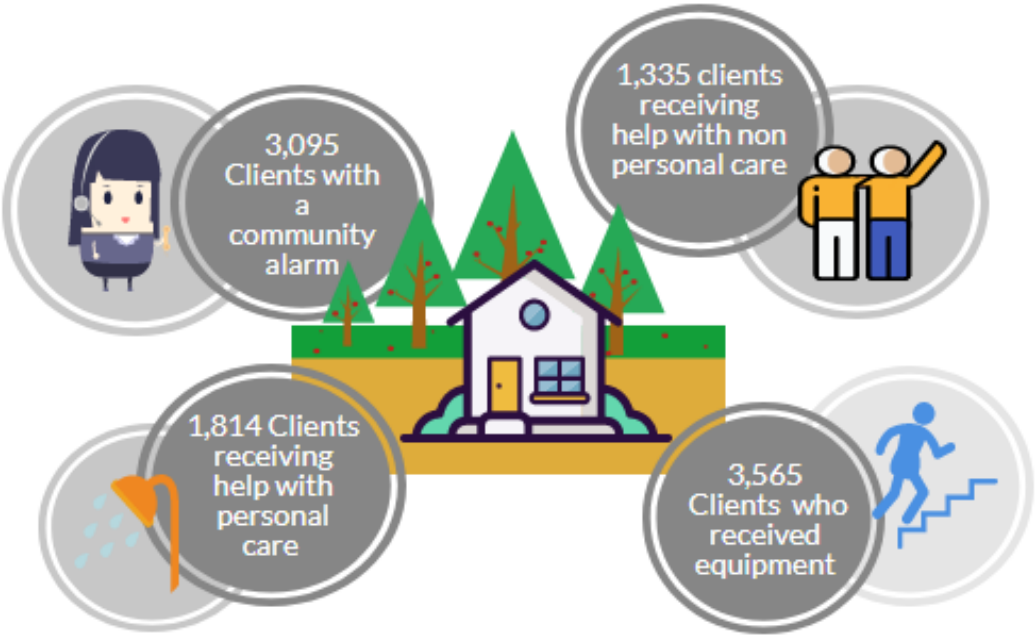
'Falls rate per 1,000 population aged 65+'
Rank 18/31
Less than Scottish average.
National Indicator 16 - 20/21

These commitments align to the priorities of the HSCP Strategic Plan which describes the move towards more outcomes focused care and support; access to modern technology enabled care; integrated community health and social care, as well as individual choice and control.

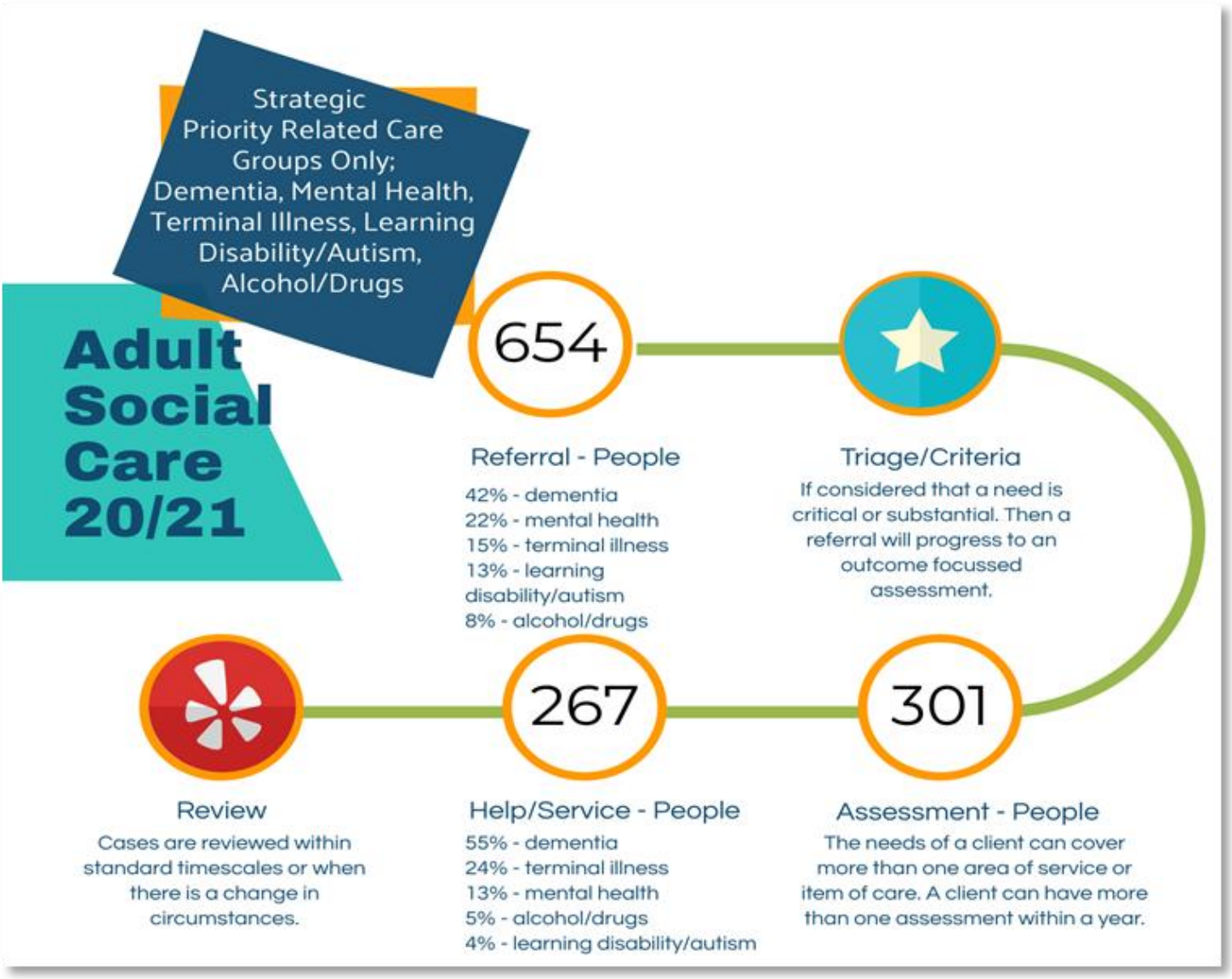
The model of care and support for Rural Southwest Stirling was been developing by working alongside our communities, third sector partners, primary care colleagues as well as leaders within community health and social care services.

Additional resources to support communities have been identified to provide more community reablement; more local providers to support personal care at home; appropriate long term nursing care, based on choice as well as a developing offer to increase technology enabled care in the rural area.

The HSCP continues to focus on the development of care and support which will offer individuals, their families and carers more choice and control. .



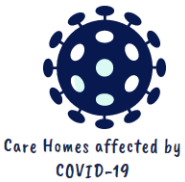
Adult Social Care – All clients - 2020/21


Strategic Priority Related Care Groups Only; Dementia, Mental Health, Terminal Illness, Learning Disability/Autism, Alcohol/Drugs
Adult Social Care 20/21
654
Referral - People
42% - dementia
22% - mental health
15% - terminal illness
13% - learning disability/autism
8% - alcohol/drugs
Triage/Criteria
If considered that a need is critical or substantial. Then a referral will progress to an outcome focussed assessment.
301
Assessment - People
The needs of a client can cover more than one area of service or item of care. A client can have more than one assessment within a year.
267
Help/Service - People
55% - dementia
24% - terminal illness
13% - mental health
5% - alcohol/drugs
4% - learning disability/autism
Review
Cases are reviewed within standard timescales or when there is a change in circumstances.

What Do We Know About Carers in Scotland:[3]

- Caring responsibilities affect many carers' physical and mental health.
- Nearly half of carers have long-term conditions themselves.
- Many carers are looking after people with complex needs.
- There are more older carers and a higher number of carers looking after more than one person.
- The time individuals spend caring is also increasing.
- Almost half of carers in the most deprived areas care for 35 hours a week or more. This is almost double the level in the least deprived areas

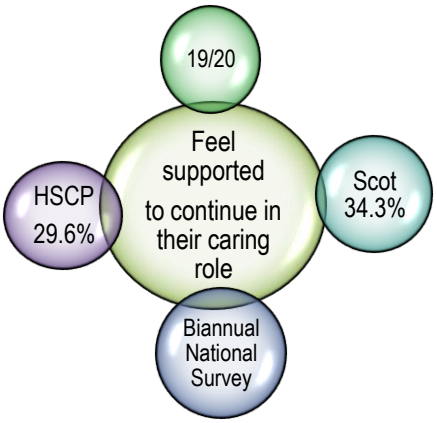
national implementation plan



We know that respite services, especially within care homes, was affected by the Covid Pandemic. With placements moving to a more crisis only response.

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, which sets out our approach to short breaks from caring and what is available.

The HSCP Carers Planning Group was refreshed and the membership expanded to include more unpaid carers and the options for the Carers Forums to feed in directly to the local planning and delivery of carers care and support. An updated Action Plan was agreed based on good outcomes for carers and ensuring the needs of carers are being met.



Source: National Core Indicators

Local Carers Centre's are funded to undertake Adult Carer assessments, offer carers information and advice as well as provide training to carers and workers across the HSCP. Carers organisations locally are key partners of the HSCP as representing the voice of carers and offering carers locally focused care and support.

Source: Local Data – Adult Social Care/Carers Centres

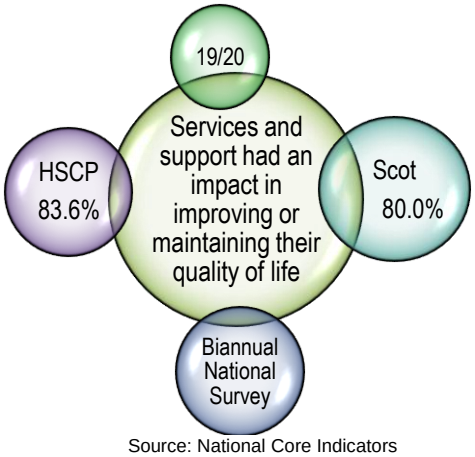
[3] Scotland's Carers, Scottish Government, 2015 - www.gov.scot/Publications/2015/03/1081

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 based on the current demographic trajectories.

The HSCP works to offer choice of care and support for individuals at end of life.



Source: National Core Indicators

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

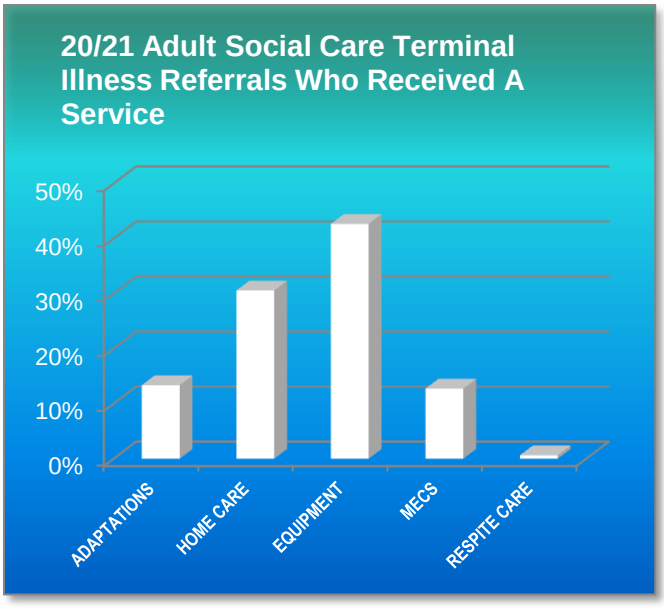
'Proportion of last 6 months of life spent at home or a community setting.'
Rank 10/31
More than Scottish average
National Indicator 15 - 20/21

96 referrals to Adult Social Care for those in Terminal Illness care group over 2020-21

38 referrals assessed

63 clients received a care package

Source: Local Data – Adult Social Care



Source: Local Data – Adult Social Care

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. The wider use of self directed support allows service users and their unpaid carers to exercise choice and control over their care.

88 referrals to Adult Social Care for those in Learning Disability/Autism care group over 2020-21

27 referrals were assessed

10 clients received a care package

Source: Local Data – Adult Social Care

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.

Community Support

Primary care is the first point of contact with the NHS. This includes contact with community based services such as general practitioners (GPs), community nurses, and Allied Health Professionals (AHPs).

The mental health nurse team are now embedded in the majority of GP practices offering around 500 weekly appointments across the area. The service is redirecting consultations which would otherwise be with a GP: We know that: 96% of new consultations were appropriate for the service, and less than 3% of people required to go on to see a Doctor.

The primary reasons for seeking medical support are known to be:
1) Anxiety, 2) Low mood and 3) stress

Community Support – Outpatients

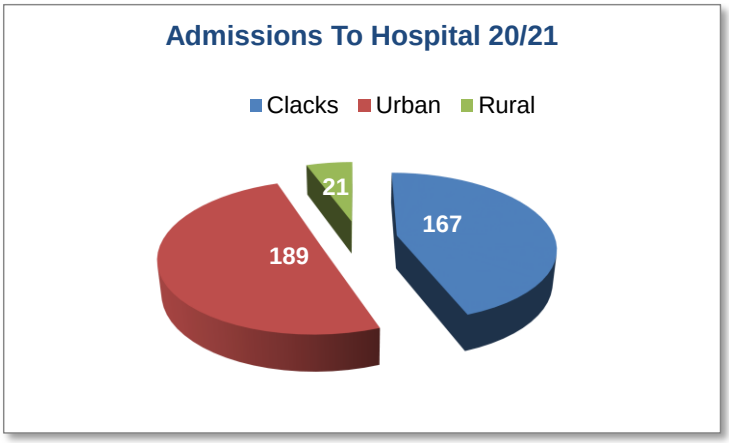
Patients who require the medical opinion of a specialist clinician may be referred to an outpatient clinic for treatment or investigation. Outpatients are not admitted to a hospital and do not use a hospital bed.

Community Mental Health Teams (CMHTs) support people with severe and enduring mental health in the community. They saw 1,375 new referrals in the period, and 21,024 return appointments over 20/21.

Acute Support

Acute hospital care includes activity occurring in major teaching hospitals, district general hospitals and community hospitals. It includes services such as consultation with specialist clinicians; emergency treatment; routine, complex and life saving surgery; specialist diagnostic procedures; close observation; and short-term care of patients.

There were 390 admissions to hospital over 20/21, and the chart below shows the proportion by locality area.

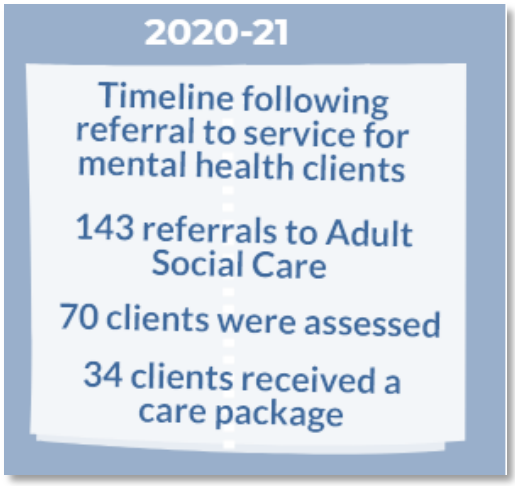


Source: Local Data – NHS FV

The Mental Health Acute Assessment and Treatment Service (MHAATS) receive urgent referrals from the Emergency Department at Forth Valley Royal Hospital and General Practitioners across Forth Valley.

Social Care

19% of people with mental health problems who were referred in Quarter 4 2021, went on to receive a care package from Adult Social Care that provided them with practical support and personal/non-personal care.

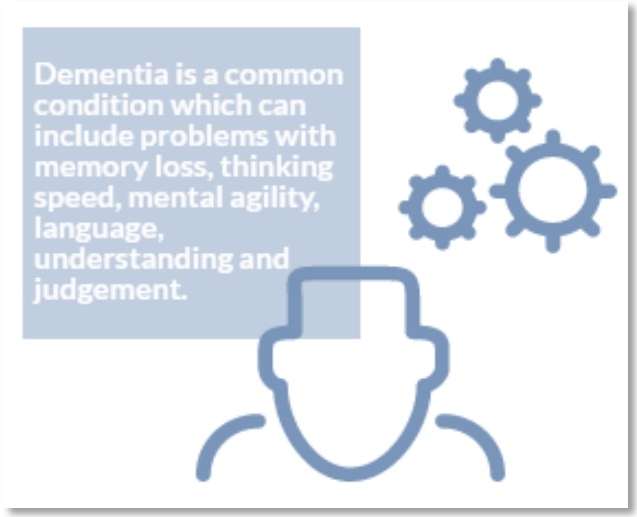


Source: Local Data – Adult Social Care

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."

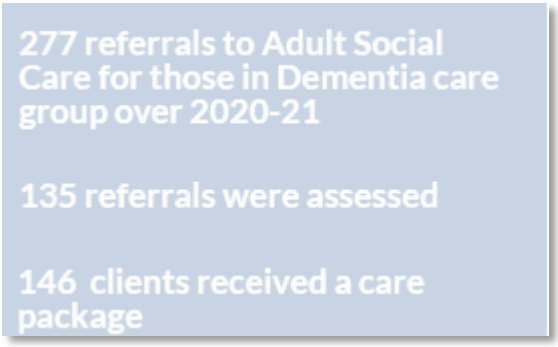
Every person with a new diagnosis of dementia in Scotland is entitled to a minimum of one year of Post Diagnostic Support (PDS) from a named person who will work alongside the person and those close to them.



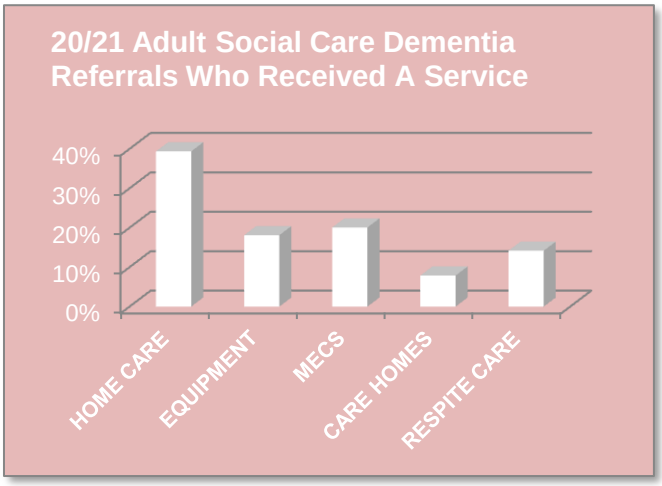
The 5 Pillars Model provides a framework for people living with dementia, their families and carers with the tools, connections, resources and plans to allow them to live as well as possible with dementia and prepare for the future.

Approximately 37.6% of newly diagnosed people within the HSCP were referred to post diagnostic support in 2020/21.However, both the Dementia Post Diagnostic Support service provision and data submission to Public Health Scotland were affected by the COVID-19 pandemic. Most of the PDS referrals for 2020/21 are still ongoing, and therefore the percentage quoted is subject to change.

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.



Source: Local Data – Adult Social Care



Source: Local Data – Adult Social Care

Section 7 - Alcohol & Drugs

"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

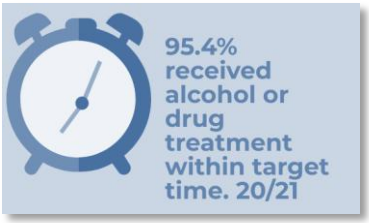
Community addiction services support people to participate in meaningful activities within their communities.

Change Grow Live
Recovery Service
Forth Valley

Waiting Times 2020/2021

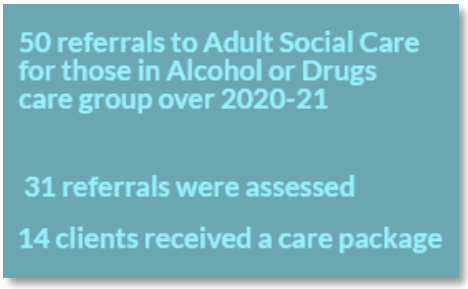
The national waiting times target - 90% of people should wait no longer than 3 weeks to access Drug and Alcohol treatment.

Clackmannanshire 96.1%
Stirling 96.7%
Scotland 95.9%
Source: National Data

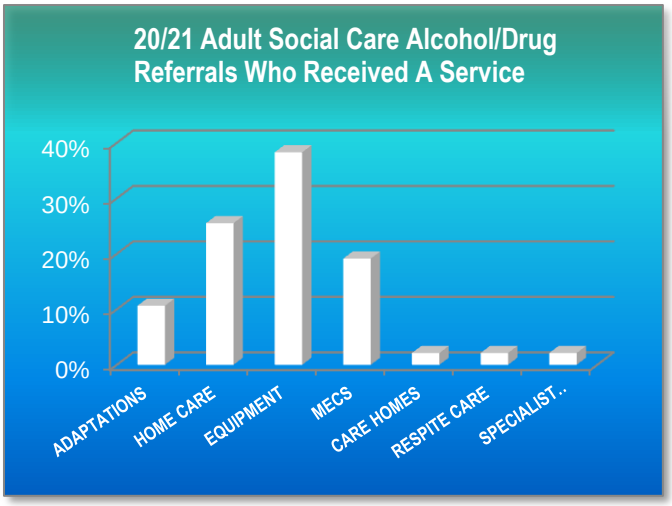


Source: National Data

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

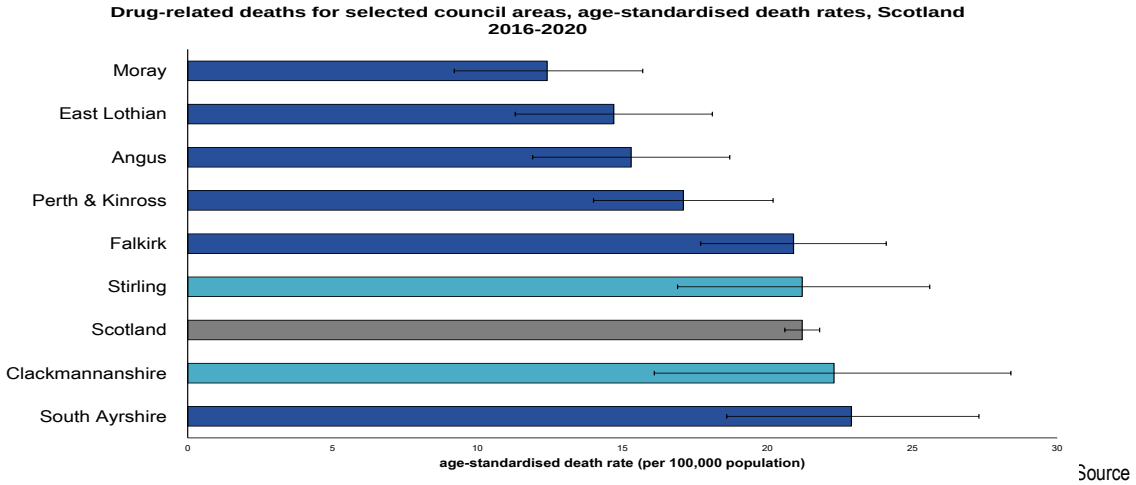


Source: Local Data – Adult Social Care



Source: Local Data – Adult Social Care

Alcohol related hospital admissions in 19/20 for Partnership residents was below the national average. The most deprived areas of the HSCP have on average 112% more alcohol specific deaths than the overall average. Which is higher than national figures. The Clackmannanshire locality is the highest with 122%.



Source

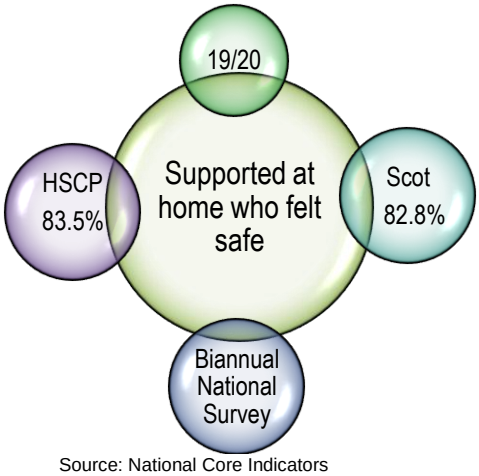
Section 8 - Adult Protection

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.

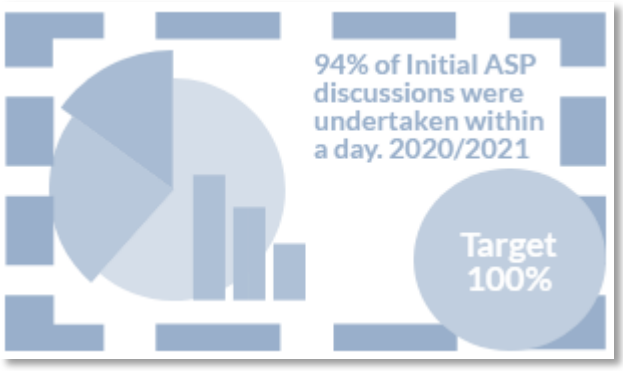
An 'adult at risk' of harm is defined as a person aged 16 years or over, who may be unable to protect themselves from harm, exploitation or neglect, because of a disability, mental disorder or mental Illness, physical or mental infirmity.

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 20/21 there were 1,261 initial discussions undertaken in Adult Social Care.

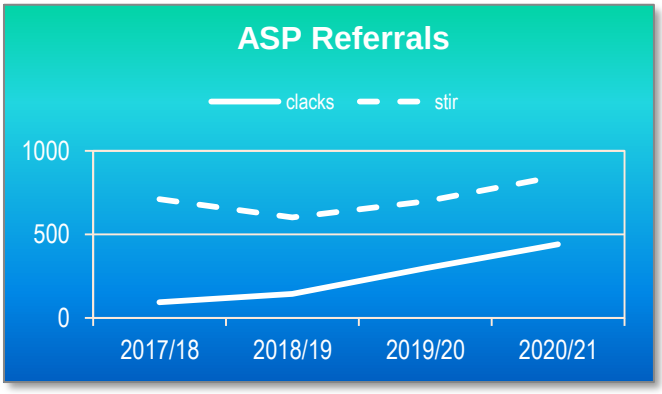


Source: National Core Indicators



Source: Local Data – Adult Social Care

There is a rising trend of ASP Referrals over the period.



Source: Local Data – Adult Social Care

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.

Source: Local Data – Adult Social Care

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

176

Source: Local Data – Adult Social Care

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. Over time our alignment of use of resources (both financial and non-financial) to Strategic Plan priorities and key performance measures is improving and will continue to do so.

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 within the responsibilities of the Integration Joint Board from Scottish Government.

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

For the financial year ended 31 March 2021 the IJB recorded an operational underspend on day to day activities of £3.323m and reserves increased by £12.516m. The increase in reserves is anticipated to be temporary and includes £6.642m of Covid-19 funding from Scottish Government which is the first call on Covid-19 costs during 2021/22.

The expenditure of the Integration Joint Board for year ended 31 March 2021 is detailed in the table below. These figures are subject to statutory audit and it is useful to read the content of the IJBs Annual Accounts alongside this report. The 2020/21 Annual Accounts and accounts relating to previous financial years are published here: https://clacksandstirlinghscp.org/about-us/finance/

Service Area	2017/18	2018/19	2019/20	2020/21
	£'000	£'000	£'000	£'000
Set Aside Budget for Large Hospital Services	19,985	20,633	22,006	23,588
Adult Social Care: Clackmannanshire Locality	16,539	17,136	16,130	17,326
Adult Social Care: Urban and Rural Stirling Localities	32,383	34,889	37,733	36,895
Health Services under Operational Responsibility of Integration Joint Board	33,543	36,039	36,129	37,623
Universal Family Health Services including Primary Care Prescribing	67,034	70,365	76,594	82,090
Integration (Social Care) Funding *	8,860	8,808	8,838	23,072
Shared Partnership Posts & Statutory Costs of Integration Joint Board	262	292	284	301
Transformation	3,086	2,734	2,202	2,454
TOTAL EXPENDITURE	**181,692**	**190,897**	**199,916**	**223,349**

*** For 2020/21 this figure includes Covid-19 funding passed through to Local Authorities and is therefore not directly comparable with previous years.**

Best Value

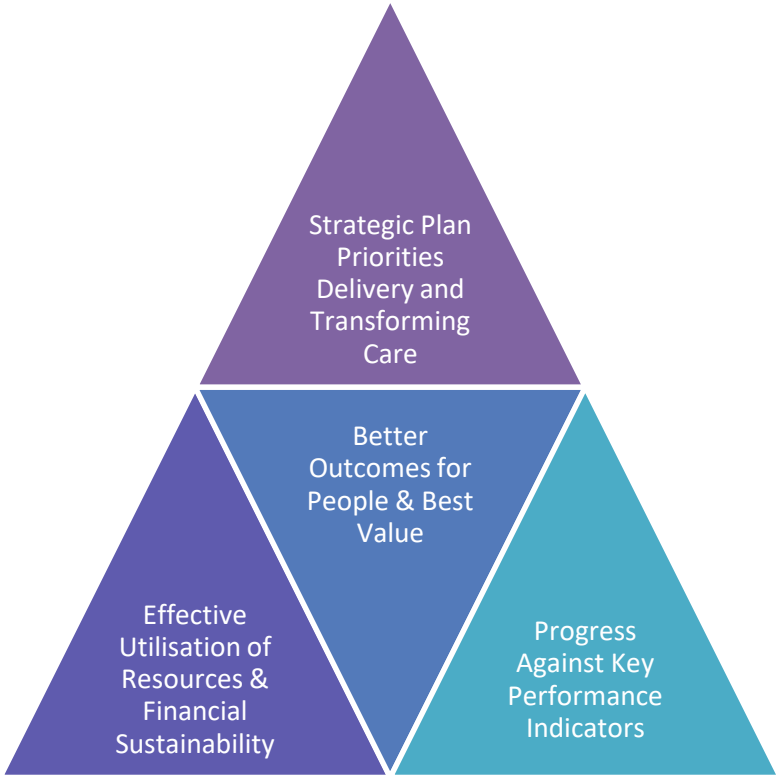
Clackmannanshire Council, Stirling Council and NHS Forth Valley (the constituent authorities) delegate budgets, referred to as payments and Set Aside budget for Large Hospital Services, to the Integration Joint Board which decides how to use these resources to pursue the priorities of the Strategic Plan 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 Leadership Team (SLT) and chairs the Senior Leadership Management Team (SMLT).

The Partnership views the triangulation of key performance indicators, measureable progress in delivering the priorities of the Strategic Plan, and financial performance as forming the cornerstone of demonstrating best value. 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 Revenue Budget and Update of the Medium Term Financial Plan (MTFP)
- Development of and reporting on the Transforming Care Programme
- Regular Financial Reports
- Regular Reporting on Strategic Improvement Plan
- Topic Specific Progress Reporting e.g. Primary Care Improvement Plan
- Reporting on Strategic Plan Priorities to the Integration Joint Board and topic specific reports.
- Best Value Statement

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 Board 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 are periodically reviewed.

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

	Indicator	Title	Partnership			
			15/16	17/18	19/20	20/21
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	95%	94%	93.6%	No Data
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible.	82%	82% Not comparable with 19/20	76.1%	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%	74.4%	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% Not comparable with 19/20	68.8%	No Data
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	78%	78% Not comparable with 19/20	75.2%	No Data
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	87%	87% Not comparable with 19/20	78.8%	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%	79.1%	No Data
	NI - 8	Total combined % carers who feel supported to continue in their caring role	32%0	38% Not comparable with 19/20	29.6%	No Data
	NI - 9	Percentage of adults supported at home who agreed they felt safe	82%	86% Not comparable with 19/20	83.5%	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	No Data

The 'outcome' indicators above are normally reported every 2 years from the Scottish Health and Care Experience Survey commissioned by the Scottish Government. The most current data for 2019/20 was available after the publication of last year's Annual Performance Report. It was published by the Scottish Government on 15 October 2020 with local level results available via dashboards on the PHS website. However, in regard to many of the indicators above, the data for 2019/20 there has been potential changes in methodology that affect the presentation of indicators 1 to 9.

	Indicator	Title	Partnership					
			Baseline 15/16	Current				
				16/17	17/18	18/19	19/20	20/21
Data indicators	NI - 11	Premature mortality rate per 100,000 persons aged under 75 years	425	389	379	371	429	459
	NI - 12	Emergency admission rate (per 100,000 adult population)	10,373	10,011	10,685	10,450	13,189	11,741
	NI - 13	Emergency bed day rate (per 100,000 population)	118,800	112,450	111,813	112,593	106,833	90,415
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	104	105	107	108	135	156
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%	87%	88%	88%	90.9%
	NI - 16	Falls rate per 1,000 population aged 65+	18	16	20	21	23	20.4
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	82%	88%	96%	93%	91%	91.6%
	NI - 18	Percentage of adults with intensive care needs receiving care at home	70%	70%	67%	67%	70%	69.2%
	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	665	456
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	21%	21%	23%	24%	26%	21.2%
	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	

The 'data' indicators above are based on returns from the Health Board called "Standardised Mortality Ratio" (SMR). Public Health Scotland (PHS) who collect and publish this data state there are ongoing issues with SMR data completeness in NHS Forth Valley.PHS have therefore estimated data for 2019/20 financial year for the Integration Authority areas within Forth Valley (Clackmannanshire and Stirling, and Falkirk) for indicators 12, 13, 14, 15, 16, and 20.

Indicator 20 – cost update

Previously, 2017/18 cost information was used to calculate figures for indicator 20 for all Partnerships, costs for 2018/19 are now available and have been used from 2018/19 onwards for all Partnerships apart from those in Forth Valley.

Indicator 17 - "Advice from directors of Public Health in Scotland was that inspection visits would present a real risk of introducing and spreading COVID-19 in Scotland's care homes. Therefore, to limit the spread of COVID-19, and with agreement from Scottish Government the Care Inspectorate restricted their presence in services unless necessary. This approach resulted in the majority of services not being graded as normal and instead retaining the grades they had last received. Instead the Care Inspectorate intensified oversight using a range of remote and virtual approaches to ensure services were supported and operating well throughout the pandemic."

Please note that information for indicators 10, 21, 22 and 23 is not available. These indicators are not currently reported as either national data is not available or there is not yet a nationally agreed definition.

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 was 1 service inspected during 2020/21. Additional information and full detail on inspections can be found at the Care Inspectorates website www.careinspectorate.com.

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	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?	How good is our care and support during the COVID-19 pandemic?	Recomm-endations	Requirements	Areas for improvement
Bellfield Centre Care Home	15/03/21	Good	N/A	N/A	Good	N/A	Good	0	0	1

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.

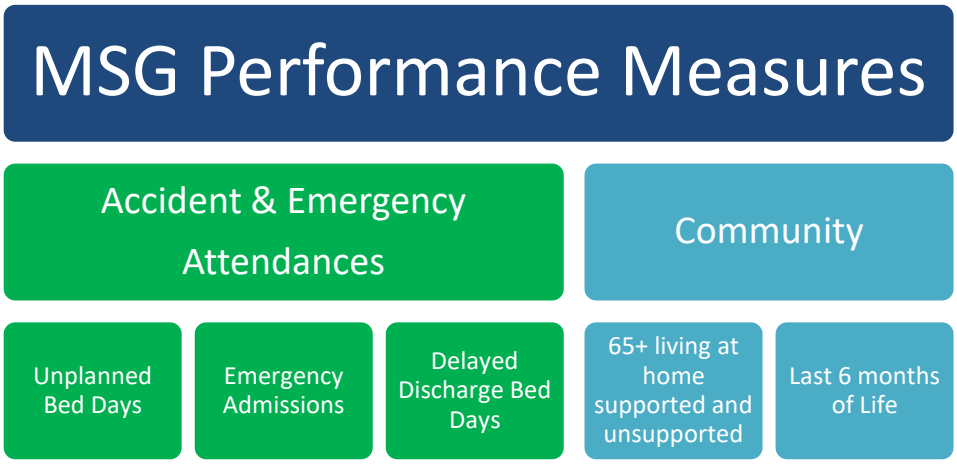
Req - A requirement sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in statutory requirements. Requirements are enforceable in law.

Inspection Requirements, Recommendations, and Areas For Improvement

Unit	Action
Bellfield Centre Care Home	
Previous 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.	Action taken since then The service had trained senior social care workers to also be able to make notifications. Suitable notifications have been getting made within the expected timescale. The service has met this area for improvement.
Previous 2. The service must now put in place their planned supervision and appraisal schedule.	Action taken since then The service made plans to meet this area for improvement but we found formal arrangements for regular, effective supervision and appraisal were not established. Staff discussion and records sampled confirmed that there were gaps. We saw examples of meaningful and supportive discussion to assist individuals' practice and development but the outcomes agreed were not completed. Staff felt well supported and led but the organisation was not meeting the standards set in their supervision policy. This area for improvement was not met. We have made another area for improvement at this inspection in relation to this. See 'Key Question 3 – How good is our staff team?'.
Previous 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	Action taken since then The service submitted a variation to address this matter. This area for improvement was met.
Previous 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	Action taken since then The service had developed a range of audit tools to assist monitoring and evaluation of this area. Whilst there were several systems in place to monitor aspects of service delivery, it was evident these systems were not consistently used to support improvement. The current Improvement plan, for example, referred to falls and medication practice. The actions planned were detailed but there was no evidence of implementation, timescales, outcomes or evaluation. We have repeated this area for improvement. See 'Key Question 1 – How well do we support people's wellbeing?'
Assessment and support planning should consistently inform all aspects of the care and support people experience. Strong leadership, consistent staff practice, meaningful involvement and embedded quality assurance and improvement processes support this happening. The quality assurance and improvement planning should include timescales, outcomes and evaluations. To ensure staff have the right knowledge, competence and development to care for and support people, the provider should ensure that staff have access to regular supervision, appraisal, and appropriate training. Staff competency and learning should be regularly assessed and evaluated with effective systems in place to evidence this.	
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 20/21 with any certainty as most figures are likely to change. Where there are completedness issues this has been noted and the figure is highlighted in italics.

18+ age group

1. Emergency admissions

Baseline year	Baseline total	% change	19/20 Target
15/16	11,141	5% decrease	10,584
16/17		0.5% decrease	11,082
17/18		5.5% increase	11,755
18/19		5% increase	11,699
19/20		31% increase	14,561
20/21	all months 97% and above complete but none 100%		*12,591*

Source: National Data

2. Number of unscheduled hospital bed days

	Baseline year	Baseline total	% change	19/20 Target
Acute	15/16	94,472	6% decrease	88,783
	16/17		5.79 % decrease	88,996
	17/18		4.68 % decrease	90,043
	18/19		1.5% decrease	93,050
	19/20		5.98% increase	100,124
	20/21	all months 97% and above complete but none 100%		*82,499*

Source: National Data

	Baseline year	Baseline total	% change	19/20 Target
Geriatric Long Stay	15/16	18,109	18% decrease	14,884
	16/17			14,884
	17/18			14,151
	18/19	Coding issues affect this area		11,421
	19/20	Coding issues affect this area		*9,047*
	20/21	Completedness issues		*613*

Source: National Data

	Baseline year	Baseline total	% change	19/20 Target
Mental Health	15/16	24,851	maintain baseline	24,851
	16/17		1% decrease	24,599
	17/18		3.8% increase	25,799
	18/19		7.8% increase	26,800
	19/20		0.32% decrease	24,771
	20/21	Completedness issues		*22,048*

Source: National Data

3. A&E attendances

Baseline year	Baseline total	% change	19/20 Target
15/16	26,585	maintain baseline	26,585
16/17		0.58% decrease	26,430
17/18		6.31% increase	28,264
18/19		13.91% increase	30,284
19/20		20.51% increase	32,040
20/21	Covid	13.1% decrease	23,091

Source: National Data

4. Delayed discharge bed days (18+)

	Baseline year	Baseline total	% change	19/20 Target
All reasons	15/16	10,069	maintain baseline	10,069
	16/17		17.69% increase	11,851
	17/18		20% decrease	8,054
	18/19		9.4% increase	11,016
	19/20		25.4% increase	12,630
	20/21	Covid	7% decrease	9,355

Source: National Data

5. Percentage of last 6 months of life spent in community (all ages)

Baseline year	Baseline percentage	Percentage point change	19/20 Target%
15/16	85.9%	4.10%	90.0%
16/17		1% increase	86.90%
17/18		1% increase	86.90%
18/19		1.9% increase	87.80%
19/20		2.12% increase	88.02%
20/21		5.2% increase	91.1%

Source: National Data

6. Proportion of 65+ population living at home (supported and unsupported)

Baseline year	Baseline percentage	Percentage point change	19/20 Target %
15/16	96.5%	0.10%	96.6%
16/17		0.10% increase	96.60%
17/18		0.10% increase	96.60%
18/19		0.30% increase	96.80%
19/20		0.70% increase	97.20%
20/21			Not available

Source: National Data

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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