Falkirk Health and Social Care Partnership

Annual Performance Report 2019-2020

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Introduction

Welcome from the Integration Joint Board Chair and Chief Officer

The Covid-19 pandemic and our response is at the forefront for the Partnership at the time of preparing this report. Whilst the Annual Performance Report covers the period from 1 April 2019 – 31 March 2020, we have to acknowledge the global pandemic.

Our experiences over the past few months have been inspiring and uplifting, showing us all how much we can achieve when we pull together in the face of a pandemic. Communities have shown how quickly they can respond, building resilience and capacity to provide essential supports and services to people, families and those in need, particularly during the challenges of lockdown. Of course it has also been extremely challenging, and has had a devastating impact on people, our communities and the economy. We still face many uncertainties about the future in terms of social and financial challenges.

The work taken forward by the Partnership over 2019/20 meant we were in a much stronger place to respond to the challenges we faced, and continue to face. Together we will look at how we can redesign our services and create new and innovative ways to deliver these. This is going to need to be done against an increasingly difficult financial position.

We have a shared vision in our Strategic Plan to “enable people in the Falkirk Health and Social Care Partnership (HSCP) area to live full and positive lives within supportive and inclusive communities”. With the HSCP, partners and communities working together to deliver this vision, we can continue to support and care for those most in need and deliver essential health and social care services. While our services and staff continue to respond and rebuild, our focus continues to be on ensuring safe effective services for those at risk in our communities. The HSCP Remobilise, Recover and Redesign Plan outlines the key elements for recovery and the potential opportunities for redesign. This is within the context of the delivery of the National Framework, the IJB Strategic Plan and national policy and guidance.

With our health and social care partnership in pandemic response mode since March 2020, this year’s annual performance report is subject to the impact of Covid-19. It is therefore more concise than in previous years. This is because members of staff who contribute to the report and are responsible for information illustrating our partnership’s effectiveness have supported our pandemic response.

Our annual performance report, April 2020-March 2021, will outline the effect of the pandemic across our services and communities, and will highlight ways in which

integrated partnership working has moved ahead at pace and scale, and ensuring person-centred care.

Thank you for taking the time to read our Annual Performance Report.

Fiona Collie
Falkirk IJB Chair

Patricia Cassidy
Chief Officer

Our Partnership

Strategic Plan 2019 – 2022

The Strategic Plan outlines how we will deliver adult health and social care services in Falkirk over the next 3 years. It sets out how we will deliver the national outcomes for health and wellbeing, and achieve the core aims of integration to:

- improve the quality and consistency of services for patients, carers, service users and their families
- provide seamless, integrated, quality health and social care services that care for people in their homes, or a homely setting, where it is safe to do so
- ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

Our Strategic Plan sets out our vision, local outcomes and priorities that we aspire to achieve for the people of the Falkirk area.

Our Vision

"to enable people in Falkirk HSCP area to live full and positive lives within supportive and inclusive communities"

Our Priorites

1. Deliver local health and social care services, including Primary Care services that are able to respond to people and communities
2. Ensure carers are supported in their carer role
3. Early intervention, prevention and harm reduction that:
    - Improve people's mental health and wellbeing
    - Improve support for people with substance use issues, their families and communities
    - Minimise the impact of health inequalities on individual and communities
4. Make better use of technology to support the delivery of health and social care services

Our Outcomes

Local Outcome 1: Self-Management	Individuals, their carers and families can plan and manage their own health, care and well-being. Where supports are required, people have control and choice over what and how care is provided
Local Outcome 2: Safe	High quality health and social care services are delivered that promote keeping people safe and well for longer
Local Outcome 3: Experience	People have a fair and positive experience of health and social care, delivered by a supported workforce that are skilled, committed, motivated and valued
Local Outcome 4: Strong Sustainable Communities	Individuals and communities are resilient and empowered with a range of supports in place, that are accessible and reduce health and social inequalities

Table 1

National Health and Wellbeing Outcomes

The Scottish Government has nine national health and wellbeing outcomes to improve the quality and consistency of services for individuals, carers and their families, and those who work within health and social care.

Our Annual Performance Report 2019 - 2020 sets out the progress that we have made working towards the National Health and Wellbeing Outcomes and our Strategic Plan priorities and outcomes which are set out above. Table 2 shows the association between these national outcomes and Falkirk Strategic Plan priorities.

Falkirk HSCP Strategic Plan priorities to the nine Scottish Government National Health and Wellbeing Outcomes and Integration Priorities

Falkirk HSCP Strategic Plan Priorities	National Health and Wellbeing Outcomes									Scottish Government Integration Priorities
	1	2	3	4	5	6	7	8	9	
Deliver local health and social care services, including Primary Care services that are able to respond to people and communities	✓	✓	✓	✓	✓	✓	✓	✓	✓	Reduce occupied hospital bed days associated with avoidable admissions and delayed discharges
Ensure carers are supported in their carer role	✓	✓	✓	✓	✓	✓	✓	✓	✓	Increase provision of good quality appropriate palliative and end of life care
Early intervention, prevention and harm reduction that: ▪ Improve people's mental health and wellbeing ▪ Improve support for people with substance use issues, their families and communities ▪ Minimise the impact of health inequalities on individual and communities	✓	✓	✓	✓	✓	✓	✓	✓	✓	Enhance Primary Care Reflect delivery of the new Mental Health Strategy Support delivery of agreed service levels of alcohol and drugs partnership work Ensure provision of the living wage to adult care workers and plan for sustainability of social care provision
Make better use of technology to support the delivery of health and social care services	✓	✓	✓	✓		✓		✓	✓	Continue implementation of Self Directed Support Prepare for commencement of the Carers (Scotland) Act on 1 April 2018

Table 2

Our Localities

The development of three localities within the Falkirk Council area is rooted within the integration legislation - the Public Bodies (Joint Working) (Scotland) Act 2014.

For service planning and development purposes, the three identified localities for the Falkirk HSCP are West, Central and East (illustrated in Figure 1).

1. West
2. Central
3. East

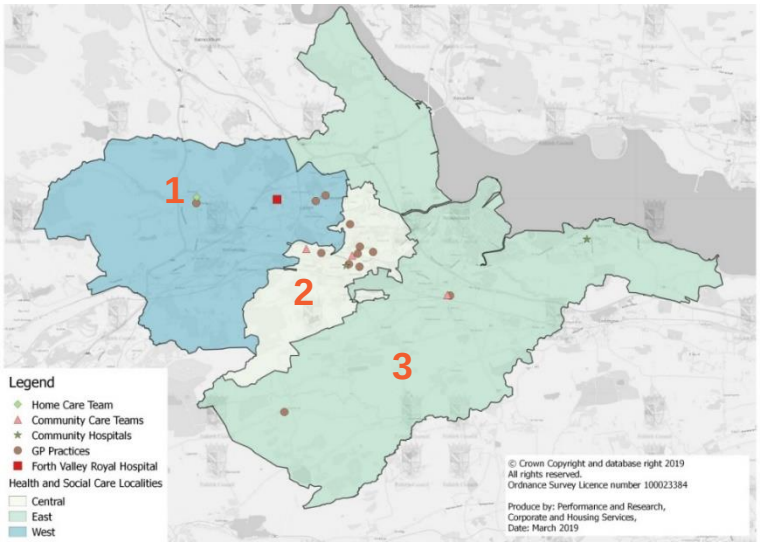


Figure 1

Although at the early stages of designing integrated services, we are realigning resources to ensure the Strategic Plan is delivered based on the needs of people living in these localities. During the height of the Covid-19 pandemic, it was even more imperative to deliver integrated services, and this accelerated many of the changes required that were set out in the Strategic Plan Delivery Plan. We will continue to build on this over the coming year through the HSCP Remobilise, Recover and Redesign Plan.

The Locality Managers will develop Locality Plans that reflect the needs of the local communities reflecting the Strategic Plan priorities. Locality plans will be developed with a community engagement approach along with partners to:

- ensure partners, communities and people who use services have their voices heard
- develop integrated, local services to improve health, promote good health and provide protection support
- build on the community capacity which has grown during the Covid-19 pandemic which is intended to reduce social isolation and improve the well-being of the people of Falkirk.

These Locality Plans will show how the Strategic Plan is being implemented locally to ensure services respond to the needs and issues within our communities.

This will also include working alongside our communities and partners and their plans. This includes the Community Planning Partnership (CPP) who are in the process of refreshing the Strategic Outcomes and Local Delivery (SOLD) Plan. A new Local Outcome Improvement Plan is planned for April 2021.

The following information has been summarised from the Locality Profiles for each of the locality areas.

Our Communities

A growing population, home to 160,340 residents
An ageing population, home to 30,465 residents 65+ years

West

21,520 households

7% live in the most deprived SIMD quintile

18% live with long-term health conditions

20% have anxiety, depression & psychosis prescriptions

Central

21,952 households

33% live in the most deprived SIMD quintile

20% live with long-term health conditions

22% have anxiety, depression & psychosis prescriptions

East

31,754 households

12% live in the most deprived SIMD quintile

19% live with long-term health conditions

20% have anxiety, depression & psychosis prescriptions

43,462 A&E visits

1148 were for falls

17,251
emergency hospital admissions

2,739
potentially preventable admissions

4,200 **residents have a community alarm system**

98% **have been replaced with digital equipment, with full digital service by Summer 2021 ahead of the 2025 Scottish Government deadline**

Our Progress against the National Health and Wellbeing Outcomes and Strategic Plan Priorities and Outcomes

The Scottish Government has nine national health and wellbeing outcomes to improve the quality and consistency of services for individuals, carers and their families, and those who work within health and social care.

01	People are able to look after and improve their own health and wellbeing and live in good health for longer
02	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
03	People who use health and social care services have positive experiences of those services, and have their dignity respected
04	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
05	Health and social care services contribute to reducing health inequalities
06	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 wellbeing
07	People who use health and social care services are safe from harm
08	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
09	Resources are used effectively and efficiently in the provision of health and social care services

Table 3

Our Annual Performance Report 2019 - 2020 sets out the progress that we have made working towards the National Health and Wellbeing Outcomes and our Strategic Plan priorities and outcomes, set out at pages 5 and 6.

O1 People are able to look after and improve their own health and wellbeing and live in good health for longer

Living Well Falkirk website

Living Well Falkirk (livingwellfalkirk.lifecurve) is a guided self-management web based service. It offers people an opportunity to find support, advice and solutions about their health, wellbeing and self-management. Anyone can access the website 24 hours, 7 days a week, 365 days a year.

The research behind this showed that if people act early, they can have the greatest impact on their ageing journey. Most people will start to lose the ability to carry out 15 daily tasks in an order similar to that shown in figure 2 below. Only a small proportion of an individual's ageing journey is genetic, how quickly things change is determined by what they do about it. Those who keep their abilities for the longest possible time at the early stages in this decline, will have the best ageing journey. This in turn can lead to less need for health and social care services.

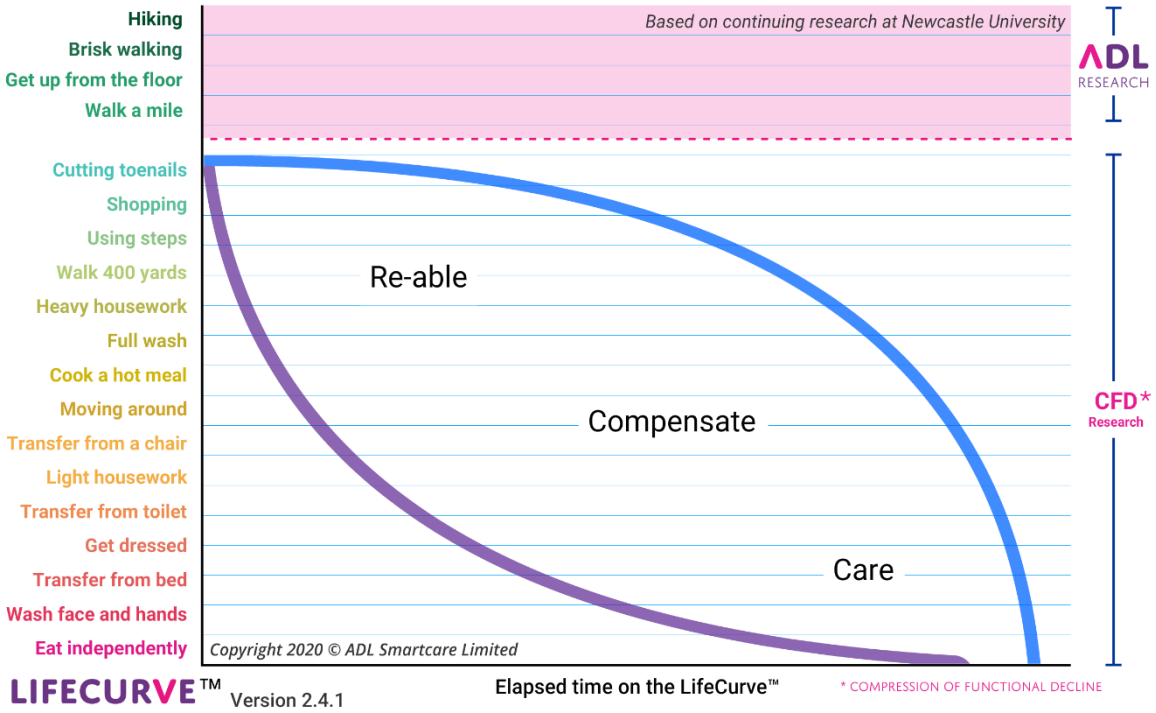


Figure 2– LifecurveTM Graph

There are different sections of Living Well Falkirk:

- Lifecurve™ allows people to plot their position on the ageing journey and to access advice that is designed to help them keep or regain their ability to do that task
- self-assessment allows people to access tailored advice and solutions relating to specific difficulties with everyday tasks in and around the home and out in the community. These can be about the person getting their ability back, or finding suitable equipment to help, or a combination of these.

- wide range of information about and links to local and national health and social care services. It can help people to connect to local groups and services.
- a special section on keeping well while isolating at home during the pandemic restrictions on movement introduced in March 2020. From 1 April to 30 June 2020, the site had 645 users, engaging in 859 visits. Usage from outside the Falkirk area overtook usage from Falkirk for the first time. This may indicate that relatives who were unable to visit to help their loved ones in Falkirk were able to investigate other sources of help or solutions on their behalf.

2019 – 20 key management information

- 3186 people have used the site, with a total of 4963 visits – an increase of 41.6% on users from the previous year
- 42% of visits to the site are made out of office hours, when staff would not be available.

Living Well Falkirk Centre

When people identify that they have difficulty with daily living tasks, for example bathing or managing the stairs, it is important that they receive the right support at the right time. The aim of the Living Well Falkirk Centre is to assess people quickly and where there is a need, provide equipment or adaptations to help maintain independence.

The first Living Well Falkirk Centre opened in April 2019 within the Forth Valley Sensory Centre, running three days a week. People meet with an experienced worker who, using the Living Well web based assessment, can give personalised advice on healthy ageing and on keeping active and independent for longer results. As a result of this more efficient way of meeting with people, the waiting time for this type of assessment reduced to typically 2 weeks. Over the year, Living Well Falkirk Centre assisted 250 people with assessments. This has also had an impact on the waiting times for Occupational Therapy (OT), as noted in local indicator 85 below.

A successful official launch event was held on 4 October and was attended by Provost Buchanan, IJB members, elected members, some of the first people to use the Living Well Falkirk Centre and managers and staff of the HSCP, Falkirk Council and NHS Forth Valley.

Living Well Falkirk Centre appointments are suspended in line with government advice, but it is hoped that we will be able to re-start at least some service in the Autumn.

		At 31 May 2019	At 31 May 2020	Direction of travel
85	The number of overdue 'OT' pending assessments at end of the period	315	122	▲

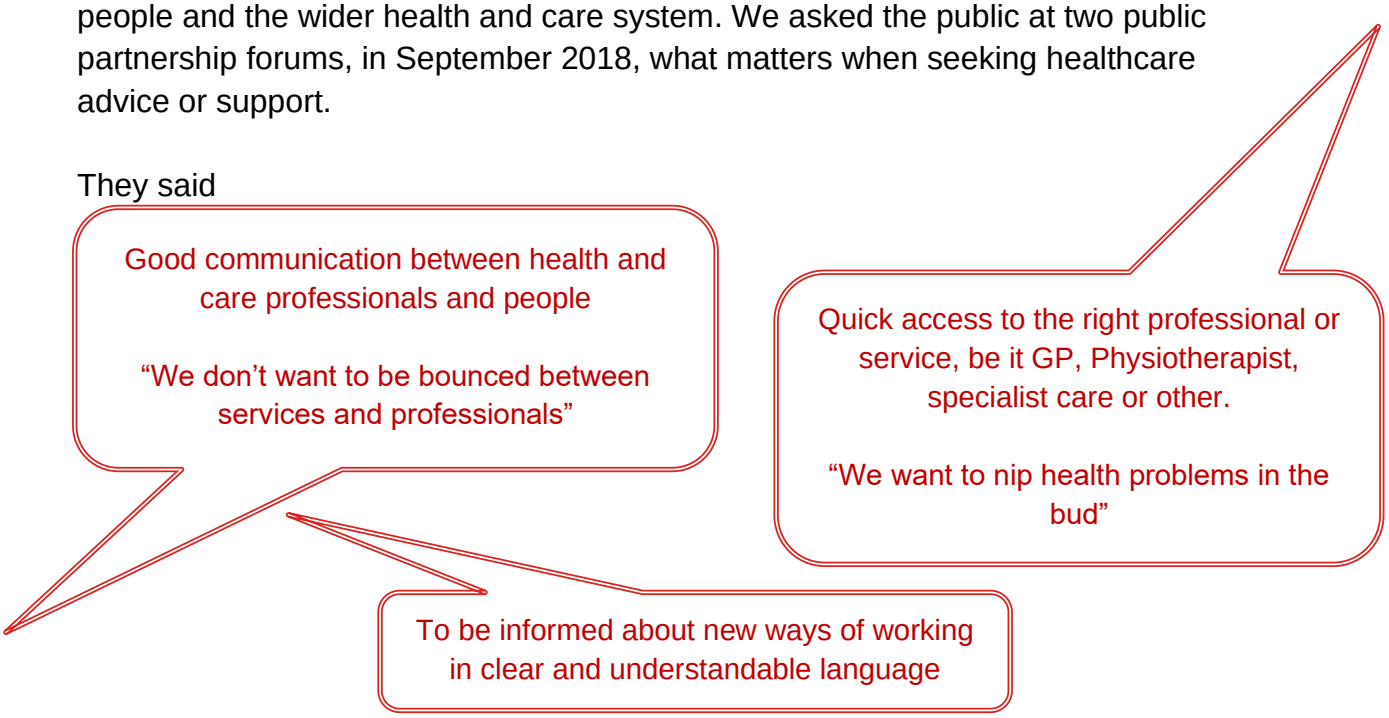
Table 4

New Models for General Practice

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

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

They said



The primary care improvement plan sets out how we will scale up the support to all GP practices in Falkirk. The following are examples of what has been achieved to date.

Vaccinations

The Community Vaccination Team are now co-ordinating and delivering all pre-school immunisations across Falkirk practices. The historically good immunisation uptake has been maintained through this transition.

Pharmacotherapy

Development of a Pharmacotherapy (Pharmacy Support) Service within GP practices is a key component of the Primary Care Improvement Plan. Nearly 18 additional Pharmacists and pharmacy technicians support GP practices in Falkirk to ensure that patients receive the best outcomes from their medicines as well as reducing GP workload.

Activities that the pharmacy team are involved in include assessing and authorising acute and repeat prescriptions and ensuring GP records are accurately updated when patients are discharged from hospital with changes to their medicines or when patients are seen at specialist clinics. Recognising that pharmacists are the experts in medicines, their specialist knowledge can be utilised in pharmacist led clinics to review patients who are taking multiple medicines or with conditions such as diabetes or chronic pain. There are multiple benefits to these type of reviews e.g. improved patient understanding of the medicines they are taking, a reduction in medicine related hospital admissions and improved patient safety.

There is a Pharmacotherapy Service running across all GP practices in Falkirk HSCP. In the Falkirk Town, Denny / Bonnybridge and Stenhousemuir / Larbert clusters the service is running at full capacity. Within Grangemouth / Bo'ness and Slammanan and The Braes a partial service running with plans to develop that to a full service mid to late 2021.

Additional Professional Roles

Across Falkirk GP practices we now have

- 5 full time Advanced Practice Physiotherapists
- 8 full time mental health nurses
- 8.2 full time Advanced Nurse Practitioners
- 5 Health Care Support Workers.

Working closely with General Practice Teams, these additional roles act as a first point of contact providing more than a thousand additional weekly general practice appointments across the 25 Falkirk GP practices. These clinicians will assess and direct care for urgent health issues, muscle and joint problems, mental health issues, provide additional access for blood tests and support patients in care homes.

Primary Care Mental Health Nurses

During a Forth Valley audit of 37 practices and 1800 appointments over a 2 week period in early 2020, 900 appointments were from 17 Falkirk practices and 50% were new patients to the service.

Almost two thirds of patients attending appointments with the Primary Care Mental Health Nurses are female (63%)

Almost two thirds of all attendances are made by younger adults, those aged 15 – 44 years (65%).

The issues most mentioned were:

- Low mood (33%)
- Anxiety (26%)
- other stress (11%)
- Situational crisis (5%).

Self Help support was a key outcome for more than 50% of people attending their first appointment.

- Return appointment (28%)
- Nurse led interventions (20%)
- Medication reviews or changes (38%),
- 20% Referral to other services including GP and secondary care (of which 11% to third sector).

Patient Survey Nov 2019 (478 patients)

- 95% of respondents said that "In the future, I would be happy to see the most appropriate professional for my needs"
- 89% of people who had experience of an appointment with a new professional role (305) agreed that their needs were met by the new healthcare professional.

Comments from GPs (GP survey October 2019)

"Having pharmacy support from fully trained and experienced pharmacists has made a huge difference to GP workload daily. We are still to establish clinics for the pharmacist although we are keen to do so but Acute scripts and most Docman medication requests and reconciliation is done daily."

"Every patient that is seen by the APP or MHN is freeing up valuable time for our GPs. Having these specialists in Practice is excellent"

O2 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

Home First

Following a successful test of change of the Home First Team in September 2019 in 3 wards in FVRH, the service has been extended to cover all of FVRH and Falkirk and Bo'ness Community Hospitals. The Team work at the FVRH front door with the Frailty team, with the Discharge Hub team and in the weekly multi-disciplinary team meetings at the community hospitals. They also have strong links with Summerford Intermediate Care Facility.

Home First is a local initiative to focus on supporting people to avoid a delay in their discharge from hospital. They work with the person and their carer/relative to agree how they can support them to get home, without any delays. Since the start of the test of change to now, the team has completed nearly 580 assessments.

The team consists of social work professionals who work in collaboration with health professionals to determine people's needs to return home. They are now based on the FVRH site, which has supported easier communication and contact with the wards and patients, as well as building positive relationships and being part of the integrated team.

The Falkirk Community Hospital team is growing and stabilising and are working to service standards to allocate referrals within 2 days and 5 days to complete an assessment. There are complex cases where timescales may be longer however the team approach is working to identify those people earlier and take appropriate steps to support them.

Improving our delayed discharge performance is an area for improvement and remains an area of priority for the Partnership.

Local indicators 54-59 below demonstrate considerable reductions in the number of delays and number of bed days associated with those delays in comparison to the same point last year. However it must be noted that exceptional measures and effort were made in response to the Covid-19 to ensure the acute hospital was able to facilitate potential increase in demand due to the pandemic.

		Apr-19	Apr-20	Direction of travel
54	Standard delayed discharges	38	7	▲
55	Standard delayed discharges over 2 weeks	26	1	▲
56	Bed days occupied by delayed discharges	972	128	▲
57	Number of code 9 delays, including guardianship	15	11	▲
58	Number of code 100 delays	1	0	▲
59	Delays - including Code 9 and Guardianship	53	18	▲

Table 5

Falkirk HSCP Residential Care Homes

In line with our vision, we know that people want to stay in their own homes for as long as they can, and we provide a range of services and support to enable them to do so. We are also redesigning and commissioning community based supports that will meet the known gaps we have in our provision. This means we can support more people to stay at home, and for longer.

Sometimes people will move in to a care home when the help they need to look after themselves can't be provided in their own home. People expect this to be a homely setting, and a place where they can live and have their care needs met by trained staff.

In Falkirk HSCP we have 4 residential care homes and one intermediate care facility, supporting about 129 residents. Our staff are committed to making this a homely environment, whist providing high quality care and support. This has been particularly important during the pandemic to ensure high standards of infection prevention and control are in place.

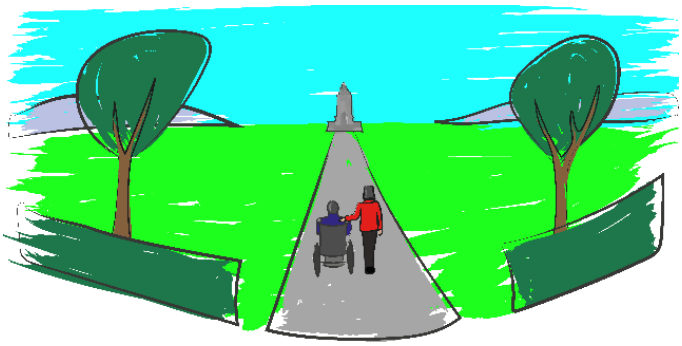
The following are some examples of how our residential care homes are supporting residents to stay connected with their families, friends and communities.

Cunningham House and Zetland Park Flag Project

Cunningham House took part in the Zetland Park Flag Project in conjunction with Friends of Zetland Park and Falkirk Council Development Services. The aim being to celebrate the communities' use of the park and to encourage more people to use and enjoy its facilities. The project was to create a set of local community designed flags that can be rotated to fly from the flagpole each year from April to September.

Funding was available for an artist, who visited the home to work with our residents over a few sessions. Residents wanted to design a flag that links Cunningham House to the heritage of the park and why it is important to our home/residents.

Through these sessions we produced the first ‘official’ flag for the park and were invited to a special raising/unveiling of flag ceremony with our resident flag designer as the honorary guest. This was followed by an invitation to a local Church for refreshments and they paid tribute to the work of Cunningham House.



The official flag flying in Zetland Park, above is the image of the flag, and below are the residents of Cunningham House attending the unveiling

Grahamston House

Residents and their families and staff have worked together to raise funds to create a therapeutic and meaningful garden area for all to use. With the funds raised, they were able to purchase two lovely summerhouses and through joint efforts planted some lovely sun flowers and potted plants. The garden is focused around being Dementia friendly. The purpose is to provide familiarity for the residents and the vibrant colours and tactical features offer excellent sensory stimulation. Everyone is looking forward to many more lovely summer days in the garden!

The staff also worked in partnership with Caledonia Service’s Conservation Group who started work on restoring the beach themed dementia garden in the grounds of Grahamston in October 2019. Caledonia Service work with adults living with severe and enduring mental illness. They offer group activities that aim to improve well-being, increase self-esteem and self-confidence while giving individuals an opportunity to learn new skills or build on existing ones. They also work with our service users individually, offering a key-worker system so we can support people to meet their future goals and aspirations. Peer to peer support is also a major part of our service as we can provide a sense of belonging to a community of people with similar experiences.

This gave Caledonia service users a feeling of contributing to the local community and a real sense of worth and fulfilment. It also benefited the residents as they could spend time in or just enjoying looking at the garden from the comfort of their room.

This working partnership developed further with a Caledonia Services volunteering to attend Grahamston to visit some of their residents in a more social environment, playing dominoes and engaging in general conversation. This gave service users a chance to develop skills in a sector many of them have goals to become a part of in the future.

Caledonia Musical Drama group also performed a Christmas Concert for the residents in 2019, giving group members a chance to showcase their talents to an outside audience which most of them had never done before. This resulted in a surge of confidence which they have been able to take into other areas of their lives and also help develop the group further.

District Nursing Services

Our District Nursing Vision is

"to support people to live and die well within their own homes. We will do this by delivering excellent nursing care in the community, 24 hours a day"

Our District Nursing Team provide a wide range of local community based services to people across a range of settings including people's own home, care homes and treatment rooms. We provide increasingly complex care for patients and support their family and carers to meet their needs. This could include access to area wide specialist teams where appropriate, such as the Closer to Home team, tissue viability

and the hospice. Providing care at home, or as close to home as possible, reduces avoidable hospital admissions or attendances and helps get people back home quickly and safely.

District Nursing Services remain both preventive and supportive delivering anticipatory care rather than crisis led intervention, allowing people to live independently, supporting health and wellbeing for both them and their carers; and support self-management. This has been increasingly important and has been clearly evidenced during the Covid-19 pandemic with the focus of care moving much more towards self-care and self-management.

Performance against our local indicators 33-35 show substantial increases in the number of people with Anticipatory Care Plans (ACP) and Key Information Summaries (KIS) compared with the same time last year. This is a key improvement in terms of enabling people to be cared for and supported in the community.

		Mar 2019	Mar 2020	Direction of travel
33	Number of patients with an Anticipatory Care Plan in Falkirk	7,061	12,454	▲
34	Key Information Summary as a percentage of the Board area list size Forth Valley	5.00%	8.10%	▲
35	Key Information Summary as a percentage of the Board area list size Falkirk	4.40%	7.80%	▲

Table 6

Palliative and End of Life Care (PEOLC)

The Partnership continues to plan our model of palliative and end of life care to provide more care in community settings and as close to home as possible, where this is desired and appropriate. Care often involves a range of health and social care services for those with advanced conditions who are nearing the end of life and this includes access to specialist palliative care services.

Approximately 1730 Falkirk residents die every year. It is estimated that up to 1300 of these people are likely to have palliative or end of life care needs. Our ageing population means that the number of projected deaths is expected to rise, which will also increase demand for palliative and end of life care services.

We measure the percentage of last 6 months of life spent at home or in a community setting to provide a broad indication of progress in implementing our action plan to improve palliative and end of life care. This will help to increase the percentage of time that people spend at home or in a community setting during their last 6 months of life.

Our key priorities include:

- update models of PEOLC to ensure the provision of services meets the existing and future needs of the local population. This will ensure earlier identification of patients who have palliative care needs and/or may be approaching the end of life. The delivery of more care closer to home and in community settings will ensure that everyone has equitable access to high quality care and support.
- improve communication and care planning to promote a person-centred approach which puts the person at the centre of their care and involves those who matter most to them. Utilising tools and technology to support sensitive communication, prognostication and more collaborative multi-disciplinary working will support this.
- develop PEOLC skills for staff to have a balanced workforce with the right capacity, knowledge and skills.

Key areas of activity over the last year have included:

- Macmillan Healthcare Support Worker (HCSW) project involves HCSW's providing support to Community Nursing teams to support people to remain in their own homes for as long as possible. There is good evidence that early intervention is enhancing patient and carer experience and that crisis admission near the end of life is likely to be avoided. This project will inform future collaborative service development.
- Hospice at Home Service (H@H), provided by Strathcarron Hospice, has operated over the last six years. Initially supported mainly through Big Lottery funding, this service has been entirely funded by Strathcarron Hospice since 1 August 2019. H@H supports people in their own home who are in the last weeks of life and their carers through practical, emotional and personal care. H@H is delivered by a small team of health care assistants who have specific experience and training in palliative and end of life care. A core element of the service is flexible support to family carers as death approaches. An external evaluation (which includes comparative data from ISD) has evidenced that this sort of practical support can play an important role in helping more people to die at home, where this is their preference and where this can be realistically supported. The evaluation highlights that when this service is in place, working alongside other community-based care services (such as GP Out of Hours and District Nursing services), people were less likely to have an attendance at the Emergency Department, less likely to be admitted to hospital and more likely to have a reduced length of stay in ether hospital or hospice. 198 people across the Falkirk area were provided with 1266 visits from H@H during 2019/20. Potentially, this sort of integrated working helped these people spend an average of 6 days less in hospital or hospice during their last 15 days of life. Importantly, the H@H service has demonstrated high user satisfaction and

achieved ratings of ‘excellent’ from the Care Inspectorate for 4 consecutive years

- Compassionate Communities - Living Right Up to the End used an Asset Based Community Development approach. The project is developing a community-led model where social connection is recognised as crucial to wellbeing in the face of illness, dying and grieving. It is discovering what communities can do for themselves and what help they need from professionals and others. By encouraging connections at a neighbourhood level, the project supports communities to become more competent at creating a space where people with long-term conditions, or who have experienced loss, can feel nurtured and included.
- Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Process which creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about a person’s care and treatment. People who go through the ReSPECT process are more likely to remain at home after hospital admission, more likely to die at home if end of life, more likely to have a useful and up to date Key Information Summary (KIS) which is essential in the out-of-hours period in particular and patient and carer feedback from patients and carers was very positive.

  Next steps are to promote a unified approach to emergency care planning with use of the ReSPECT process, as the go-to ACP tool across all care settings in Forth Valley. This will be supported by the work with NES Digital Service in 2019 and the migration away from the use of DNACPR and other ACP tools.
- Quality End of Life Care for All (QELCA) programme - Care homes within the Falkirk area have been participating in the accredited QELCA programme delivered at Strathcarron Hospice. This comprises a 5-day experience at the Hospice with structured reflective learning and follow up actions learning sets. There is strong evidence that this approach results in lasting impact and attitudinal change and practice improvement.
- Extension for Community Healthcare Outcomes (Project ECHO) **-** Based at Strathcarron Hospice, the ECHO model uses videoconferencing to enable health and social care professionals to learn with and from one another and drive participant-led change. There has been excellent engagement from Care Homes in the Falkirk area who have set up a rolling programme of learning. During the Covid-19 pandemic, more care homes have joined the network and have found it to be a valuable space for mutual learning and support.
- Planning, Designing and Commissioning services
  - we held two local workshops (facilitated by NHS Healthcare Improvement Scotland ihub) to review how people use local services, how this is

balanced between hospital and community settings and potential areas for change and improvement.

- the core information we will use to support decisions regarding care needs and the shape of future services has been refreshed with the support of the Public Health Scotland (PHS) LIST analysts.
- PHS supported a review of patient pathways in Falkirk during the last 6 months of life, for those dying at home versus those dying in a hospital setting, identifying need for improved alternative pathways both in and out of an acute hospital setting e.g. Home First, to minimise the likelihood of people dying in a hospital setting due to a delayed discharge.
- a bereavement stakeholder event was held in September 2019, which will help to inform the development of a tiered model of support.

During the pandemic, all teams were faced with totally unprecedented circumstances that impacted on end of life care significantly. There was excellent collaborative working to ensure the safest and most effective care was provided. This included supporting staff in care homes. The learning from Covid-19 will be used to inform future planning of services.

		2015/16	2018/19	Direction of travel
86	Proportion of last six months of life spent at home	86%	86%	◄►

Table 7

Self-Directed Support (SDS)

Progress towards full implementation of Self-Directed Support continues. Significant effort is being made to keep abreast of evidence-based learning and resulting developments. Continuous improvement is a central aim within the implementation process. At the same time, trying to ensure communication, engagement and participation of individuals, carers and staff across all partners, including Third Sector partners and care and support providers, remains current and accessible.

The SDS team works across Adult Services and Children's Services to support assessment and care management, workforce development, finance and contracts and commissioning teams.

The Social Care (Self Directed Support) (Scotland) Act 2013 ensures that people with eligible support needs and their carers can exercise choice and control over the support they receive, in line with their agreed personal outcomes.

SDS Forth Valley is a local user-led support service and are strategic partners for SDS implementation and assist with development of local SDS policy and procedures. The local Carers Centre is also a strategic partner and is fully involved

on policy development for carers. These partnerships are collaborative and ensure consistency and clarity of approach; a good understanding of the local and national guidance, with positive working relationships.

Staff continue to discuss and promote the options during assessment and support planning. They are encouraged to carry out joint visits with SDS Forth Valley to ensure a full explanation of the nature and impact of each of the Options is given to enable individuals and carers to make an informed choice. Online/telephone support is being provided during Covid-19.

During the pandemic the SDS team has been working closely with SDS Forth Valley to implement the new national guidance. This includes more flexibility in the use of funding during the restrictions of Covid-19 and less bureaucracy for setting up support arrangements, where possible. This joint working is also ensuring that individuals can continue to meet their responsibilities in managing their support.

Our performance against local indicators 37- 40 demonstrate the choices made by individuals under each of the four Self Directed Support options shown. People assessed as requiring a social work services will be able to take more control over how their support is provided. They will have more choice about who provides their support, what is provided and when it is provided. We measure the options that people have chosen. A slight increase in the past year highlights that now 9 out of 10 people have selected option 3 for the local authority to arrange a care and support package for them.

	Self-Directed Support (SDS) options selected: People choosing	Mar 2018	Mar 2019	Direction of travel
37	SDS Option 1: Direct payments (data only)	30 (0.7%)	35 (0.8%)	**n/a**
38	SDS Option 2: Directing the available resource (data only)	192 (4.8%)	192 (4.5%)	**n/a**
39	SDS Option 3: Local Authority arranged (data only)	3,522 (87.3%)	3,875 (90.1%)	**n/a**
40	SDS Option 4: Mix of options (data only)	292 (7.2%)	197 (4.6%)	**n/a**

Table 8

Local indicators 60 – 63 demonstrates the satisfaction levels of people who use services and their carers in the services they receive from social work adult services.

		2018/19	2019/20	Direction of travel
60	Percentage of service users satisfied with their involvement in the design of their care package	98%	99%	▲
61	Percentage of service users satisfied with opportunities for social interaction	90%	91%	▲
62	Percentage of carers satisfied with their involvement in the design of care package	93%	93%	◄►
63	Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	91%	91%	◄►

Table 9

Joint Dementia Initiative (JDI): Housing Support Service

The JDI provides a one-to-one housing support and care at home service for people diagnosed with dementia or memory problems living in their own homes. The service provides support for people living with dementia and their family members.

People using the service can also use the weekly drop in café based in the JDI offices at Dollar Park in Falkirk. This gives people an opportunity to meet other people living with dementia and their relatives. A monthly support group takes place for people under the age of 65 years who have been diagnosed with early onset dementia. This service is user led and provides practical support and advice as well as social and leisure opportunities.

In August 2019, the service was graded 6 for Care and Support by the Care Inspectorate. The report stated:

> "We graded the care and support people were receiving as excellent. This meant we considered the service was sector leading and demonstrating innovative and effective practice from which others could learn. People's experiences and outcomes were of an outstandingly high quality.
>
> We found the entire team in the service were values led and demonstrated an outstanding level of commitment to providing excellent outcomes for people using the service and carers. Staff were passionate about upholding service users' rights, promoting and maintaining their independence and maintaining and increasing, if possible, their quality of life."

Joint Loan Equipment Service (JLES)

JLES continued to provide and maintain equipment alongside an increase in demand for equipment to support delayed discharges and end-of-life care in people's homes. This has led to a change in the delivery and collection schedules to focus on the delivery and collection of 2 person jobs including beds, mobile hoists and specialist seating etc. There are now multiple 2 person deliveries and collections everyday instead of the 3 slots each week we had in the past. The fitting of grab rails previously carried out by a contractor has returned to JLES and is carried out by the technicians 'in house'.

JLES has supported the delivery and fitting of equipment such as bath lifts, following Living Well Falkirk assessments. The stores/driving staff received manufacturer training to ensure these tasks were carried out safely.

We have encouraged members of the public to collect and return equipment from/to the depot where possible to allow us to prioritise deliveries and collections more effectively. This has increased the footfall to the building and we have reconfigured the staff accordingly.

Our performance over the year:

- 13,756 total number of deliveries
- 5,431 total number of collections
- 514 beds were delivered
- 312 beds were collected

Thank you to all those involved from JLES in providing equipment to my late husband, it made his life easier and more comfortable during his last "months"

O3 People who use health and social care services have positive experiences of those services, and have their dignity respected

Transitions From Children to Adult Services

Joint plans with Children's Services to improve transition planning and adopt a lifespan approach to this milestone in the lives of young people have progressed. It builds on the Principles of Good Transitions and is guiding ongoing developments

Over 2019/20 we have benefited from the secondment of a social worker to work in a dedicated manner on scoping need, and working with children and adult social work staff and our Additional Support Needs school provision. This allowed the groundwork for the role of the Transitions Coordinator who will work across both services and be based at Carrongrange School and took up post in summer 2020.

The 'hub' concept is gradually developing around the school with a dedicated school transitions post looking at opportunities for young people and a school social worker funded via the Scottish Attainment challenge monies. This will have an impact on the breadth of experience for young people, transitions in to secondary school and bringing best practice research and experience to how we support children and adults with additional needs.

Achievements over the year include:

- the establishment of networks and relationships to raise the profile of transitions, including highlighting the importance and impact of assessment, education and facilitation
- early development of a central information hub on transitions with provision of advice to the wider children and adult service. This is informed by engagement in national groups, and local networking and is enhanced by local transitions resources which were updated with SALT colleagues eg resources pack, professionals booklet, social activities booklet.
- a draft Transitions Pathway is in place
- analysis of need and implementation of systems ensured initial assessments were in place for all 2020 and 2021 school leavers from Carrongrange High School, and other specialist hubs across Falkirk and further afield
- blurring of the traditional boundary between children and adult services which has facilitated a more person centred approach to working with school leavers with additional needs at the appropriate time and at a level appropriate to their individual situation.
- increased integrated assessment and work between health and education colleagues as well as our own children and adult social work services and including services such as SLT and psychology.

- initial database of children with disabilities in the Falkirk area from the first year of secondary school has been developed and early work on records of children with additional needs from birth is underway to inform and support the lifetime transitions approach.
- underlining the commitment to relationship based and person centred practice, positive relationships have been built with families, particularly during difficult times. Of note is the level of engagement during the Covid-19 crisis and the high number of young people still able to achieve a positive destination.
- development of links with local colleges and other resources is increasing the opportunities for young people.

Looking to the future, services will develop over 2020/21 a five year vision for transitions and seamless provision of support from birth to adulthood. The aim is to minimise barriers, develop a system for smooth transitions over the lifespan focusing on the core principles of Closer to Home and build on existing progress to achieve excellence in practice and provision.

O4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Support for people with dementia and their carers

Post Diagnostic Support (PDS)

The Partnership is working to deliver the national Dementia Strategy commitment that every person newly diagnosed with dementia will be offered a minimum of a year's support from a named and trained person. In Falkirk, this support may come from an Alzheimer Scotland Dementia Link Worker. The worker can help and support people to:

- understand their illness and manage their symptoms
- keep up their community connections and make new ones
- plan for future legal and financial decisions
- plan for their future support and care needs.

The Post Diagnostic Support Group & Carer Information Sessions are for those living with a diagnosis of dementia and their partner, relative or friend who provide them with support.

There are a range of community based groups available for anyone living with dementia or experiencing difficulties with their memory. An important aspect of the groups is being able to socialise and share individual experiences with other members, along with developing natural support networks through peer support. Some of these groups available are included below:

Over the year

- 484 people received PDS.
- 271 referrals received
- 2 PDS courses delivered to 22 people.

(The third course planned for March 2020 was cancelled due to Covid-19)

Dementia Cafés

These drop in cafés provide a gentle introduction for people with dementia, accompanied by their carers, to meet Alzheimer's Scotland staff and familiarise themselves with the support that is available, as well as meeting others in the same situation. The dementia cafes in Bo'ness and Falkirk had an average of 516 attendances each quarter and the community groups had a further 595 attendances each quarter.

Brain Gym

Alzheimer's Scotland offer people with dementia the opportunity to attend a ten week programme that promotes wellbeing, maintains skills and supports self-management, with stimulating and fun activities. The Brain Gym is based on the principles of Cognitive Stimulation Therapy which is an evidence based treatment, supported by

NICE guidelines that focus on strengthening and maintaining orientation; short- and long-term memory; understanding, recognition and problem solving.

The group provides a relaxed, light hearted and confidential safe place to meet, with the aim that group members will support each other to cope with memory loss.

In feedback provided, people reported

- So much fun
- Great bunch of people & very friendly
- Good activities to keep you thinking
- It's the place to go for some fun & laughter
- The staff are great & do the best for everyone

Football Reminiscence Groups

This group is for people with dementia to meet others who like to chat about sports.

Thrive Active Minds and Bodies

This is a weekly club with a rolling programme of activities to keep people with dementia physically well and provide an opportunity to meet with friends in a relaxed environment. Keeping physically active is key to reducing falls and supporting people to remain independent at home. Activities offered include a group walk, senior zumba, senior pilates, indoor games, music and dance.

Musical Memories

This is a monthly singing group for people with dementia and their carers. No singing experience is necessary to join in with this group.

The following graph provides information on the number of people who attended the community groups delivered by Alzheimer's Scotland.

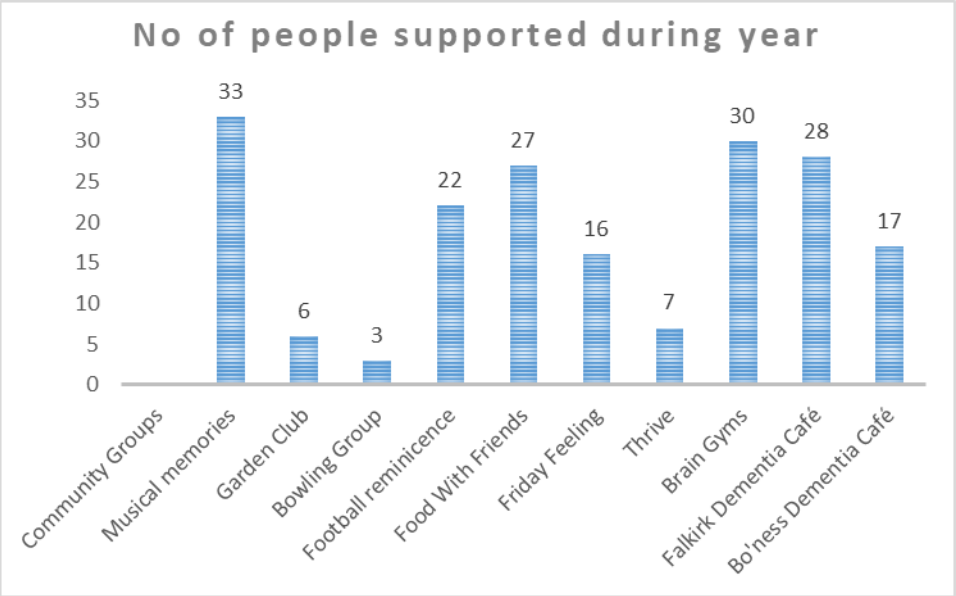


Figure 3

JDI Home from Home groups

JDI work to ensure people achieve positive outcomes and are part of their community. Prior to Covid-19, our Home from Home groups regularly visited a local café for lunch and built a rapport with staff, owners and visitors.

This was evident when the café donated (take away) afternoon teas to service users whom they were missing during Covid-19 and that the café community were thinking about them. Our Home from Home Carers in their own time distributed the afternoon teas along with a bunch of flowers from themselves. This brightened up the day for both service users and carers and it was clear that the gesture helped people to feel valued and respected.

JDI and Cycle without Age

JDI worked in partnership with Cycle without Age and developed opportunities for people when accessing the JDI café to go out for a cycle. The folk who accessed it loved it, one person stated " That's the first time, in such a long time that I have been able to visit Falkirk Main Street and see the shops and people milling about." Another person commented "I just love it, it's great getting out in the fresh air."

Activity Co-ordinator, Community Hospitals

Following the success of a 6 month pilot to trial a dedicated activity co-ordinator within one of our specialist dementia units at Bo'ness Community Hospital, this has been extended to both the specialist dementia units at Bo'ness and Falkirk Community Hospitals for a further year.

The activity co-ordinator focussed on providing opportunity for meaningful activity for the patients in both group and one to one sessions. A number of positive outcomes were evidenced in improving the overall experiences of patients, visitors and staff. These outcomes included a significant reduction in falls and falls with harm recorded within the unit. There was also a 48% reduction in the use of psychotropic medication noted which will in turn reduce the risk of unwanted side effects.

Visitors' experience was also recorded and following the introduction of activities the feedback included:

- "I haven't seen him that happy or excited in a long time, it meant the world to have that moment with him again"
- "anything which stimulates the person in any way has an uplifting effect on both patient and visitor"
- "enjoyed seeing him more happy"
- "visiting is more pleasant"
- "the activities have changed the ward for the better"

Ward staff reported that on the whole it had been a positive experience for the patients, promoting and enhancing person-centred care and the activity coordinator is a crucial part of the team. Staff appear inspired by the positive outcomes from the activities with several commenting that they would get involved more, taking part when able to do so or offering an activity to de-escalate a situation.

Mental Health and Well-being

Community Mental Health Teams

Mental Health Services provide secondary care assessment, diagnosis and treatment for a wide range of mental health conditions. These include severe and enduring mental illnesses and caring for those receiving treatment in the community under the mental health act. The Community Mental Health Teams (CMHTs) see people who are referred with mental health problems from GPs (and other healthcare professionals) and provide assessment, diagnosis and treatment for a wide variety of illnesses as well as providing follow up for people discharged from inpatient services. During the financial year 2019/20, these services in Falkirk provided over 25,000 appointments for people of all ages *(data does not include April 2019 due to migration to TrakCare).*

Mental health services work as a multidisciplinary team to coordinate and provide a variety of treatment interventions to support people in the community with mental disorder. These include out-patient appointments and home visits with mental health nurses, occupational therapists, mental health officers and consultant psychiatrists, psychological therapy sessions, such as group therapy and support around

managing medicines. The CMHTs are made up of many different professionals including nurses, doctors, occupational therapists, arts therapists, social workers and psychologists. The CMHTs provide brief interventions and management of long-term conditions and take a holistic view of the person and in some cases, provide monitoring of aspects of physical health, working closely with primary and secondary care.

For those referred to the adult mental health services based at Woodlands Resource Centre, the average time to wait to be seen for routine initial assessment was 39 days and those referred urgently are seen within 5 days and for older adults being referred to the older people's mental health team the average waiting time was 35 days.

Mental Health Officers (MHO)

We have developed a Pathway for Adults with Incapacity legislation that allows effective and timeous decision making in the use of the legislation. The pathway streamlines the legislative process and minimises delays in discharges from hospital. MHO's attend all case conferences where Guardianship for Adults is under consideration. MHO's also attend Delayed Discharge meetings in all localities to minimise any delays.

Through Covid-19, the MHO's have continued to work with the Integrated Teams to provide the service with the advice provided from the Mental Welfare Commission.

With partner across Forth Valley, the team is completing a comprehensive review and updated guidance on the use of Care Programme Approach. This continues to promote effective multiagency management of significant risk and ensure people are fully involved in decision making.

Emergency Assessments

When an emergency mental health assessment is required, this is provided by the Mental Health Acute Assessment and Treatment Service (MHAATS). The data below shows the number of referrals received by this service between during 2019/20. The total number of assessments undertaken was 3,891.

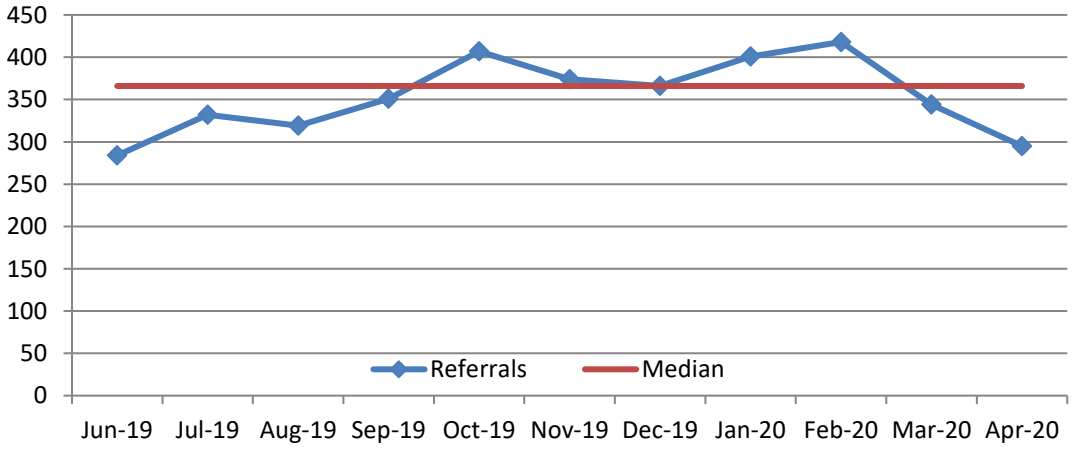


Figure 4: *Source – TrakCare*

Mental Health Admissions

Where it is not possible for people with mental ill health to remain at home for treatment, either by the CMHT or by MHAATS, the Mental Health Unit at Forth Valley Royal Hospital provides inpatient mental health services. These are delivered across five wards, catering for people of all ages across the Forth Valley area. In the financial year 2019/20 there were a total of 120 admissions to these wards from people living across the Falkirk area.

Dundas Resource Centre

The centre provides day service opportunities for people with a learning disability and/or a physical disability. The staff and people who use the service have worked together to support the successful merger of day opportunities provided in the centre. Through reviews, service users meetings and joint programmes new friendships and interests have developed and more will be done to build on this. The community groups continue to grow with more people accessing activities including swimming, art classes, yoga, walking groups and bowling. Service users also joined a drama group in the community at Kersiebank. This led to a Christmas pantomime performed to parents, carers and other stakeholders. The Centre successfully secured funding for a digital inclusion course. During six week blocks service users learned about the safe use of the internet, emails and online banking.

The gym at Dundas has had a revamp of some of its equipment. We involved service users, gym instructors, Occupational Therapist and Physiotherapists in the selection of new equipment. Our service users are now benefiting from the physical activities developed for them with the health professionals and keyworkers.

During the pandemic we closed and had to consider other ways to support people. We set up regular contact by phone, which has continued, and sign posted families who were needing additional health and Social Work support. Doing this enabled the service to develop a Risk Management Plan and understand the potential impact closure could have on people and their families at week 1, week 4 and week 12 of the lockdown.

Oswald Avenue Day Centre

The service supports people who have complex learning and physical disabilities. The service has continued to grow and develop programmes in line with people's individual care plans and wishes. Examples of the service provided include therapies, snoozelin sessions, gardening programmes including the Jupiter project for volunteers, relaxation techniques, nature outings and programmes developed both within and out with the centre. Display screens are throughout the building and provide pictorial information to service users, visitors and staff members about the service, the programmes and activities on offer each day.

An informal programme of drop ins for parents and carers is held every second month. This has proved to be successful and enabled good communication with parents and carers. Doing this led to information sessions for parents and carers:

- by the Ontex nursing service on continence products to support service users in their home environment.
- to demonstrate therapies on offer from trained staff members.

Sensory Team

The Sensory Team is based in the Forth Valley Sensory Centre in Camelon. The team offer support to both adults and children and work closely with colleagues in health, staff within the centre, local schools and other children's services.

The team has specialist training to support people with a sensory impairment and aim to promote continuing independence, reduce risks, make the home environment and going out safer and to reduce isolation and anxiety. A range of services are available including, Translation Service, Visual Rehabilitation and Habilitation, Deaf Rehabilitation and the Support service.

Since the start of 2020 the Sensory Team has had its own social media pages on Facebook and Twitter. This has enabled the team to reach more people with a sensory impairment and provide information in British Sign Language. This resource proved to be invaluable during the Covid-19 pandemic as they were able to provide daily updates of the First Minister's briefings and statements in BSL to ensure the community were kept informed. Social media has also been used as an educational platform to inform others about sensory impairment and to raise awareness during Deaf/Blind week.

Over the past 6 months we have reached over 10,000 people including our deaf and sensory impaired community, other local authorities, the Third sector and charities.

How We are Working with Housing Services

Housing has a key role for people to stay at home, in accommodation that meets their needs, in their communities. The contribution of Falkirk Council housing services and Registered Social Landlord's (RSL's) is key to delivery of the HSCP Strategic Plan.

Our Housing Contribution Statement (HCS) 2019 - 2022 provides an essential link with the Strategic Plan and the Local Housing Strategy. The HCS Steering Group will take forward the HCS priorities:

- make best use of technology to help people to stay in their communities as long as possible

- recognise the importance of wellbeing and social connection
- make the most of the built environment to meet housing and care needs
- improve access to housing for all
- provide housing options for homeless people.

Key outcomes from the Housing Contribution Statement 2016 – 2019 include:

- Dementia awareness raising sessions were carried out for 71 front line housing staff to raise awareness and increase understanding of the condition
- Falkirk Council Empty Homes Officers work with people with vulnerabilities and mental health concerns and have developed working arrangements with a range of internal and external agencies
- a New Build Design Guide for Affordable Housing has been produced for private landlords with sites which come under the Falkirk Council Affordable Housing Policy and social landlords with sites supported through the SHIP Design Guide
- a review of communal facilities, services and accessibility in RSL and council developments for older people identified a wide range of communal facilities. A consultation with residents was undertaken to establish ways in which they would like to access these facilities to improve their health and wellbeing and reduce social isolation
- discussions with stakeholders and residents highlighted that the language we use to describe different levels of housing with care should be clearer and easier to understand
- a “retirement living” development with 36 flats for older people with easy access to the town centre is under development by Link Housing Association.

O5 Health and social care services contribute to reducing health inequalities

Health Promotion Service

The Health Promotion Service aims to improve health and wellbeing, address inequalities and prevent ill health for all who live and work in Forth Valley. The team work in partnership to improve the health and wellbeing of individuals or communities through enabling and encouraging positive health behaviour changes as well as addressing the underlying determinants of health such as poverty and educational opportunities. With partners we work to shape policy, service provision and environmental factors that support positive health outcomes for our population, especially those in greatest need.

The service has two overarching principles which are embedded in all our work to:

- reduce health inequalities, and
- improve mental health and wellbeing

The Health Promotion Service organises activities under three themes:

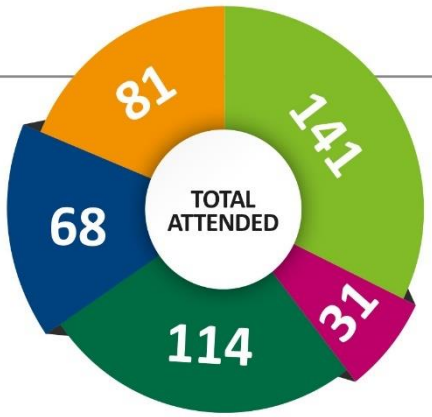
- Facilitating behaviour change and capacity building for health
- Supporting healthier lives for children and young people
- Creating supportive communities and environments for health

The Health Promotion Service created a 2 year plan (2018-2020) and the following shows some highlights from our work with the wider health improvement workforce, communities and adults over this time period.

Substance Use Workforce Development 2018-20

Workforce development:

- Overdose Awareness and Naloxone
- Volatile Substance Abuse (Partnership with Re-Solv)
- Tobacco Awareness
- Alcohol Brief Intervention learnPro
- Alcohol Brief Intervention Face-to-Face



Scotland's Mental Health First Aid
(2 day training course) delivery 2018-20

Stress Control - a community based 6 week self-help course to support individuals around anxiety and stress

Mental Health and Wellbeing Digital Bookshelf - a series of downloadable self-help leaflets and guides to support mental health and wellbeing (outputs 2018-20)

http://www.selfhelpguides.ntw.nhs.uk/forthvalley/index.php

Falkirk Alcohol and Drug Partnership (ADP)

Falkirk ADP commissioned a review of the services that are in place for people with a drug and/or alcohol problem across the Falkirk Council area. A report was produced and a suite of recommendations have been made, all of which will be included within the revised three year ADP Delivery Plan. The Delivery Plan will also include the finding of research commissioned on the impact of Non-Fatal Overdose on those who have experienced this type of trauma.

The ADP commissioned a new drug and alcohol support service - Change Grow Live -and this brought together multiple elements of our treatment approaches in to one single pathway which will enhance support to people.

There continues to be a focus on the prevention of drug related deaths, and actions taken include:

- sub groups set up to try and increase understanding of these cases and put in place services and additional support within the localities to support our families and communities
- additional investment made in assertive outreach (Enhanced Harm Reduction) services
- Cyrenians were funded to deliver a Peer Mentor Project.

Recovery Cafes

We continue to see growth in this area and the success of the Forth Valley Recovery Community has grown from strength to strength. Footfall in the Stenhousemuir, Central Falkirk and Grangemouth Cafes is growing incrementally. Links are being made to wider community projects, to maximise opportunities, for example Growing Projects (Community Food Projects such as allotments), yoga and alternative therapies. We have supported an increase in employability within the Forth Valley Recovery Community. Eleven community members from the Falkirk area have moved into further education, employment and/or other volunteering roles over the year after their engagement with the Community.

Alcohol Related Brain Injury Service

Additional investment to enhance the support available to those affected by ARBI has been provided. This includes Occupational Therapy, Psychology, Psychiatry and a Social Care Support Worker.

Performance

Treatment Waiting Times-Drug and alcohol services continue to deliver an excellent level of performance relating to the three week waiting time for alcohol and drug treatment. Performance levels are consistently higher than Scotland.

The delivery of Alcohol Brief Interventions within Primary Care, Drug and Alcohol Services, Keep Well and Sexual Health Services has been maintained and exceeds the national target.

The Naloxone Programme (Opioid Reversal Drug) is available to all our service users and family members within all of our localities. The number of kits provided has grown steadily, with plans in place to increase coverage to all of those who attend hospital that are affected by drug use.

		Apr 2019-Mar 2020	Apr 2019-Mar 2020	Direction of travel
67	Number of Alcohol Brief Interventions delivered –annual target 3410	7368	8955	▲

Table 10

		Quarter to Mar 2019	Quarter to Mar 2020	Direction of travel
68a	Substance Use - Percentage of patients that commence treatment within 3 weeks of referral – Forth Valley Alcohol & Drug Partnership (90% target)	97%	95.9%	▼
68b	Substance Use - Percentage of patients that commence treatment within 3 weeks of referral – Forth Valley Prisons (90% target)	98.7%	94.6%	▼
69	Access to Psychological Therapies – Percentage of people that commenced treatment within 18 week of referral (65% trajectory March 2020)	60.8%	60.6%	◄►

Table 11

Falkirk Users Soccer Experience (F.U.S.E.)

(F.U.S.E) involves a working partnership between Caledonia Service, Woodlands Resource Centre and Bellsdyke Hospital. The group receive weekly coaching sessions with Stenhousemuir Football Club on their main pitch.

The football group is non gender specific and the aim of the project is for football to help in people's recovery as it can help to manage symptoms and can radically improve the quality of people's lives. There are three key ways that football can help:

- delivering social inclusion
- helping physical health and well being
- improving peoples mental health.

O6 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 wellbeing

Supporting Carers

We have been working with carers and carer organisations to implement the Carer's (Scotland) Act 2016. Our Strategic Plan 2019 – 2022 has prioritised support for unpaid carers as a key issue. We recognise the need to support carers in a range of ways to meet the projected increase in the older population and people with complex needs.

The work we are doing is consistent with the main direction of the Act, which extends and enhances the rights of unpaid carers. It aims to consistently support carers to continue to care, if they wish, and to be able to do so in good health and with a life alongside their caring responsibilities.

Our Carer's Strategy, *Getting it Right for Carers in Falkirk*, was co-produced with carers and carer organisations and covers both young carers and adult carers.

In partnership with carers' organisations, we have agreed a shared local vision:

'*everyone has freedom to live their own lives while they are caring'*

We have reviewed the Short Breaks Services Statement, which sets out information about local short breaks provision. It describes a variety of ways carers can access short breaks through funded support from the local authority or through access to community based support. This will be reviewed each year to make sure the information it contains is kept up to date.

We have continued to support carers through the completion of Adult Carer Support Plans (ACSP) and Young Carers' Statements (YCS). Our progress is as follows:

Performance Indicators 2019/20	Yearly totals
Number of carers who requested or were offered an ACSP	451
Number of ACSPs completed	404
Number of young carers who requested a YCS	40
Number of YCS completed	41
Number of ACSPs referred to Social Work	344

Table 12

There is ongoing work to maintain services for carers that provide information and advice about carers' rights, income maximisation, education and training, advocacy for carers, health and wellbeing, bereavement support, and emergency planning and future care planning. We have commissioned a number of Carers Fund projects to help deliver this:

- Falkirk Citizens Advice Bureau uses Carers Funds to provide an outreach clinic in the Carers Centre to identify financial options, income maximisation and solutions to meet carer needs. Falkirk CAB works closely with other agencies to ensure that if further assistance required carer are signposted or referred appropriately.
- Falkirk District Association for Mental Health uses Carers Funds to deliver a service to carers / families who are caring for someone impacted by mental illness or reduced psychological wellbeing. This includes crisis support.
- Falkirk Council uses Carers Funds to support access to short break options through the Falkirk Short Breaks Bureau. The funding has increased the capacity of the service as demand has increased and can support carers of all ages. Funding also supports policy and practice development to ensure implementation of the 2016 Act links with the strategic aims and other related strategies and policy objectives of the HSCP.
- Falkirk and Clackmannanshire Carers Centre have Carers Funds to resource Carer Support Workers to complete both Adult Carer Support Plans and Young Carer Statements. They also raise awareness, provide promotional resources and workforce training, and provide information and support to carers.
- work to involve carers in hospital discharge planning for the person they care for is ongoing, with increased carer awareness of hospital staff and partnership working with both hospital and Carers Centre staff.
- JDI worked in partnership with the carers centre and put on an 8 week mindfulness course for carers. The feedback was positive with comments.

Some carers were unsure about the need for or benefit of completing an Adult Carer Support Plan, however the feedback has been positive.

One gentleman sent an email to the Short Breaks Bureau to say that, while he hadn't been convinced of the need for the ACSP, he was really glad he had done this and it had been "very helpful and informative"

In 2019-20 Falkirk and Clackmannanshire Carers Centre has

- supported 1848 individual carers
- identified 1030 new carers
- provided 57 health and wellbeing sessions
- provided 201 carers with a grant to purchase a short break (Creative Break fund and Carers Trust grants).
- supported 246 carers to attend a Better Break trip funded by Shared Care Scotland
- referred 869 Carers to the CAB outreach workers securing £1,260,525 in welfare benefits for carers.
- supported 99 carers to access a Respitality offer
- delivered 107 Care with Confidence sessions
- provided 33 carer involvement opportunities with 257 carers attending
- delivered 51 carer awareness sessions for professionals
- participated in 116 meetings with external organisations
- represented the views of carers at 29 planning group meetings

" I didn't think it was for me but it was great and helped me to relax."

"I loved the opportunity to get some me time."

Thornton Gardens

We successfully transferred respite provision at the Rowans Short break service to Thornton Gardens. In doing so, we addressed the structural problems with the building and created more short break beds for adults with a learning disability.

Meetings and a consultation exercise was held with service users, parents, carers, and other stakeholders including the Care Inspectorate. This identified that Thornton Gardens would be a premises that could offer lots of opportunity to expand the service, including emergency respite capacity. Throughout the preparation for the move, people were involved, including a visit whilst the works were being carried out and an open afternoon once near completed. These plans and maintaining staff continuity were accepted as a positive development by the people who value the service provided.

In March 2020, Thornton Gardens opened up with increased capacity and service provision. However due to the pandemic this was closed for a short period after it

opened. The availability of services, including short breaks, has had an impact on parents, carers and service users. We have worked together with the Care Inspectorate to update Thornton Gardens Service registration to increase its capacity to 14 beds. This means we can support emergency respite and short breaks. The service reopened on 3 June 2020.

'As a carer for two young boys with profound learning needs and with one of my boys having a severe illness just diagnosed in the last year, carer support for me has never been more important. Meeting people in a similar situation has been a great help. The support groups have helped me to feel less isolated. We have attended trips and breaks that we wouldn't have had the confidence to go on as a family. The groups bring together carers and professionals in a safe space where its ok to say that things are a bit rubbish and those around you understand. Isolation is a big thing being a carer, it doesn't matter how many friends you have or how close you are to them – if they aren't in the same or similar situation of being a carer they just don't get it. I'd say to other carers this is a great network of support and information. The friendships that I have made, have made all the difference'.

Parent carer quote

O7 People who use health and social care services are safe from harm

Safe and Together approach

The Health and Social Care Partnership and Falkirk Child Protection Committee continue to support a whole system approach to achieve the necessary culture, systems and practice change to domestic abuse. This is through the Safe and Together approach in Falkirk that provides a framework for partnering with domestic abuse survivors and intervening with domestic abuse perpetrators in order to enhance the safety and wellbeing of children. It partners with the non- abusive parent and holds the abusive parent accountable for their violence which is framed as a parenting choice.

In comparison to other local authority areas, Falkirk has consistently sat at the high end of reporting domestic violence. Local data gathered in relation to adult support and protection referrals and child protection registration provides additional information about the incidence and nature of domestic abuse in Falkirk.

A rolling programme of training has been delivered each year by fully accredited local trainers. Participants are drawn from Children and Adult Social Work Services, Education, Health, Third Sector and Community Justice Services. Trainers also support ongoing workforce development post training and awareness raising.

Members of the workforce who successfully complete four day core training are automatically signed up to the mentors group. This group meet bi-monthly to consider the model further, reflect on practice and gather examples of good practice. Mentors also have a role in actively promoting the model across Falkirk

During 2019 Safe and Together surgeries were established to offer frontline practitioners not yet trained in the approach the opportunity to experience reflective discussion related to their specific cases. Feedback has evidenced that these opportunities are helpful as they include, hearing about the model and time to network with services that could potentially assist current and future survivors of domestic abuse.

Falkirk Children and Adult Social Work Services and trained mentors participated in research in 2019 undertaken by Social Work Scotland to assist the bid to Scottish Government for a Scottish Safe & Together Institute. This resulted in an ESRC funded project “Developing the evidence base for innovation in social care for children and families affected by domestic abuse”. Falkirk Council were one of three Scottish Local Authorities chosen to participate. This research will span from December 2019 to early 2023.

Falkirk Learning Disability Team and Adult Support and Protection

A working group has been established looking at the needs of younger adults with a diagnosis of mild learning disability who are subject to repeat adult protection referrals and where harm is often occurring within the same social networks.

Falkirk Learning Disability Team (FLDT) are working creatively to respond to the needs associated with risk in these cases. They are supported by the Adult Support and Protection (ASP) lead officer to negotiate universal services which is often the preferred pathway for younger adults with mild intellectual disability. We are learning that on account of a diagnosis of learning disability adults are often referred straight into the tier of FLDT, missing lower level community based resilience activity. This results in a disconnect from their communities and perpetuates the contexts which lead to repeat referrals.

FLDT have also attended the Adult Protection Committee to present a complex case which involved different elements of Mental Health legislation. The team took a multidisciplinary approach to adult support and protection and adopted a flexible and person centred approach to managing the risk. This involved joint work with Police Scotland's Domestic Abuse Unit and included creating an easy read document to support the police's communication with the person.

The group are reporting to the Adult Protection Committee on the analysis of these cases and recommendations for both necessary statutory intervention and what earlier intervention and preventative work could be promoted to avoid repeat episodes of harm.

MECS (Mobile Emergency Care Service)

In Falkirk, about 4,200 people have a community alarm system to support them to live at home. The service provides a prompt and appropriate response for emergency help from people in their own homes, for example if they have fallen and can't get up.

National changes are taking place to replace old analogue lines to digital lines by 2025. This means we have to replace all analogue Alarm Receiving Centres (ARCS) or call centres to digital ones for the equipment to work.

Falkirk HSCP, in partnership with the Scottish Government Local Digital Office, are at the forefront of leading this development. Currently about 98% of all service user equipment has been replaced by new digital ready equipment. We have installed a new digital ARC, which is being PEN tested (penetration tested by potential hackers to ensure its safety). This should result in a certified safe and secure system.

Initial testing of all the digital kit migrating to the new digital ARC is now completed and MECS are now preparing to extend testing to a wider scope. This is likely to be

completed by the end of September. At that stage we will begin the migration of all of our service on to the new digital service. We anticipate full end to end digital service will be achieved by Summer 2021, well ahead of the 2025 deadline.

Once complete Falkirk will have an end to end digital telecare service which will enable future benefits such as the use of personal devices and service re-design. This will lead to an improved service for people and a reduction in operation costs.

As one MECS Service User Group member told us

> *"I am so pleased by this progress as it gives me hope that I will be able to live independently at home for longer."*

Falkirk is the only HSCP in Scotland who have progressed its digital journey to this point and are leading the way and sharing its knowledge about the process for the benefit of other HSCP's and Councils.

		2018/19 H1	2019/20 H1	Direction of travel
45	Number of Adult Protection Referrals (data only)	557	576	n/a
46	Number of Adult Protection Investigations (data only)	68	64	n/a
47	Number of Adult Protection Support Plans at end of period (data only)	8	19	n/a
48	The total number of people with community alarms at end of the period	4,027 at 31/03/19	4,087 at 29/02/20	n/a
49	Percentage of community care service users feeling safe	90%	90%	◄►

Table 13

O8	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

Supporting our workforce

Putting learning at the heart of transformational change

Our workforce remains the single most important resource in delivering high quality services and the transformation required to ensure the delivery of health and social care integration.

Our approach to training, learning and development is underpinned by our ambition to be recognised as a *Learning Organisation.* We strive to follow the five golden rules in this respect:

1. encouraging experimentation
2. thrive on change
3. reward learning
4. facilitate employees to learn from one another
5. encourage learning from our surroundings

The scheduled programmes of training are developed, delivered and coordinated to meet statutory and regulatory body requirements and are designed to ensure our workforce is competent and confident. There is a strong commitment towards supporting innovative and creative thinking. In the past year this has included a growing interest in Service Design and in empowering individuals and communities receiving public services by involving them in the design, and delivery of services they use.

Our commitment to involving members of the workforce in projects and pilots focused on collaboration between services has enabled us to focus on reducing duplication and share services where possible across public, third and private sectors.

The Partnership supports workforce development opportunities in a range of different ways:

Further Education

Sponsorship for academic study is available, ensuring frontline managers and practitioners have access to current research and teaching that meets the learning requirements of contemporary practice. Course assessment is focused on application of learning in practice.

We have well established and strong working relationships with our colleagues in *Further Education* and appreciate the many mutual benefits to our working collaboratively. For example, supporting student placements, external marking of assignments, contributing to one another's training and teaching programmes, collaborating on the development of tools and resources and a common interest in the promotion of career pathways.

We are proud of our track record in recruiting Social Work and Social Care students previously on placement with us into permanent employment across our services. Over the past year we have worked on strengthening our approach to mentoring and have a pool of mentors committed to developing the young workforce and supporting adult returners into employment through the provision of modern and foundation apprenticeships alongside inducting new staff into services.

It is our intention to extend our sponsorship opportunities to re-establish our aim of supporting existing staff to obtain professional qualifications and reward learning by recruiting them into ring-fenced vacant posts through the *'grow our own'* strategy.

Partnership working with Forth Valley College has enabled us to translate aspects of *Scotland's Digital Health and Care Strategy* into improving local services and supporting person centred care through the development of online learning for the workforce. A joint project funded by the Scottish Funding Council resulted in a new Digital Skills Transforming Care course. This flexible online course is a blended approach to learning combining the knowledge and skills required by staff to comply with sector standards with a requirement to demonstrate competences using digital technology within the workplace. This has given us the appetite to collaborate further and work towards the development of a Training Passport in partnership with independent and voluntary sector partners.

Vocational Qualifications

Our Social Services Assessment Centre continues to support employee candidates and modern apprentices to achieve Scottish Qualification Awards (SQA) to meet either registration requirements as outlined by the Scottish Social Services Council or as required as part of the Modern Apprenticeship programme. A pilot programme designed in partnership with our Employment Training Unit and supported by Social Work Adult Services now gives Modern Apprentices the opportunity to secure permanent employment whilst they complete their vocational training.

The Centre has continued to perform very well as evidenced via External Verification visits by Scottish Qualification Authority verifiers. The team thrive on change and moved swiftly into adopting a key mentoring role in supporting the recruitment of new and redeployed staff into essential frontline services at the outset of our response to the impact of Covid-19 pandemic and lockdown. This has ensured a sustained focus on staff wellbeing during this time of uncertainty working closely with service based mentors to address challenges in delivering comprehensive induction and flexible support online and in the workplace.

The Centre has also been able to extend the programmes which are approved by SQA to deliver to include British Sign Language (BSL) Scottish Vocational Award Level 2 and 3. In the past year a pilot programme has been developed in partnership with the Forth Valley Sensory Service. A small group of staff representing a range of local services began the programme in the weeks leading up to lockdown. Lessons learned from the delivery of the pilot will be included in the review of the implementation of our first BSL Plan.

Workforce Wellbeing

The Health and Social Care Partnership, Falkirk Council and NHS Forth Valley are committed to organisational and employee wellbeing. Significant attention is being paid to the key threats in the UK workforce, particularly the increase in mental ill health, stress, ‘presenteeism’ and ‘leaveism’, as well as potential risks to well-being as a result of technological advances, in particular the ‘always on’ culture. Taking action to identify and reduce stress in the workplace has seen us increase awareness of mental health issues and provide learning and development opportunities aimed at building personal resilience and offering employee assistance programmes.

We recognise there is always room for improvement. For us to remain proactive in our approach to wellbeing we need to maintain our investment and continue to provide opportunities to actively listen to employees across our services and use findings to inform our workforce development strategy and plan.

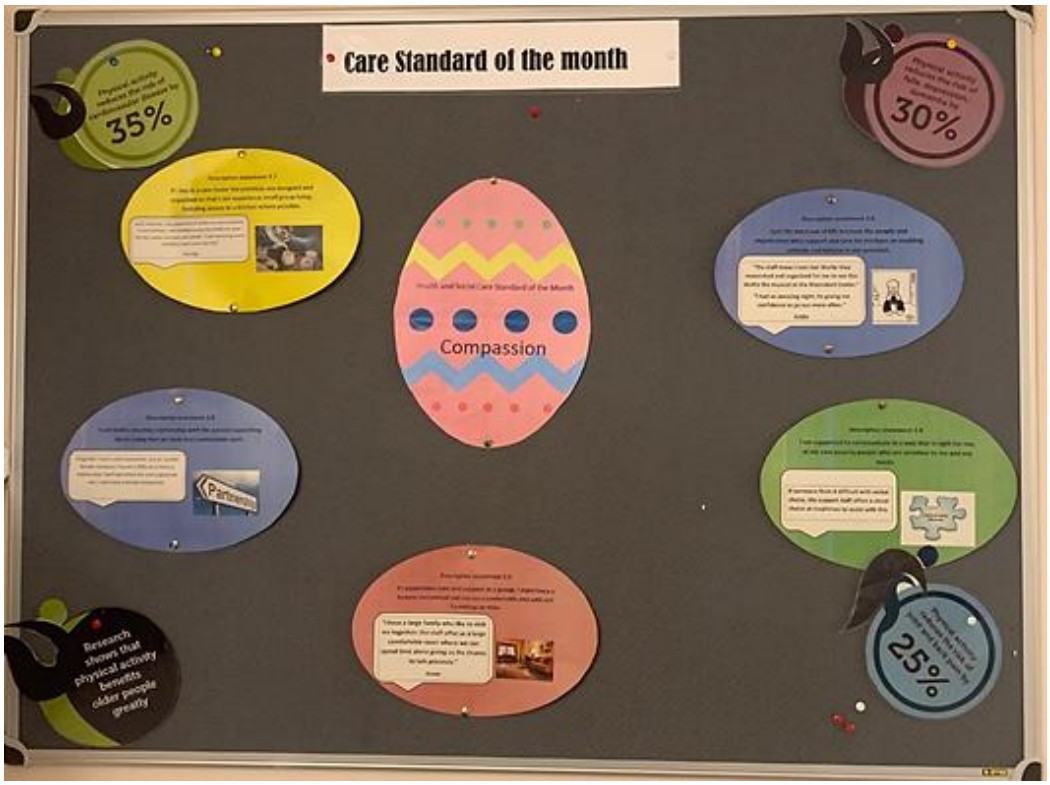
The impact of the current pandemic on employee morale alongside the significant shift in using technology as the primary means of communication brings multi-faceted challenges which requires significant engagement with the workforce to address.

We provide people focused services that to be meaningful, depend on culture and systems that support relationships based practice. It’s critical that we find the ways and means going forward, in these uncertain times, to ensure this remains at the heart of our thinking and actions.

Care about Physical Activity (CAPA)

Over the year, Cunningham House care home developed our CAPA support and training for staff to enhance the health, well-being and independence of staff. CAPA is an improvement programme led by the Care Inspectorate to help older people in care to move more often. From little things like encouraging older people to post their own letters or walk up the stairs instead of using the lift. It's about staff, people experiencing care and their friends and family working together to increase health, well-being and mobility. It's about making things easier so that people can do things for themselves.

The care home assigned CAPA key contacts in implementing, promoting and developing the model within the care home. Staff created a noticeboard with support from residents and focussed on a National Care Standard each month and theme suitable to time of year - for example Easter's theme was Compassion (see photo below).



The Independent Sector lead worked with 22 care home providers across Falkirk who participated with the Care Inspectorate CAPA team. This programme was met with great enthusiasm amongst providers and will continue to be promoted. These sessions explored using the QI method of Plan Do Study Act approach; how 'moving more' helps to evidence meeting the health and social care standards; develop local networks to share ideas and resources and for participants to leave with their own ideas to make a difference to those they support. A range of activities were identified including wildlife walking, belly laughing, belly dancing and keeping active exercises.

Quality Improvement Workshops

Adult Social Work Care Homes and Day Services, working in partnership with Scottish Government Leading Improvement Team, delivered and planned workshops based on using Improvement methodology, Appreciative Enquiry and story-telling. The staff developed their knowledge and understanding of the Three Step Improvement Framework for Public Services. There were plans to return for a follow up session to reflect on their experiences of building will, creating the conditions for change, developing and carrying out tests for change. This work was paused because of the Covid-19 pandemic.

Staff who will be working in the West Integrated Locality Team have been involved in workshops to support integrated practice. As a group the aim was to carry out a collective analysis of stories from service professionals focused around 3-4 selected cases, in order to generate insights for future service design and delivery.

Building on the learning from this workshop, further similar sessions were anticipated to be facilitated for the workforce in the two other locality areas as part of the inclusive, evidence-based approach being taken to shaping new service delivery. This development work was also impacted by Covid-19.

Work also included Outcome Focused, Good Conversation Training, with the Independent Sector Lead continuing to roll out good conversation training to providers. The aim was to build confidence in holding outcomes focused conversations, 'good conversations', in a variety of common and difficult situations. It also considered the organisational supports required for staff to continually develop their practice and embed the approach. This was done in 3 half day sessions, with work postponed due to the Covid-19 pandemic.

O9 Resources are used effectively and efficiently in the provision of health and social care services

Stronger Communities

During 2019/20, the HSCP have continued to work with partners to support and promote community capacity and activity. The Stronger Communities Steering Group has provided a solution focussed platform for collaborative working. The group has brought together the skills and expertise of partners to help link a range of work strands with shared outcomes; to build stronger and more resilient communities.

Members of the group include representatives from HSCP, Falkirk Council, NHS, CVS Falkirk, third sector agencies and also service user and carers. Figure 5 below provides an overview of the range of workstreams linked through the Stronger Communities Group.

In December 2019, the group reviewed its remit and scope. Underpinning principles were agreed as Transformation, Quality Improvement and Co-design/Co-production. In practice, this is being achieved by:

- co-ordinating engagement and sharing community 'data' and feedback
- pro-actively raising community issues across Partnership
- influencing Partnership settings with patient experiences/carer/lived experience
- celebrate and sharing success
- jointly evaluating impact
- sharing information about what we are doing and working together to identify solutions and actions.

In March 2020 at the outset of the Covid-19 pandemic, the Stronger Communities Group paused to enable a focus on responding to the immediate crisis. Although the formal group stopped, partners continued to work with communities, but in a different way.

Figure 5

Communities across Falkirk mobilised quickly and effectively to respond to Covid with a shared outcome; to support vulnerable people. Social networks were formed within communities, bringing local knowledge and a willing to get involved. The Partnership did not lead this mobilisation, instead the HSCP, Falkirk Council, NHS and CVS Falkirk worked collectively to support and enable community action. The assets the partnership brought included specialist support such as purchasing, food hygiene and financial resource.

The learning from the community response to Covid is now being reviewed and evaluated. It is hoped that as services resume over the coming months, that we can maintain this new, balanced relationship with communities. In addition, the evaluation of the Covid response will also inform locality planning.

Working in partnership with the Independent Sector

The Independent Sector is committed to improving the sustainability of care provision in Falkirk and is a key partner in the delivery of integrated health and social care services in the area.

Scottish Care through its Partners for Integration (PFI) team build on its experience, knowledge and existing relationships to effectively support providers as our key partners, as well as our collaboration with all other HSCP partners to meet the challenges we all face.

By working collaboratively, exploring new and innovative approaches to service delivery, adopting a culture of service improvement and development and the sharing of good practice the PFI team support transformational change in how services are delivered in Falkirk.

We have invested in the Independent Sector by funding a Local Independent Lead who works with and on behalf of partner providers and the HSCP. The Lead has formed positive relationships, credibility and trust with both their statutory and provider partners.

The last six months have been a huge period of unplanned and assessed adjustment for everyone across the HSCP. On a positive note we have also witnessed closer working relationships and strengthened foundations for continued development and collaborative working with all HSCP partners.

The Independent Sector is committed to improving the sustainability of care provision in Falkirk and is a key partner in the delivery of integrated health and social care services in the area.

During the Covid-19 pandemic the independent sector lead has continued to support the Care Home Managers Support Network and the Care at Home Providers Network. These networks were well established before the pandemic and ensured continuity of support during this challenging period. The role also extended to proactively supporting the partnership through membership of the Care Home Improvement Team and the Care Home Oversight Group. This has ensured vital and regular communication with the independent sector providers and the Partnership.

Falkirk HSCP Performance

National Integration Indicators

The IJB fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services, relevant targets, and measures which are set out in the Strategic Plan and integration functions. The Partnership reports progress against the suite of 23 national integration indicators. This enables us to understand how well our services are meeting the needs of people who use our services.

Our performance for 2019 - 2020 is set out in the following tables. Indicators 1-9 are populated by the bi-annual Health and Care Experience Survey. The survey was due to be updated in April 2020 to include data for 2019/20. However, due to staff redeployment during the Covid-19 period this publication has been delayed. Therefore, the most recently available data relates to 2017 – 2018 and was published in last year's annual performance report.

Indicators 11-20 are in the main populated from the Scottish Morbidity Records (SMRs) which are submitted from local Health Boards to Public Health Scotland (PHS). As the records are generated on discharge, PHS has recommended using calendar year 2019 instead of financial year 2019/20 for some indicators in order to avoid under reporting.

SMR data for the NHS Forth Valley area is currently experiencing a backlog and although an improvement plan has been developed and implemented, 2019 calendar year data remains incomplete. Data from the previous year has been used to create an estimate for indicators 12, 13, 14, 15, 16 and 20. For more details, please see the notes following the table. Significant caution should be undertaken in interpreting the national indicators for the reasons outlined above.

The Annual Performance Report provides an update on progress against the national indicators, augmented with the local indicators. We will publish the revised data for the national indicators when this is available.

Direction of travel relates to previously reported position	
▲	Improvement in period
◄►	Position maintained
▼	Deterioration in period
N/A	Not applicable
—	No comparative data

Performance at a Glance

Outcome Indicators		2015/16	2017/18	2019/20	HSCP Trend	Scotland Trend
NI-1 Percentage of adults able to look after their health very well or quite well	Falkirk	93%	92%	N/A	↓	↓
	Scotland	95%	93%	N/A		
	Comparator	x	93%	N/A		
NI-2 Percentage of adults supported at home who agreed that they are supported to live as independently as possible	Falkirk	85%	83%	N/A	↓	↓
	Scotland	83%	81%	N/A		
	Comparator	x	81%	N/A		
NI-3 Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	Falkirk	80%	76%	N/A	↓	↓
	Scotland	79%	76%	N/A		
	Comparator	x	75%	N/A		
NI-4 Adults supported at home agreed that their health and social care services seemed to be well coordinated	Falkirk	79%	72%	N/A	↓	↓
	Scotland	75%	74%	N/A		
	Comparator	x	77%	N/A		
NI-5 Total % of adults receiving any care or support who rated it as excellent or good	Falkirk	81%	81%	N/A	↔	↓
	Scotland	81%	80%	N/A		
	Comparator	x	81%	N/A		
NI-6 Adults had a positive experience of the care provided by their GP practice	Falkirk	85%	81%	N/A	↓	↓
	Scotland	85%	83%	N/A		
	Comparator	x	83%	N/A		
NI-7 Adults supported at home agreed their services and support had an impact on improving or maintaining their quality of life	Falkirk	84%	78%	N/A	↓	↓
	Scotland	83%	80%	N/A		
	Comparator	x	82%	N/A		
NI-8 Carers feel supported to continue in their caring role	Falkirk	43%	37%	N/A	↓	↓
	Scotland	40%	37%	N/A		
	Comparator	x	37%	N/A		
NI-9 Adults supported at home agreed they felt safe	Falkirk	85%	84%	N/A	↓	↓
	Scotland	83%	83%	N/A		
	Comparator	x	84%	N/A		

Table 14

Data Indicators	Falkirk Partnership					Comparator Average	Scotland
	2015/16	2016/17	2017/18	2018/19	2019	Latest	Latest
NI–11 Premature mortality rate per 100,000 persons	440	466	427	449	435	430	426
NI–12 Emergency admission rate (per 100,000 population)	11,529	11,771	12,325	12,125	13,432	13,954	12,616
NI–13 Emergency bed day rate (per 100,000 population)	136,482	144,772	138,571	137,502	135,736	125,652	118,127
NI–14 Readmission to hospital within 28 days (per 1,000 population)	113	121	121	118	122	106	105
NI–15 Proportion of last 6 months of life spent at home or in a community setting	86.1%	85.5%	86.4%	86.3%	86.6%	88.4%	88.6%
NI–16 Falls rate per 1,000 population aged 65+	20.0	19.8	21.9	23.9	24.9	22.5	22.5
NI–17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	83.8%	85.8%	88.2%	83.8%	87.4%	83.4%	81.8%
NI–18 Percentage of adults with intensive care needs receiving care at home	64.1%	64.6%	64.2%	64.8%	NA	61.5	62.1%
NI–19 Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	864	1,023	910	1,178	1,020	895	774
NI–20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23.2%	23.4%	23.6%	23.9%	24.0%	24.8%	23.7%
NI–21 Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	NA	NA	NA
NI–22 Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	NA	NA	NA
NI–23 Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	NA	NA	NA

Table 15

Source: ISD Scotland
Notes:
1. NA indicates where data is not yet available.
2. NI 1 – 9: Data are presented on financial year file and 2017/18 is the most recent data available.
3. NI 11 and 18 are presented on calendar year. The data for NI 18 is from 2018, as this is the most recent data available.
4. NI 12 – 16 and 20: are presented on calendar year. Data for Clackmannanshire is from June 2020 calendar year file.
5. NI 17 and 19 are presented on financial year. Data for Clackmannanshire for 2019/20 is from the June 2020 financial year file.
6. NI 1 – 9, 11 and 17: for these indicators the data available for each Council Area in the Comparators group is a percentage or a rate only. So, the 'Comparator Average' is the average of the percentages or rates for each indicator, rather than a true weighted average.
7. NI 12 – 16 and 18 – 20: for these indicators, the 'Comparator Average' is a true weighted average.
8. NHS Forth Valley data completeness is estimated to be 100% until June 2019, then drops to 7% or lower for all following months. The 2019 calendar year estimates have been calculated as follows: (a) NI 12, 14 and 20 have been estimated by replacing April to December 2019 data with data from the same period in 2018. Due the nature of SMR01 inpatient and day case records (submitted on patient discharge), these indicators are affected by discharges in the months after March 2019, so data in that period must also be complete. (b) NI 13, 15 and 16 have been estimated by replacing July to December 2019 data with data from the same period in 2018. These indicators are based only on discharge records to June 2019 and so can use more recent data than NI 12, 14 and 20. Estimates have also been incorporated into the Scotland figures.
9. Population figures used to calculate rates are from the mid-2018 release from the National Records of Scotland.
Comparators: Includes members of Family Group 3: Clackmannanshire, Dumfries & Galloway, Fife, Renfrewshire, South Ayrshire, South Lanarkshire and West Lothian: http://www.improvementservice.org.uk/benchmarking/how-do-we-compare-councils.html

Our Governance

IJB Governance and Decision Making

Falkirk IJB has responsibility for the strategic planning and commissioning of delegated health and social care functions. They are also responsible for ensuring the delivery of its functions, through the locally agreed operational arrangements for:

- Social Work Adult Services
- Community and Family Health Services relating to in-scope functions
- Large hospital services planning, with partners who will continue to manage and deliver the services as part of the pan Forth Valley structures.

NHS Forth Valley and Falkirk Council delegate budgets to the IJB, which decides how resources are used to achieve the objectives of the Strategic Plan. The IJB then directs the partners, through the HSCP, to deliver services in line with this plan. The IJB controls an annual budget of approximately £235m.

A governance framework is in place which includes the Integration Scheme, IJB Standing Orders, Risk Management and Clinical and Care Governance. These frameworks set out the rules and practices by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The IJB has legal responsibilities and obligations to its stakeholders, staff and residents of the Falkirk Council area.

Membership of the IJB is set out in legislation and is made up of 19 members. The Board has 6 voting members – 3 Falkirk Council Elected Members and 3 NHS Forth Valley non-executive Board members. The membership includes senior officer representation from Health, Social Work and stakeholders including service users, carers, Third Sector and staff representatives.

The IJB also has an:

- Audit Committee, responsible for the promotion of best practice in the areas of risk management, financial procedures, internal controls, development of continuous improvement and review of External Audit issues

- Clinical and Care Governance Committee to provide assurance on the systems for delivery of safe, effective, person centered care in line with the IJB's statutory duty for the quality of health and care services.

The range of Board members has enabled informed decision-making through the insightful contributions from different perspectives. The voice of service users and carers in particular, has been of importance and value to the Board.

The diagram below provides an overview of the meetings schedule of the IJB and its wider governance arrangements during 2019 – 2020.

	A	M	J	J	A	S	O	N	D	J	F	M
	2019									2020		
IJB Meetings	✓		✓			✓			✓			✓
IJB Development Session		✓	✓		✓			✓			✓	
IJB Audit Committee			✓			✓			✓			✓
Clinical and Care Governance Committee			✓		✓			✓			✓	
IJB Budget Approved			✓									
Strategic Planning Group			✓		✓		✓				✓	
Partnership Funding Group		✓	✓				✓	✓			✓	

Table 16

Financial Performance

As part of the National Health and Wellbeing Outcomes Framework, the IJB is expected to demonstrate that *"resources are used effectively and efficiently in the provision of health and social care services".* As part of this requirement, an overview of 2019/210 financial performance is provided below, including consideration of best value and the financial outlook for 2020/21.

2019/20 Financial Performance

Total resources of £234.989m were available to support the delivery of health and social care services in the Falkirk area during financial year 2019-20. This reflects £234.637m of combined funding received from Partners plus £0.352m released from IJB reserves (mainly in respect of funds carried forward from 2018-19 for use in 2019-20 for ongoing implementation of the Primary Care Improvement Plan).

The vast majority (72%) of IJB expenditure incurred during 2019/20 related to Primary Healthcare and Social Care Services as outlined in table 17.

Total Expenditure	2019/20 £m	2018/19 £m	2017/18 £m
Large Hospital Services	27.741	26.026	25.207
Primary Healthcare Services	81.941	75.816	70.734
Social Care Services	88.259	83.694	78.297
Community Healthcare Services	36.604	35.422	36.785
IJB Running Costs	0.444	0.410	0.351
Total	**234.989**	**221.368**	**211.374**
Set Aside	27.741	26.026	25.207
Integrated Budget	207.248	195.342	186.167
Total	**234.989**	**221.368**	**211.374**

Table 17

During the course of the 2019/20 financial year a number of demand led pressures were experienced across all services, resulting in significant budget overspends which required to be managed through risk sharing arrangements with Partners.

In line with previous years, the format of the risk sharing agreement meant that both Falkirk Council and NHS Forth Valley made an additional payment to the IJB (£0.759m and £1.706m respectively) in order to deliver an overall breakeven position on the specific services delegated to them.

Key pressure areas included:

- Care at Home – reflecting increased demand for care at home packages resulting in a 13% rise in costs compared to the same period in the previous year (primarily in relation to external providers). Ongoing issues were also reported in relation to housing aids/adaptations and residential services.

- Primary Care Prescribing – reflecting higher than expected volume growth in the number of items prescribed and increased uptake of expensive new drugs and devices (including direct acting oral anticoagulants and a new blood glucose monitoring system now available on prescription). Ongoing price concessions due to short supply issues also contributed to the overspend position.

- Community Hospitals – due to increased use of temporary staffing to cover sickness absence and maternity leave. In addition, a number of patients required specialist nursing input resulting in increased staffing ratios over and above the budgeted establishment.

- Set Aside (large hospital services) – relating to ongoing reliance on temporary nursing staff to cover absence and patients requiring special

clinical observation. In addition, pressures were reported in terms of drug costs and medical staffing specifically within old age psychiatry services.

- the emerging impact of Covid-19 late in the financial year resulted in additional costs being incurred during the month of March. This impacted on GP Prescribing costs, due to early reordering of repeat prescriptions in advance of lockdown arrangements, together with the costs of local care home contingency measures and provision of personal protective equipment (PPE).

During the course of the year the IJB also invested various transformational change projects and service improvements designed to promote recovery, reablement and rehabilitation to support the people of Falkirk to remain independent in their own homes (supplemented with appropriate anticipatory and preventative care planning).

As described earlier in this report this included the area wide roll out of the Home First approach, ongoing implementation of person centred assessment and planning informed by a strengths based systemic social work model, development of the integrated organisational structure to reflect localities and expansion of the Living Well Falkirk Service.

Best Value

As a public body, the IJB has a duty to make arrangements to secure best value. As defined by Audit Scotland, best value is concerned with "*good governance and effective management of resources with a focus on improvement to deliver the best possible outcomes for the public*".

With this in mind, the IJB's governance framework is intended to support continuous improvement and better outcomes, whilst striking an appropriate balance between quality and cost, as illustrated in this diagram.

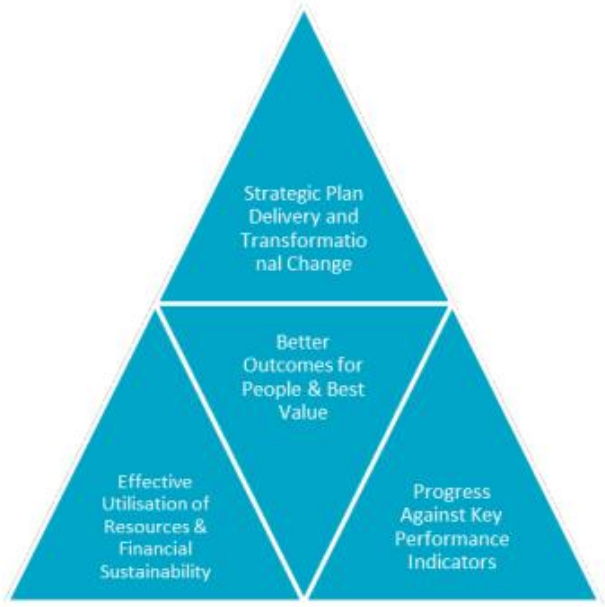


Figure 6

The key features of the IJB's governance framework which were in place during 2019/20 to support best value are outlined below:

- the IJB is bound by section 95 of the Local Government Scotland Act 1973 to make arrangements for the proper administration of its financial affairs, and to secure that the proper officer of the IJB has responsibility for the administration of those affairs. A dedicated Chief Finance Officer was in place during 2019/20 to fulfil this role.
- in line with best practice and the principles of good corporate governance, the IJB's process of strategic decision making continued to be formally documented and controlled during 2019/20 via the Integration Scheme, Directions, Standing Orders, Scheme of Delegation and Financial Regulations. In addition, a Code of Conduct was in place for all IJB members in terms of ethical considerations and required standards of behaviour (including a register of interests) in order to promote transparency and maintain public confidence in IJB decision making.
- during 2019/20 the IJB continued to operate a subcommittee structure to ensure appropriate scrutiny and oversight of a wide range of strategic risks. This was comprised of an Audit Committee (to provide assurance in relation to corporate governance issues, risk management and all internal and external audit matters) and a Clinical and Care Governance Committee (to provide assurance in relation to the delivery of safe, effective and person-centred care).
- the IJB's current 3-year strategic commissioning plan (2019 to 2022) reflects a range of national policy and legislative requirements together with agreed local developments to transform and improve services and/or outcomes for patients, carers, service users and their families. During 2019/20 this was underpinned by a detailed delivery plan (and corresponding Medium-Term Financial Plan) which identified the specific workstreams, funding and actions required to progress the IJB's strategic priorities.
- a comprehensive performance management framework was in place during 2019/20 to demonstrate best value and monitor a range of national and local key performance indicators (KPIs) aligned to the IJB's Strategic Plan outcomes. This included routine quarterly KPI reports (incorporating both local and national targets), monthly standard financial reporting and specific ad hoc reports presented to the IJB via the Chief Officer update and/or individual Locality Service Mangers, to enable progress to be assessed (including identification of corrective action in order to mitigate operational and financial risk where appropriate).

Forward look 2020/21 and beyond

A budget shortfall of £4.977m was originally identified for financial year 2020/21. To date efficiency savings of £4.564m have been identified to close the gap, resulting in a residual savings target of £0.413m.

The vast majority of work to progress the overall 2020/21 savings plan (including identification of further initiatives to address the residual shortfall) was temporarily suspended to enable frontline staff to focus on immediate Covid-19 priorities. As a result, it is recognised that a number of the original planned savings schemes are unlikely to be fully delivered.

It is apparent that the 2020/21 financial year will be dominated by the ongoing financial and operational impact of Covid-19. At this stage, it is assumed that any additional costs incurred as a direct result of Covid-19 will be fully funded by the Scottish Government. However, confirmation of the funding position in respect of potential unachieved savings remains outstanding. In the meantime, the overall 2020/21 savings programme is currently being reassessed to enable existing savings schemes to recommence as soon as possible and to identify new initiatives arising from potential opportunities to redesign services as part of the pandemic response.

In addition to the impact of Covid-19 during 2020/21, several new and emerging risks are apparent at this point, including pressures arising from implementation of various national policy initiatives including the Scottish Living Wage, the new General Medical Services contract (and associated Primary Care Improvement Plan), the Mental Health Strategy, uncertainty in relation to Brexit and ongoing local pressures.

Looking ahead to the medium term, is clear that future demand for health and social care services is rising at faster rate than the increase in future funding levels, resulting in significant budgetary constraints and ongoing savings requirements.

This reflects the impact of demographic change where people are living longer into old age, often with multiple long-term conditions which require more complex multidisciplinary care and support. At the same time, the age profile of the IJB's workforce is also rising (and this is more prominent in certain staff groups e.g. District Nursing) which presents a number of issues in terms of succession planning and the ability to maintain services and meet future demand. This is also exacerbated by ongoing recruitment and retention difficulties particularly in relation to Social Work services (where current staff turnover is in the region of 11.6%).

In order to respond to these demographic and workforce challenges (combined with the impact of growth in general price inflation and advances in new technology and medical treatments), it is clear that major reform and transformation of health and social care services is essential in order to deliver better care, better health and better value.

This “triple aim” is recognised in the IJB’s current Strategic Commissioning Plan and Medium-Term Financial Plan, which outlines the requirement to deliver significant transformation and redesign in order to generate £23.809m of recurring cash releasing efficiency savings by 2024/25 as illustrated in table 18 below:

2020/21 £m	Funding Gap	2021/22 £m	2022/23 £m	2023/24 £m	2024/25 £m
2.142	Health	1.447	1.555	1.671	1.795
2.835	Social Care	3.091	3.091	3.091	3.091
4.977	**Total**	**4.538**	**4.646**	**4.762**	**4.886**

Table 18

Notwithstanding the significant operational disruption and financial risks arising from Covid-19, it is recognised that there are also a number of unique opportunities relating to:

- potential non-recurring savings arising from the temporary suspension of services including reduced staff travel, supplies, and premises costs;
- savings linked to service redesign in terms of new ways of working in response to ongoing social distancing requirements, including a move away from building based services, increased use of technology enabled care and cessation of non-essential and/or non-value added services;
- acceleration of key elements of the IJB’s Strategic Plan to shift the balance of traditional bed based services towards more care in the community and at home by bringing forward a number of longer term savings initiatives relating to Community Hospitals and residential care services.
- building on the pandemic response from local communities and the voluntary sector by increasing capacity through targeted investment and exploring options relating to health promotion, prevention and early intervention.

These opportunities support the progress already achieved during 2019-20 to transform local services to increase effectiveness, efficiency and productivity in order to meet rising demand and are expected to positively influence delivery of the Strategic Plan and financial sustainability the longer term.

Partnership Funding 2019-20

The IJB continues to hold a Partnership Funding reserve to take forward a range of transformation and test of change programmes to support integration in line with local priorities. This funding provides a critical opportunity to establish, redesign and deliver integrated services and to test and drive innovation. During 2019/20, the Partnership Funding programme was reviewed to ensure that the structure and allocation of funds remains flexible to support both transformation and emerging improvement need within the Partnership.

Partnership Funding is grouped into two strands; the main programme and the Leadership Fund. During 2019/20, the total allocation of funding from the main programme was £3.28m, with an additional allocation of £0.66m from the Leadership Fund.

A summary of main programme investment by category during 2019/20 is provided within the table below.

Partnership Funds Investment by category during 2019-20	Funds Allocated	% allocated
Avoiding Admission/Supporting Discharge	£1,856,388	56%
Mental Health	£424,962	13%
Transformation	£303,604	9%
Health Inequalities	£229,827	7%
Support for Carers	£203,510	6%
Substance Use	£190,721	6%
Locality/Community Led Activity	£77,988	2%

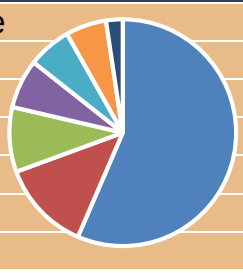


Table 19-Partnership Funds Allocation 2019-20

Shifting the Balance

The Partnership Funding reserve was created in financial year 2016/17 from the former ring-fenced delayed discharge and integrated care fund allocations. Historically these allocations were used to support statutory services and tended to focus on the provision of health and social care within centralised and/or institutional settings.

Following a review of the use of these funds, a key element of the creation of the Partnership Funding reserve was to shift the balance of historic investment towards more integrated services and projects in the community. This included redesign of a number of existing projects relating to timely hospital discharge and avoiding admission, where the focus has now transferred to supporting service users at home.

The subsequent impact on the overall profile of the partnership fund investment programme over time is illustrated in table 20.

Partnership Funding Allocation by Category	2016-17	2019-20
Avoiding Delayed Discharge / Admission to Hospital	75%	57%
Community Based support	11%	28%
Infrastructure	9%	9%
Support for carers	5%	6%

Table 20

£3.94m Partnership Funding for 2019-20 was invested in **37** initiatives demonstating improved outcomes, integrated working and collaborative practice

8 programmes supported the HSCP infrastructure to enable transformational change

Community / Third Sector Provision

Community

9 organsiations provided volunteering opportunities for over 60 volunteers

7 community grants, benefited an estimated 350

26 grant applications received in Q4 for community response to Covid-19

Carers

584 received individual support

443 attended Care with Confidence course

84 received a short breaks grant

260 attended 57 Heath & Wellbeing Sessions

175 were involved in engagement activities

Dementia

1043 people affected by dementia supported with Post Diagnostic Support (205 ave caseload)

Ave **370** people access average **38** groups per month

Mental Health

2806 referrals of which **686** were from NHS

GP Feedback:

"Patients often improve quicker with your help, meaning less appointments with me"

"Patients quicker improvement results in shorter durations for meds and some don't need meds at all"

"You help a large number of our patients to improve the quality of their lives and reduce the impact that mental health problems have on them. You enhance our practice greatly."

Health and Social Care Provision

Community

218 of 501 admissions to ECT were from Falkirk (11months, excludes Dec)

63 patients referred to REACH from ECT

120 people received reablement support from REACH with **813** contacts

Ave **4050** Community Alarms in place and a further **560** Telecare equipment is used per quarter

Ave **251** Night MECS visits per month

Intermediate Care

196 AHP assessments and plans for patients

135 admissions to Summerford

116 patients completed reablement

1016 moves to Community Hospital supported by Discharge Hub and further **53** to home

'Mrs S came into the overnight service with a palliative diagnosis and requested to be at home for her final days. Staff attended Mrs S for tissue viability and to encourage her to take some fluids and assist with personal care. Feedback from Mrs S and her family included their gratitude that their loved one will be able to pass peacefully at home in the manner she has decided upon.'

Inspection of Falkirk HSCP Registered Services

The Care Inspectorate is responsible for the regulation of care standards in Scotland and introduced new Health and Social Care Standards on 1 April 2018. The Care Inspectorate utilise the Standards to form the decisions they make about care quality and as such they changed how they inspect care and support and will be phasing in the new assessment starting with Care Homes for Older People.

Throughout 2019 - 2020 we continued to work with providers to strengthen relationships and develop systems to effectively monitor all registered and commissioned services being delivered across the Falkirk HSCP area.

Residential Care Homes (Older People)

In the Falkirk HSCP area there are 16 independently run care homes and 5 local authority care homes in the Falkirk Council area. All independent sector care homes operate under the National Care Home Contract and have a capacity to accommodate 812 older persons. The local authority care homes accommodate 129 older persons.

There are a total of 941 beds in the Falkirk area, split between 753 nursing placements and 188 residential placements. These beds are used to accommodate Falkirk Council funded residents, self-funders and placements from other placing Local Authorities.

There were no care home closures or new care homes built during 2019-2020. As at August, 3 Care Homes are planning extensions, which would total an additional 63 beds.

Care Inspectorate Quality Assessment Framework

Since 1 April 2018, the new Health and Social Care Standards have been used across Scotland. The Care Inspectorate utilise the Standards in the decisions they make about care quality and as such they changed how they inspect care and support. From July 2018 the Care Inspectorate amended their inspection framework for care homes for older people and the previous inspection themes of care and support, environment, staffing and management and leadership were replaced with 6 Key Questions, as follows.

- Key Question 1 - How well do we support people's wellbeing?
- Key Question 2 – How good is our leadership?
- Key Question 3 – How good is our staff team?
- Key Question 4 – How good is our setting?
- Key Question 5 – How well is our care and support planned?
- Key Question 6 – What is the overall capacity for improvement?

All Care Homes have now been inspected under the new Framework. At the end of the 2019/20 financial year the percentage scores from all Homes in the Falkirk Council area were as follows:

	Good/Very Good/Excellent	Unsatisfactory/ Weak/ Adequate	Not inspected
KQ1	86%	14%	0%
KQ2	34%	14%	52%
KQ3	38%	10%	52%
KQ4	34%	14%	52%
KQ5	71%	24%	5%
KQ6	this is not graded		

Table 21

Residential Care Homes (Younger Adults)

Falkirk HSCP area has 159 adult care home beds between 12 residential care homes (Learning Disability, Mental Health, Complex Care beds). One of the care homes is owned by NHS Forth Valley and the other 11 are owned by independent sector care

home providers. At the end of 2019-20 47% of the beds were occupied by the HSCP, 30% by other local authorities and the remaining 23% were vacant.

At the end of the financial year 11 out of the 12 care homes were inspected under the new Quality Assessment Framework and 6 Key Questions Inspection regime described in the section above.

	Good/Very Good/Excellent	Unsatisfactory/ Weak/ Adequate	Not inspected
KQ1	73%	27%	0%
KQ2	27%	0%	73%
KQ3	18%	9%	73%
KQ4	27%	9%	64%
KQ5	82%	9%	9%
KQ6	this is not graded		

Table 22

The care home assessed under the old inspection regime was graded 100% in good, very good and excellent and 0% in weak or unsatisfactory. By comparison under the new quality assessment process only 45% of providers scored excellent, very good or good across all Care Inspectorate themes. A further 11% scored adequate/unsatisfactory and 44% were not inspected. It is difficult to compare both Inspection systems and make a judgement on why grades have dropped.

As at 31 March 2020 there was only 1 care home that had a weak/unsatisfactory grade and 4 with adequate grades. The area of focus in 2020-2021 will be to improve any weak and unsatisfactory grades, particularly in the theme of Care and Support or Key Question 1 and to work with providers to assist them in improving adequate grades to an improved level.

Care at Home and Housing Support Services

Falkirk HSCP area has 44 organisations engaged in the delivery of Care at Home and Housing Support Services, supporting in excess of 1500 people to remain living in their own homes in their local communities.

The Care Inspectorate is responsible for the registration, regulation and inspection of all care at home and housing support providers carrying out inspections under 3 themes:

- care and support
- staffing
- management and leadership.

At the end of the 2019/20 financial year the percentage scores from all Care at Home and Housing Support providers engaged in service delivery in the Falkirk Council area were as follows:

	Good/ Very Good/Excellent	Unsatisfactory/Weak/ Adequate
Care & support	95.5%	4.5%
Staffing	59%	4.5%
Management & Leadership	50%	9%

Table 23

Leadership

Due to the way in which services are inspected not all organisations are inspected under all themes at each inspection which accounts for the lower percentage of providers graded under the themes of Staffing and Management and Leadership.

Key Themes

The following key themes emerged during the financial year 2019/20

- 95.5% of providers attained grades of excellent, very good or good in the theme of Care and Support an increase of 0.4% from the previous year
- 4.5% of providers were graded as adequate, weak or unsatisfactory in the theme of Care and Support an decrease of 0.4% from the previous year
- 2 providers were suspended from the framework in 2019/20 due to contractual matters, all matters were resolved and both providers were reinstated to the framework within a short period of time
- due to the impact of the Covid19 pandemic routine inspections have been suspended, despite this the Care Inspectorate, Falkirk Council and Falkirk Health and Social Care Partnership continue to maintain contact and communication with providers responding to any matters or concerns that arise
- Provider Forums were held throughout 2019, the forums provide an invaluable opportunity for local providers to come together to network, share good practice as well as hear about what's going on within the HSCP and more widely across the Falkirk area. Forums in 2019 included presentations from many partner agencies such as Forth Valley Disability Sports, Falkirk Community Trust, Scottish Fire and Rescue Service and Police Scotland. The range of topics covered has been wide and varied including health and wellbeing, community activities, assistive technology, adult support and protection and home safety. In addition providers have also been able to share practice and innovation from within their own services which has proven really beneficial in developing relationships and practice.

Falkirk and Bo'ness Community Hospitals

An unannounced visit by Healthcare Improvement Scotland (HIS) took place between the 3 and 5 December 2019 at Falkirk Community Hospital (FCH) The three day visit was a very positive inspection focusing on Care of Older people in the community hospital. The published report made recommendations that have been captured in 8 action points and the inspection team shared no concerns relating to care standards on the visit.

As requested by HIS, an update on progress on actions was returned by the Chief Executive on the 31st August 2020 providing assurance that all actions have either been completed or are in progress through a detailed improvement plan.

Inpatient Mental Health and Learning Disability Services

The Mental Welfare Commission (MWC) undertakes a rolling programme of visits to mental health and learning disability inpatient services. Some are planned visits (announced) and others are unannounced or are part of a national themed approach by the Commission.

Reports from all visits are published on the MWC website and services are asked to provide an action plan within 3 months of a report being published. Reports cover areas of good practice as well as areas where the Commission would like to see improvements.

There have been seven published reports in Forth Valley over the past year covering inpatient areas at FVRH, Bellsdyke hospital and Lochview (Learning Disability).

Announced visit to Russell Park, Bellsdyke hospital on 9 October 2019 and the report was published on 18 March 2020
The MWC staff on visiting found care plans were found to be holistic, covering a wide range of needs for each patient. There was evidence of patient involvement in developing their care plans, where some patients had signed their care plans and received a copy. They reported good detailed assessments and activity care plans devised by the occupational therapist where patients were being supported to utilise and develop their skills as part of the rehabilitation process in preparation for discharge back to the community.
There was one recommendation made: "Managers should ensure specified persons procedures are implemented for patients where this is required to authorise room searches, or other restrictions which has been actioned by the service. This recommendation has formed a robust action plan for the service and is in progress.

Announced visit to Wards 2 &3, FVRH on 22 October 2019 and the report was published on 18 March 2020
On the day of the visit the MWC wanted to follow up on previous recommendations and noted an improvement in some patients records but the quality of care planning remained variable, with some records demonstrating detailed , person centred care and active participation whilst others were not as good.
There were two recommendations made following this announced visit. Each recommendation is being addressed through a robust improvement plan overseen by senior managers.

Announced visit to Ward 4, FVRH on 3 December 2019 and the report published on 19 February 2020
Improvements in the environment were noted by the MWC on the day of the visit which had been highlighted on previous visits and there were two recommendations which have formed an action plan which is being addressed by the service and its managers.

Announced visit to Loch view on 14 January 2020 and the report published on 17 June 2020
The Commission highlighted areas of good practice. There was good evidence of multidisciplinary working with family involvement and relatives fed back they were pleased with the care and treatment.
There was one recommendation made: “Managers should undertake a review of the psychology service that is provided to the wards.“ This recommendation has been taken forward with the management team.

Announced visit to Hope House, Bellsdyke hospital on 6 February 2020 and the report published on 15 April 2020
There were no recommendations and the commission noted: Patients care plans that were holistic and recovery-focussed. Interventions were detailed and evidence that each care plan was reviewed regularly with the patient. There was detailed recordings of one-to-one meetings with nursing staff in the patients file as per

care plan. Patient participation was recorded in the file and there was evidence of specific care plan that centred on patient rights.

Unannounced visit to Tryst view Bellsdyke hospital on 18 February 2020 and report published on 15 April 2020
There were 2 recommendations which have been progressed within the service

Announced visit to Tryst Park Bellsdyke hospital on 27 February 2020 and the report published on 20 May 2020
There were 4 recommendations following the visit which have formed an improvement plan and supported by senior managers.

Reports are presented to both the Health Board Clinical Governance and IJB Clinical and Care Governance Committee.

Looking Forward

The Partnership, with support from a range of partners, has made good progress, and remains committed to continue to improve the services available to people.

We know people are living longer with increasing numbers being cared for at home with the most complex health conditions. There are still health inequalities across our communities and people are developing preventable conditions that often result in ill health. The needs of our local communities are changing and we plan to develop services which make the most of new technologies and new ways of working to tackle these pressures.

The pandemic has also meant we will have to refocus our resources on key areas going forward. The Delivery Plan agreed by the IJB in December 2019 indicates that the key elements of the plan are very relevant for post Covid-19 planning. The Falkirk HSCP Remobilise, Recover, Redesign plan outlines the key elements for recovery and the potential opportunities for redesign, within the context of the delivery of the National Framework, the IJB Strategic Plan and national policy and guidance.

Recovery will require acceleration of some elements of the plan. The whole system approach will address inequality and strengthen community-based care through improved care pathways, review of the community bed base and shifting the balance of care. It will require strong financial stewardship and bold decisions to reframe our services and commissioning to support our communities to improve wellbeing.

We will work to ensure that all planned work for 2020/21 is completed however dependent on the pandemic, some areas may be delayed.

Key areas of work include:

- Review of Assessment & Care Planning
- Develop Integrated Localities
- Increase Bed Based Intermediate Care
- Review of Falkirk & Bo'ness Community Hospitals
- Review & Redesign of Home Support
- Review of Older Adults Day Services
- Review of Day Services for Younger Adults
- Work with NHS Forth Valley to implement Urgent Care Centre

Glossary of Terms

A&E	Accident and Emergency Department (casualty)
Acute	Acute Care is a branch of health care where people receive active but short-term treatment for a severe injury or episode or illness, an urgent medical condition, or during recovery from surgery. Acute care services are generally provided in a formal hospital setting.
Adaptations	Adaptations can help older people and people with disability to live independently in their own homes. They can reduce the risk of falls and other accidents in the home and also reduce the need for home care or long term admission to a care home. A wide variety of aids and equipment is available to help with daily living tasks. This ranges from simple adapted cutlery, to telecare alarms, specialist seating and beds. Common examples of adaptations include replacing a bath with a level access shower, or making it easier to get in and out of the home by widening doors or installing a ramp.
Admitted / Admission (to hospital)	Being taken into hospital
Advocacy	Advocacy means getting support from another person to help someone express their views and wishes, and to help make sure their voice is heard. Someone who helps in this way is called an advocate. In the Standards, we are referring to formal advocacy provided by an organisation to someone using care.
Adult support and protection (ASP)	Things we can do to identify, support and protect adults who may be at risk of harm or neglect and who may not be able to protect themselves
Alcohol and Drug Partnership (ADP)	ADPs are multi agency partnerships established to implement and respond to the national strategies on alcohol, drugs, tobacco and volatile substances across the whole population. ADPs also have a responsibility to develop a local substance strategy which addresses prevention. This must ensure that the range of treatment options that are required to promote recovery from substance use problems are provided for and available at point of need.
Anticipatory Care Plans (ACPs)	A plan prepared by a person with health/care needs along with a professional. The plan lays out what the person would prefer if/when their condition changes.
Assessment	Process used to identify the needs of a person so that appropriate services can be planned for them
Avoidable admission	An admission to a bed that may be regarded as unnecessary had other more appropriate services been available
Balance of care	How much care is given in the community compared to how much is given in hospitals etc
Bed based services	Those services such as inpatient wards in a hospital where people are cared for overnight
Bed days	The number of days that beds in hospital are occupied by someone

Capacity	Capacity refers to an individual's ability to make decisions about their wellbeing. This may change over time and may refer to different aspects of their life. For people who have been medically assessed as lacking capacity there is legislation to protect their wellbeing.
Care home	A care service providing 24 hour care and support with premises, usually as someone's permanent home.
Care Plan	A Care Plan is the plan of treatment or actions agreed with a service user, their carer and family, following an assessment of need by a health or care agency.
Carer	A carer is a person, of any age, who looks after family, partners or friends in need of help, because they are ill, frail or have a disability and need support to live independently. This care is unpaid however the carer may be in receipt of carers allowance but this is not considered to be payment.
Chief Officer	Chief Officer of the Integration Joint Board was appointed to provide a single point of management for the integrated budget and integrated service delivery. They are accountable to the Integration Joint Board and to the Chief Executives of their Health Board and Local Authority for the delivery of the integrated services.
Choice and control	Choice and control is about shaping services to meet people's needs, rather than allocating people to fit around services
Adult Carer Support Plan	An assessment to find out what a carer (unpaid, informal carer) needs (such as respite, short breaks etc) and how services can support them better
Clinical and Care Governance	Clinical and care governance is a systematic approach to maintain and improve care in a health and social care system. This will provide assurance to the IJB on the systems for delivery of safe, effective, person centred care in line with the IJB's statutory duty for the quality of health and care services.
Commission (a service)	Buying a service from another to meet the needs of a population
Community Based Support	Services that are delivered within community settings, sometimes within a person's home. Community based support is provided by NHS Forth Valley, Falkirk Council and also by voluntary and community organisations.
Community Planning Partnership (CPP)	Where public agencies work together with the community to plan and deliver better services which make a difference to people's lives
Daily living	Tasks that people carry out to look after their home, themselves and when taking part in work, social and leisure activities
Delayed discharge	Where someone is unable to leave hospital because the appropriate care and/or support is not yet available for them at home
Delegated function	A service that HSCP partnership will be responsible for
Delivering (a service)	Carrying out a service
Demographic change / workforce challenges	Changes in population (e.g. more older people) that mean we have to change how we provide our services
Direct payments	Means-tested payments made to service users in place of services they have been assessed as needing. This allows people to have greater choice in their care

Early intervention	Giving support, care and/or treatment as early as possible
End of Life Care	End of life care addresses medical, social and emotional, spiritual and accommodation needs of people thought to have less than one year to live. It often involves a range of health and social care services for those with advanced conditions who are nearing the end of life.
Engagement	Having meaningful contact with communities e.g. involving them in decisions that affect them
Facilitate/facilitator /facilitation	Making a process easy or easier
Front line staff	Staff who work directly with users of a service
Governance	The way that an organisation is run
Health and Social Care Integration	In the UK, Health and Social Care (often abbreviated to HSC or H&SC) is a term that relates to services that are available from health and social care providers. This is a generic term used to refer to integrating/bringing together the whole of the health and social care provision infrastructure, public and private sector, including the Third sector.
Health inequalities	The gap that exists between the health of different population groups such as the well-off compared to poorer communities or people with different ethnic backgrounds
Home First	The Home First team support people to avoid delay in their discharge from hospital, they working with the person, their carer / relatives to agree how to support them to get home.
Housing Contribution Statement (HCS)	The HCS sets out the arrangements for carrying out the housing functions delegated to the Integration Authority under the Public Bodies (Joint Working) (Scotland) Act 2014
Independent sector	This includes voluntary, not for profit, and private profit making organisations. It also includes housing associations
Integration	The term used to describe the partnership working between health and social care services as outlined in the Public Bodies (Joint Working) (Scotland) Act 2014
Integration Joint Board (IJB)	The IJB is responsible for running the partnership and has members from Falkirk Council and NHS Forth Valley, staff representatives, the Third Sector and the public
Integration Scheme	The detail of our model of integration is laid out within our Integration Scheme. This scheme sets out a robust and transparent framework for the governance and operation of the Falkirk Health and Social Care Partnership. This includes detail such a financial arrangements, governance arrangements, data sharing, liability and dispute resolution.
Intermediate Care	Intermediate Care services support people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community and residential settings. The term has been defined as a "range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living"(NSF for Older People, DOH, June 02).

Joint working	Different teams and organisations working together
Long term conditions	Long-term conditions are conditions that last a year or longer, impact on many aspects of a person's life, and may require ongoing care and support. The definition does not relate to any one condition, care group or age category. It covers adults and older people as well as children and those with physical and mental health issues. Common long-term conditions include epilepsy, diabetes, some mental health problems, heart disease, chronic pain, arthritis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease.
Multidisciplinary	Where several different professionals work together in the interests of service users and carers
Palliative care / Palliative and End of Life Care	Palliative care aims to improve the quality of life of people, and their families, with life-threatening illness that can't be cured. It helps to prevent and relieve the problems associated with their condition, through early identification and assessment of their needs, care planning to address any symptoms and pain and address any social, psychological or spiritual needs.
Partnership	A partnership refers to two or more individuals or organisations working together to achieve a shared aim. Within the context of health and social care integration, the Partnership consists of Falkirk Council, NHS Forth Valley, Third and Independent sectors working together to provide effective, joined up service.
Personal outcomes	The changes or improvements that have taken place during the time someone has been receiving support
Person centred	Putting the needs and aspirations of the individual service user at the centre of our work
Priorities	Things we think are important to do
Proactive	Creating or controlling a situation rather than just responding once it's happened.
Public Bodies	NHS Forth Valley and Falkirk Council are both public bodies. A public body is democratically accountable at either national or local level. They have specific functions and requirements generally driven by legislation, which they must undertake. The Public Bodies (Joint Working) (Scotland) Act requires the integration of health and social care, and is an example of legislation.
Readmission	Being taken back into hospital shortly after having been discharged
Recruitment and retention	Being able to recruit and keep staff
Reablement	Reablement service will begin at the point of assessment and have a focus on independence through the delivery of a short-term person centred approach by a multidisciplinary team of well-trained staff working with patients, carers and their families
Resilience	Being able to cope with and recover from difficult situations
Redesign	Redesign within the context of health and social care integration, relates to services may be changed and improved. Redesign is based on evaluation and

	review of existing services and will often include listening to service users, their carers and families about what services are important to them.
Rehabilitation	Rehabilitation entails restoring someone to health or normal life through guidance and therapy after addiction, or illness.
Remobilise, Recover, Redesign	An overview of the HSCP mobilisation response to the Covid-19 pandemic, and the key elements for recovery and the potential for redesign
Risk management	The process of identifying, quantifying, and managing the risks that an organisation faces
Self-management	Where people take responsibility for and manage their own care. Encouraging people with health and social care needs to stay well, learn about their condition and remain in control of their own health
Self-directed support	When the person who needs services directs their own care and has choice when it comes to their support
Social Care	Any form of support or help given to someone to help them take their place in society
Stakeholders	Stakeholders include any person or group with a vested interest in the outcome of a project or plan.
Strategic Commissioning	Strategic Commissioning is a way to describe all the activities involved in: • assessing and forecasting needs • links investment to agreed desired outcomes • planning the nature, range and quality of future services; and • working in partnership to put these in place. This is the process that informs the Integration Authorities Strategic Plan
Strategic Plan	The plan that describes what the partnership aims to do and the local and national outcomes used to measure our progress
Sustainable	Can be maintained at a certain level or rate
Technology	Specialised devices that helps people in their day to day life, such as telecare, telehealth or telemedicine, alarm call system, remote support and advice or mobility aids
Third sector	Voluntary and community groups, social enterprises, charities
Transformational change	A complete change in an organisation, designed to bring big improvements.
Transition	Used to describe a significant change for someone, such as starting to use a new care service or a change in life stage (eg becoming an adult).

If you would like this information in another language, Braille, large print or audio tape please call 01324 504021 or email integration@falkirk.gov.uk