ANNUAL PERFORMANCE REPORT 2021/22

Falkirk
Health and Social Care
Partnership

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INTRODUCTION

A year of recovery, not uninterrupted by challenges, has continued to encourage colleagues and services to work creatively to adapt and overcome.

Our 2021/22 Annual Report demonstrates the resilience of Falkirk's local communities, with many examples of new approaches and refreshed services following the pandemic.

While lessons have been learned and opportunities grasped, we and our partners continue to deliver our vision and essential health and social care services for local people, supporting those most in need.

And looking forward, the Partnership is embarking on multiple ambitious projects, transforming primary care, establishing a new strategic plan, and reinvigorating the services delivered from the Falkirk Community Hospital site with a new masterplan.

We are also looking across Scotland, working with government and fellow health and social care partnerships to help shape and prepare for a new National Care Service.

While this will involve momentous change, our focus will always remain on improving care for people and valuing the expertise and efforts of our workforce.

These long-term initiatives are again driven by the dedication and efforts of colleagues working across our local services, efforts which will result in a brighter and healthier future for the people of Falkirk.

Patricia Cassidy
Chief Officer

Dr Michele McClung
IJB Chair

OUR COMMUNITIES

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 delivery purposes, the three identified localities for the Partnership are West, Central and East (illustrated in Figure 1).

1. West
2. Central
3. East

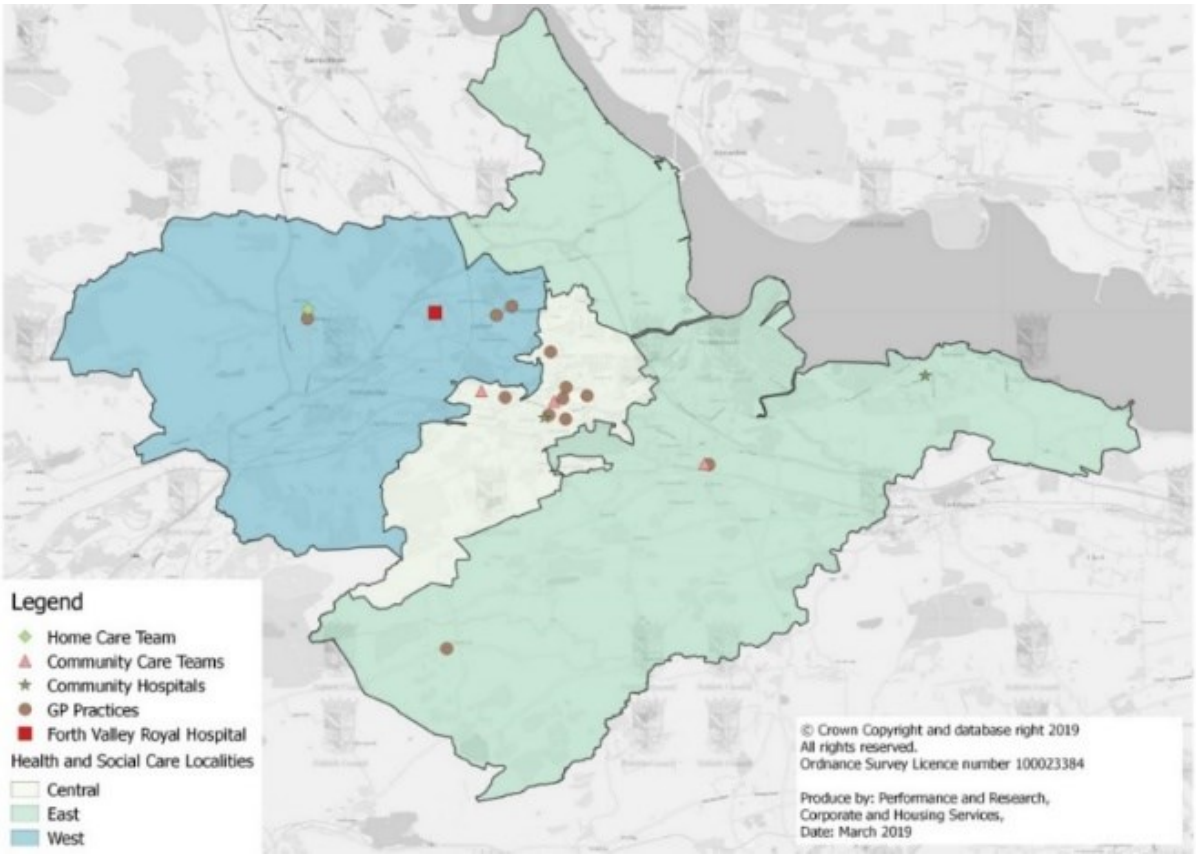


Figure 1: Falkirk Localities Map

The Partnership's locality planning approach has supported the Remobilise, Recover, and Redesign Plan - introduced in response to the Covid-19 pandemic.

Locality Managers continue to develop Locality Plans that reflect the needs of the communities and our strategic priorities, alongside joint working with communities and partner organisations. This includes the Community Planning Partnership, whose focus is on tackling poverty and inequality via the delivery of the Falkirk Plan 2021-2031, published in October 2021.

The Falkirk Plan is the framework that captures the vision and commitment of the Community Planning Partnership to work together to reduce poverty, tackle inequalities, and improve the quality of life for everyone in the Falkirk Council area.

The Falkirk Plan has been developed with community planning partners, based on research and local community feedback on the issues most important to them. The Plan has identified six priority areas to be the focus of sustained joint-working to make a positive difference to our communities. These themes are:

- Working in partnership with communities
- Poverty
- Mental health and wellbeing
- Substance use
- Gender-based violence
- Economic recovery

The plan also reflects the Public Health Priorities for Scotland, which encourages public services, the third sector, community organisations, and others to work together to address the root causes of inequalities in Scotland's health.

In addition, Grangemouth, Denny, Dunipace, and Dennyloanhead communities have published their own Community Action Plans, with Bainsford and Langlees on track to produce plans by Summer 2022.

These plans demonstrate the role and value of every volunteer and neighbour in mitigating the impact of inequality across Falkirk and preventing future health inequalities.

LOCALITY SNAPSHOTS

The following information summarises key demographic data from the Partnership's Locality Profiles.

Households

21,952 **Central**

31,754 **East**

21,520 **West**

WEST
Includes the areas of Larbert, Denny, and Bonnybridge.

% that live with a long-term health condition

20% Central

19% East

18% West

CENTRAL
Includes the areas of Falkirk Town Centre, Camelon, Bainsford, and Hallglen.

% that live in the most deprived SIMD quintile

33% Central

12% East

7% West

EAST
Includes the areas of Braes, Redding, Bo'ness, Grangemouth, Stenhousemuir, and Airth.

OUR CHALLENGES

Ageing population

Falkirk has an ageing population, increasing demand for health and social care services. People are living longer into old age, resulting in more people living with multiple or complex conditions. Our workforce is also ageing – by 2024 34% of our workforce will be over 60.

Substance use

There is a marked increase in addictions and drug related deaths across the local community, alongside an increase in mental health and social inequalities. The ADP is leading the multi-agency plan to address local challenges.

Trauma informed

We need a trauma informed workforce to evaluate services from a trauma informed and responsive perspective. We share the Scottish Government vision to recognise where people are affected by trauma and adversity and to respond in ways that prevent further harm and support recovery.

Mental wellbeing

We need to continue to work with staff, partners and communities to improve mental health and wellbeing in Falkirk. Where this is needed, we need to ensure timely access to specialist support for mental illness.

COVID-19

While we have achieved so much with COVID, there remains increased pressures for the community and the workforce to manage Covid-19.

Finance

There is an increasing demand for services with a reduction in funding that will mean we need to be creative and transformational to ensure a targeted and efficient approach.

Recruitment

There are real skill shortages in a range of posts and professions across the partnership. Traditional job roles may need to transform to meet the needs of our community and to ensure modern, integrated, efficient and high-quality services.

Technology

Digital technology is key to changing health and social care. Empowering people to actively manage their own care, means investing in new technologies and services. At the same time, there is a need to ensure our workforce have the technical capabilities to support the development of these changes.

Systems

Investment in more intuitive information management systems to support the delivery of person-centred care that empowers the workforce to improve practice in the assessment and planning of personal outcomes. We need to turn data into intelligence to aid better joint planning and co-design.

Estate

We need to make better use of available space as many buildings are not fit-for-purpose or easily adaptable to meet the needs of services, communities, and staff, and embrace mobile/flexible working to make best use of the assests we have.

OUR PARTNERSHIP

The **Strategic Plan** outlines how we will deliver adult health and social care services in Falkirk over 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 community 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 the Partnership's vision, local outcomes, and priorities that will help improve the lives of people in the Falkirk area. **The Partnership's current plan is due for renewal this year, with engagement and planning already underway to produce a new 3-year plan.**

OUR VISION

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

OUR PRIORITIES

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

OUR LOCAL OUTCOMES

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.

Safe, high-quality, health and social care services are delivered that promote keeping people safe and well for longer.

People have a fair and positive **experience** of health and social care, delivered by a supported workforce that are skilled, committed, motivated and valued.

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.

NATIONAL HEALTH AND WELLBEING OUTCOMES

The Scottish Government has nine national health and wellbeing outcomes, shown in Table 1, to improve the quality and consistency of services for individuals, carers, and their families, and those who work within health and social care.

1	People are able to look after and improve their own health and wellbeing and live-in good health for longer
2	People, including those with disabilities or long-term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
7	People who use health and social care services are safe from harm
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9	Resources are used effectively and efficiently in the provision of health and social care services

Table 1: National Health and Wellbeing Outcomes

This performance report sets out progress made towards the National Health and Wellbeing Outcomes, and our Strategic Plan priorities and outcomes during 2021/22.

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 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: Association between local Falkirk priorities, Scottish Government Integration Priorities, and National Outcomes

OUR PROGRESS

National Health and Wellbeing Outcomes

Outcome 1:

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 is an online tool that promotes healthy, independent living by emphasising people's ability to stay active and participate in their community. It has been designed for people who live in the Falkirk area and are having difficulties with everyday activities.

Living Well Falkirk offers:

- 24-hour access to hints and tips on how to stay well and live independently
- information about local and national services
- helpful advice by completing a self-assessment on your abilities
- suggestions on areas such as staying safe at home, preventing falls, help with bathing, etc.
- options to purchase, or request the loan of, equipment matched to your needs
- contact information for further support

Living Well Falkirk has become a key tool to achieving the Partnership's remit of bringing services together to support people in their own homes. The model emphasises empowerment of individuals within their community and is supported by a steering group with strong representation from third sector groups in Falkirk.

During 2021, the local services section of the website was updated. In early 2022, work began on developing an online training module aimed at giving new and existing Falkirk Council and Falkirk HSCP staff a greater understanding of the purpose of the system, how to register an account and complete the assessments, and increase their confidence in helping users of their services to get started on Living Well Falkirk.

The aim of the course is to promote a fuller understanding of the benefits of the Living Well Falkirk platform within the workforce. Once developed, participants will gain a fuller understanding of a prevention-focused platform where data is used to help individuals to help themselves.

This online course will be made available to the workforce via Falkirk Council's OLLE training platform.

During 2021/2022:

- 5,013 users engaged in 6,634 sessions on the Living Well Falkirk website
- 408 Lifecurve assessments were started
- 572 Lifecurve assessments reviewing individual areas of need - users can select more than one area to assess
- 572 self-assessments were started
- 421 individual areas of need assessed were recommended a suitable piece of equipment
- 170 individual areas of need assessed were signposted to relevant advice and resources

Top five individual self-assessment areas of need	Completed
I am finding it quite hard to step into the bath and/or stand to take a shower in the bath	60
I am finding it quite hard to take a bath – what can I do to manage better?	54
I struggle when walking up and down the steps at the main entrance to my home	48
I find it difficult going up and down my stairs	34
I have difficulty getting on and off the toilet	30

Table 3: Usage stats provided via Living Well Falkirk LifeCurve dashboard, 2021 –2022.

Living Well Falkirk has been commended by Healthcare Improvement Scotland as a positive example of a community-led approach to health and social care.

To learn more about Living Well Falkirk, visit livingwellfalkirk.lifecurve.uk

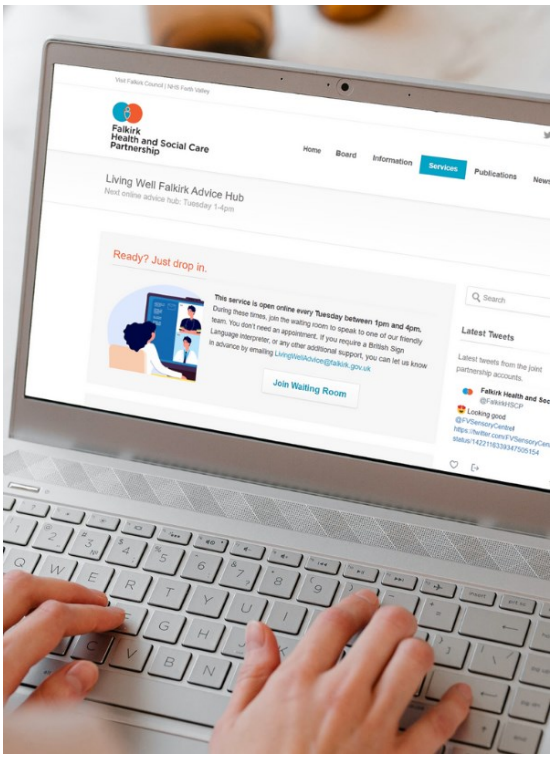
LIVING WELL ADVICE HUB

Falkirk HSCP and third sector partners embarked upon a pilot project to introduce Near Me as a means of accessing Community-Led Support. Near Me is a video consultation system that enables members of the public to meet with service providers remotely. The system has been well established by the NHS and its use has increased enormously since the start of the Covid-19 pandemic.

The pilot, known as the Living Well Advice Hub, enabled people to drop-in virtually on a Tuesday afternoon and have a conversation with our Community Link Workers about anything they needed support with. The Link Workers used the 'Good Conversations' model (promoted by NDTi) to find out what really mattered to the caller and to identify the assets in the caller's own life that they could build upon to improve their health and wellbeing. The Community Link Workers were also able to make referrals to other organisations.

Services that were available during the pilot included:

- Falkirk Council Social Work Services
- Falkirk Council's Community Link Workers
- FDAMH – Falkirk's Mental Health Association
- Strathcarron Hospice Compassionate Neighbours Service
- Cyrenians Falkirk Outreach



The pilot ran between July and September 2021 with the service available during a three-hour period on a Tuesday afternoon. While the approach promoted the innovative use of technology, the restricted opening hours limited the uptake of the service.

Following a successful bid for funding, a project is currently underway to roll out Near Me video consultancy to Duty Social Work. It is anticipated that the rollout of Near Me to Social Work will allow more flexible options for community engagement with Social Work services, including individuals awaiting community support.

COMMUNITY LINK WORKERS

The Community Link Work model allows GPs to target their time with an individual to address medical issues, while Community Link Workers use a social prescribing model to support individuals with a variety of social, financial, mental wellbeing, and practical issues that are affecting their life, and in turn their health. This provides a holistic person-centred approach to supporting individuals.

During 2021/2022, the Community Link Work service expanded with additional link workers recruited. This also included a Community Link Worker focused on supporting young people. Currently, there are seven Community Link Workers operating within the Falkirk area with each Community Link Worker hosted by a third sector organisation and aligned to GP Practices with the highest level of deprivation.

Community Link Work is one of the priorities within the Primary Care Transformation Programme.

LOCALITY:	EAST	CENTRAL	WEST
Host organisation	Cyrenians	FDAMH	Strathcarron
No. of CLW	3	2	2
Support Type	Generalist	Therapeutic Young People	Generalist
GP Location	Bo'ness Road Kersiebank	All Central Practices	Denny Cross Carronbank Bonnybridge

Table 4: Community Link Workers in Falkirk HSCP area

Community Link Workers adopt a flexible approach towards people's needs for different types of appointments and provide various methods to enable people to engage with the service. Community Link Workers have returned to providing services within GP practices, as well as conducting house visits and walk-and-talk meetings. They have continued to support people remotely via phone and video calls, and text messaging to suit the needs of the individual.

They have continued to build relationships in the local third sector and statutory services to make it easier for clients to be referred and access local support. During this period of uncertainty due to Covid-19, some community-based groups have restarted, but there are a lot of groups that have either yet to open again or have closed completely. A lot of support is currently being provided by Community Link Workers until community support is back to its full strength.

Looking ahead to 2022/2023, the Partnership is looking to further expand its Community Link Work service to have one Link Worker for every 15,000 of the Falkirk population. This expansion could see Community Link Workers being in every GP practice in the Falkirk area, which will increase the capacity of the service to eleven Community Link Workers.

CASE STUDY: CYRENIANS COMMUNITY LINK WORKER

A client was referred to the Community Link Worker (CLW) due to being in homeless accommodation and was about to be asked to leave. He was also looking for support with benefits/financial issues, mental health issues, social isolation, and loneliness.

The CLW supported the client by linking with the Falkirk Council Homeless Team and his GP to prevent him from being asked to leave homeless accommodation. The CLW linked the client in with other services who could then complete a benefits calculation and support him in applying for benefits.

The client now has his own property after over 20 years of moving around the country and he feels more secure. He is still seeing the CLW and is now wanting to look at possible volunteering opportunities in the community and attending some community activities.

**This case study has been anonymised and provided, with thanks, from Cyrenians Community Link Worker.*

DIGITAL RESOURCES

A list of health and social care digital resources available in Falkirk was produced and circulated to Social Work. This included notes about some ways that widely available devices (such as tablets and smartphones) could be used to support individuals, such as by setting reminders for medicine prompts and suggestions about programming health numbers into contacts for easy access. The document also provided links to community support groups. There is potential that this document could be developed to form a short course to generate awareness of ways that Technology Enabled Care (TEC) could support individuals.

NEW COMMUNITY NUTRITION WEBSITE LAUNCH

The Community Dietetics Healthier Future team have revamped and updated their Community Nutrition Website giving it a colourful and eye-catching new look and making it more user friendly and easier to navigate between pages. Several new pages have been created and added to the site. For example, Access to Food, Nutrition in Older People, Sustainable Eating, and a Case Studies page which illustrates how the team are encouraging and supporting local organisations, community groups, and NHS and prison staff to take forward projects around food, cooking, and growing.

The Community Nutrition website provides further information and links to nutrition resources, food funding and training opportunities, and other useful website links.

FOCUS ON FOOD IN FORTH VALLEY PRISONS

The Community Dietetics Healthier Future team have been working in partnership with the Scottish Prison Service (SPS), the Royal Caledonian Horticultural Society, Cross Reach, and the Royal Environmental Health Institute of Scotland (REHIS) to create health improvement and employability opportunities within Forth Valley Prisons.

The team delivered a Grow, Cook, and Learn Project with a group of women in HMP YOI Polmont. The project created an opportunity for people in prison to develop their gardening and cooking skills, work towards nationally recognised qualifications and receive awards that would be transferable into communities and workplaces on their release from prison. The project also recorded positive mental health and wellbeing experiences from those that took part in the project.

The Public Health Nutrition team were recognised for this work by Royal Environmental Health Institute of Scotland (REHIS) and were recently awarded The President's Award for the REHIS training and food work that they deliver across the three prisons in Forth Valley.

PRE-DIABETES INITIAL CONVERSATIONS PROJECT

The Denny and Bonnybridge GP Cluster and the Community Dietetic Healthier Future team are testing a person-led Type 2 Diabetes pathway, informed by the lived experience of citizens, third sector and community partners, and Healthcare Professionals. The team have also collaborated with GP Practices in the East Locality.

Following blood testing within their GP Practice, every person with Pre-Diabetes is offered a person-led conversation to explore their feelings, priorities, desired outcomes, and personal goals. Where a person is unable to commit to a health change, a range of support options are explored, including mental wellbeing and financial advice. The conversation will facilitate those who feel empowered to make changes on their own to set goals. A range of partner and NHS options are available for people ready to make changes with support.

Regardless of management choice, 47% of people who have had a person-led initial conversation have improved their Pre-Diabetes blood result at 12 months (HbA1c) compared to 36% who receive traditional "expert" advice.

50% of people receiving traditional "expert" advice experienced a worsening blood result at 12 months, with 42% of those who had a person-led initial conversation.

Feedback from attendees:

- "Thank you for all your assistance to date. I'm so pleased that you're taking the time to ensure all is good with my health."
- "I keep saying I know what to do, but you're the first [person] to listen to what is actually worrying me."
- "I want to do it myself. If people tell me what to do, I'll do the opposite. That's why I've been self-employed for 40 years."

SCOTTISH GOVERNMENT EARLY DETECTION OF TYPE 2 DIABETES PROJECT

One of the National Targets for Type 2 Diabetes Prevention is, that people at risk of, and with Type 2 Diabetes are identified earlier. The Community Dietetics Healthier Future team and the Keepwell (Anticipatory Care) teams collaborated to design an early detection pathway using the Diabetes UK "Know Your Risk" screening tool, with rapid access to blood testing for those at moderate to high risk. Team members can take blood, receive, and action results, and will undertake a wide range of person-centred interventions, onward referral, or signposting.

This pathway ensures that all those detected by the teams are supported out with General Practice so reducing the burden on GPs, Practice Nurses, and Primary Care Phlebotomy.

To address potential health inequality, the pathway will be delivered in more community settings and with increasing collaboration with third sector and community partners, Falkirk Council Community Learning and Development teams, and the Falkirk Council Community Advice Service during next year.

DIABETES EDUCATION PROGRAMME

"Type 2 Diabetes Explained" was developed by the NHS Forth Valley Community Diabetes Dietitians and is a nationally quality-approved education programme for people with Type 2 Diabetes. It facilitates people to understand their condition and to improve their own health and wellbeing. With face-to-face delivery not possible, the programmes have been delivered online during this year.

Measurement	
Registered participants	138
Percentage completing the programme	70%
Mean percentage improvement in empowerment score	47%
Mean programme satisfaction level	95%

Table 5: Participants across Forth Valley 2021/2022

Twelve months after participating in 2020/2021, mean weight loss was 4kg and 29% of participants were in remission from Type 2 Diabetes.

ADULT WEIGHT MANAGEMENT DISORDED EATING GROUP

Up to 50% of people referred to the adult weight management service will have experienced psychological distress, trauma, or adjustment issues. 20% of those people will require support from a clinical psychologist. However, with skills development in behaviour change strategies, trauma informed practice, and the physiology of disordered eating, the Adult Weight Management team have developed a Disordered Eating Group Programme to facilitate participants to consider how physiology impacts their relationship with food.

There have been four groups with a total of 13 participants since July 2021. 100% of participants attended all six group sessions plus two individual follow-up appointments. Delivering as a group has benefited the participants through peer support and this has had an additional benefit of saving the educator 44 hours, which has saved 59% of time resources.

Following completion of the programme:

1. 1 person was referred to the Eating Disorder Service
2. 2 people felt supported enough to join traditional weight management groups
3. 8 people have begun one-to-one weight management programmes
4. 2 people are awaiting sessions with the Healthier Future Clinical Psychologist (new post to be appointed in July 2022)

Participant feedback:

- "This feels like a safe place where I am not judged."
- "I feel hopeful about focusing on my behaviours, I have been dieting all my life. I know what to eat to lose weight."
- "It made me change how/when I eat and this made me change what I'd choose to eat."

NHS FORTH VALLEY WHY WEIGHT SERVICE

The Why Weight Service supports children and young people who have challenges with weight management and the often co-morbid reduction in confidence and self-esteem.

This treatment model offers educational, practical, and activity-based interventions to facilitate behaviour change. These interventions often involve partnership working with community organisations with the aim for young people to make longer term engagements with these mainstream services. Two recent collaborations are outlined below involve physical activity opportunities for young people.

Multi-Sports Project with Falkirk Football Community Foundation (FFCF)

The Occupational Therapist from the Why Weight team delivered mental health awareness and resilience training to coaching staff from FFCF. This training consisted of a 1.5 hour face-to-face interactive teaching session to discuss the challenges some young people may face when accessing activity

programmes and how to manage difficult situations and adapt sessions accordingly. Practical training on sports activities and coaching was delivered by active school staff.

Seven young people attended between one and six sessions of the six-week programme with all parents and young people reporting that they had found the sessions very helpful and would like them to continue.

A further long-term project is planned for Autumn 2022 and will provide a rolling programme for participants to access physical activity with the aims of increasing social communication, self-esteem, and activity engagement. The goal is to facilitate further training to allow active schools to run low-impact activity-based programmes in all Falkirk secondary schools, thereby providing activity opportunities within a local setting and to anyone who may consider weight management as a challenge.

Gym Sessions at The Mariner Centre

A block of twelve gym sessions for up to six participants was negotiated with the Active Forth Service. Each session involved support from two gym instructors and the focus of increasing decision making, choice, and independence whilst working through individualised fitness plans. Individuals completed personalised fitness, strength, and endurance tests at the beginning and end of the block and all who attended on a regular basis improved these fitness metrics.

Further discussion and evaluation have highlighted that gym participation can be challenging for this group of young people and it was agreed that some may require more than twelve initial sessions. This would be followed-up with Why Weight staff supporting, for up to a maximum of three sessions, young people to progress to the Why Active Activity Referral Scheme. This progression to the mainstream service and independent access is an integral component of the Why Weight model for long-term behaviour change.

SMILE4LIFE TRAINING

The overall purpose of Smile4Life is to enable health and social care staff and support workers to provide evidence-based tailored oral health messages to meet specific and exceptional needs of vulnerable people in Scotland.

Eleven people have received Smile4Life Training from three different community organisations that support children and families with economic and social disadvantage (New Futures Project Salvation Army Falkirk;

Rainbow Muslim Women's Group). The target group consisted mainly of staff and volunteers.

Bespoke bi-lingual and culturally sensitive training sessions have been delivered to BAME communities to create oral health awareness and to facilitate their access to local dental health services and further targeted engagement is being carried out.

As a result of the training, staff have distributed more toothbrush and toothpaste packs, provided information on local dental services and supported clients through behaviour change with regards to diet, drug use, and smoking. Future Oral Health sessions for additional groups have also been requested and further requests for Oral Health packs and information resources.

Referrals have also been made to Childsmile to deliver child friendly Oral Health education sessions and toothbrushing programmes to children/parent groups in schools in Forth Valley.

Feedback from training:

- "I learned a lot of new information about Oral Health and feel that these are important messages to share with our service users, especially those that are new to the country. It is also useful to know about how to access local dental services so we can sign-post them in the right direction."

Most Smile4Life packs have gone out to community homelessness organisations, foodbanks, substance misuse organisations, care services for children and young people, BAME groups, pharmacies, and community nurses.

During 2021/2022:

- 585 adult packs and 150 child packs have been distributed in Falkirk
- 33 packs have been distributed to Community Pharmacies in the Falkirk area
- 1,013 adult Mouth Matters packs and 150 child Mouth Matters packs have been disseminated to Polmont Prison

STOP SMOKING SERVICE

Free behavioural support and pharmacotherapy is offered to individuals wanting to stop smoking in Forth Valley. The Stop Smoking Service and Community Pharmacy support delivery of the cessation service to support the wider target of reducing smoking rates to below 5% across the country by 2034.

Due to Covid-19, local boards were asked to work towards LDP targets retaining the same figures that were set for 2019/20. Therefore, NHS Scotland set out the LDP Standards to achieve at least 7,036 self-reported successful 12-week quits (individuals still not smoking after 12 weeks) through smoking cessation services in the 40% most deprived areas. The local target for Forth Valley 2021/22 was 347 successful 12-weeks.

Prior to Covid-19, the Stop Smoking Service delivered six primary care clinics in Falkirk and a drop-in clinic in Camelon. However, all face-to-face clinics were suspended from March 2020 and throughout 2021/22. Therefore, behavioural support was conducted via telephone and Near Me video consultations. The service also adopted a process to post Nicotine Replacement Therapy (NRT) to clients who would have previously received NRT at clinics.

SIMD	No. of Referrals	No. Set Quit Date	12 Week Quit Success	Contribution towards Forth Valley LDP %
SIMD 1-4	419	183	136	39%
SIMD 5-10	244	96	90	N/A
Grand Total	**663**	**279**	**226**	**39%**

Table 6: Falkirk Quit Dates Success by SIMD area and contribution to LDP

No Smoking Day

No Smoking Day took place on Wednesday 9 March 2022. This year's campaign "Quit Your Way" was driven by ASH Scotland through media platforms and promoted through our Health Improvement Resource Service (HIRS).

The campaign encouraged people to make a quit attempt by sharing stories of individuals who have successfully stopped smoking. Falkirk HSCP and third sector partners supported the campaign through social media platforms.

HEALTH IMPROVEMENT RESOURCE SERVICE (HIRS)

The Health Improvement Resource Service (HIRS) provides registered library users with access to information on a range of health improvement issues in a range of formats.

Topic	Total Requests
Alcohol	390
Drugs	113
Tobacco	530
Grand Total	**1,033**

Table 7: Total Number of Health Improvement Resource Requests in Falkirk

SMOKING AND MENTAL HEALTH: UNDERSTANDING THE IMPACT

This training session consisted of two E-Learning modules to be completed prior to a one-hour virtual training session delivered via MS Teams. This training equipped workers who support people with lived experience of mental ill-health with the knowledge, skills, and confidence to initiate a conversation about smoking and to discuss options for supporting those who are ready to quit. In 2021/2022, this training was attended by 19 participants from Falkirk.

STEP ON STRESS

Step on Stress is a stress management course delivered over three weekly sessions. The course is pre-recorded to enable live streaming over MS Teams during the Covid-19 pandemic with a moderated question and answer function. Each session covers a different topic and lasts just over an hour. A resource pack accompanies the course and is posted in advance to registered participants. During 2021/2022, 167 individuals registered from Falkirk.

ASK TELL WORKSHOPS

Ask Tell is a series of three facilitated animation workshops that inform individuals working with adults about mental health, how to maintain this, the factors that can lead to mental distress or mental ill-health, and how to have compassionate conversations, which sets out how to support people who are experiencing mental distress or may be feeling suicidal and support them to seek help. During 2021/2022, 117 individuals registered from Falkirk and 87 (74%) individuals attended two or more workshops.

MUSCULOSKELETAL PHYSIOTHERAPY SERVICES

Musculoskeletal (MSK) Physiotherapy services for Falkirk residents were relocated from Forth Valley Royal Hospital to the Westburn Building at the Falkirk Community Hospital in October 2021.

Staff have worked hard to make the outdoor space attractive by arranging planters to be built and planting plants, some of which have been donated by patients. This has allowed some patients to receive their therapy outdoors and staff to have a space to relax during their break.

Outcome 2:

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

DAY SERVICES

All internal and external Day Care provision was stopped during the first lockdown in 2020, including community-based groups such as lunch clubs. The HSCP has worked with Corporate & Housing Services and third sector partners to ensure that service users, unpaid carers and families have continued to receive support where possible.

Day Services, in conjunction with the Public Health Team, have worked to reopen day services provision for adults. The three-phase reopening of the Partnerships' adult day services began in May 2021, with a limited number of staff and service users returning. For volunteer-led groups, HSCP Community Learning and Development staff and CVS Falkirk have been providing support about safely restarting services.

COMMUNITY RESOURCE PACK AND GRANTS

The Partnership and CVS Falkirk & District jointly produced a new community resource pack with information and tools to support groups and organisations to restart (or set up) activities following the Covid-19 pandemic.

The pack includes sample policies and templates, including health and safety, risk assessments, volunteering policy, and much more.

To support groups to restart, or start new, activities following the pandemic, the Partnership established a Restart/Start-up Grant with up to £500 of funding available to applicants.

The grant was designed to be flexible for groups and organisations to restart activities in different ways. Since the grant launched in November 2021, the Partnership has awarded a total of £7,203.50 to 15 community-based groups across the Falkirk area.

Some of the successful applicants have used this fund to:

- Support the costs of holding meetings designed to meet the identified information and support needs of local people affected by epilepsy

- Cover the costs of services and repairs of various machines within the venue facilities following restarting lunch clubs for the elderly and the disabled
- Purchase new disability accessible equipment to support delivery of events to introduce individuals back into sport and physical activity after Covid-19 lockdown
- Cover part of the cost for minibus repairs used to pick up and return group members. The minibus hadn't been used due to the Covid-19 pandemic and required essential repairs. The Tuesday Club supports mainly elderly people with dementia and runs sessions every Tuesday, including social activities, morning tea, and lunch

CASE STUDY: REOPENING COMMUNITY RESOURCES

Based at Talbot House, the Grangemouth Old People's Welfare Committee runs regular lunch clubs for the local community, combating loneliness among elderly and disabled groups. The Talbot base is also used by other local organisations, including Falkirk Carers and the Town Break Dementia Club.

Closed due to the pandemic, the Old People's Welfare Committee applied to the Restart Grant to cover the costs of servicing and re-opening the facility, which required maintenance following its 18-month hiatus.

The funding enabled the safe reopening of Talbot House, opening the door to restarting lunch clubs and other community activities.

**This case study has been anonymised and provided, with thanks, from Grangemouth Old People's Welfare Committee.*

JOINT DEMENTIA INITIATIVE (JDI)

The Joint Dementia Initiative (JDI) aims to help people with Dementia to continue to live the life they want to live by supporting them to live at home in their own communities for as long as possible. The JDI team work with the service user and carer to find ways to reduce the risks surrounding remaining at home. This is done by:

- Identifying familiar routines and patterns for everyday living
- Supporting people to maintain skills, such as taking a bath, dressing, or cooking
- Supporting people to learn new skills, such as computer skills to reduce social isolation
- Supporting the development of new hobbies and interests

- Helping people to maintain friendships and relationships
- Assisting involvement with the local community and the communities understanding of Dementia to make communities more Dementia Friendly
- Supporting access to services, such as health services
- Providing critical breaks for carers to allow rest from their caring role

The Joint Dementia Initiative (JDI) service offers a person-centred approach. The One-to-One service is available to anyone who has a diagnosis of dementia. It aims to support individuals with everyday tasks and help them to maintain relationships and friendships. The Home from Home service provides the opportunity for people to meet in a small group, with others who are having similar experiences. The aim is for people to receive support within a homely setting while being kept connected to their community. The Home from Home service is hosted by a self-employed home day carer who owns the home and who works alongside another self-employed carer.

The service also offers peer support groups for carers and for younger people who have a memory impairment or a diagnosis of early onset dementia.

The Covid-19 pandemic has had an adverse impact on older adults and their carers, making it the right time to start reviewing the service in April 2021. The aim of the review is to improve outcomes and opportunities for service users and to re-establish links to enhance partnership and collaborative working. This review aligns with the ongoing review of day opportunities for older people.

Consultation with service users, carers, staff, and key stakeholders demonstrated that the service should continue to be person-centred and adapted to meet the individual needs of service users and carers. The service is working collaboratively with partners to ensure that there is a spectrum of support available for people who are at different stages of diagnosis and to suit their varying needs.

As part of the engagement process for the review of the JDI services, feedback was also gathered on the views and benefits of developing a Dementia Friendly Falkirk community. The aim of this work is to raise community awareness around dementia and support the local community to be more inclusive of people living with dementia and their carers.

The first Dementia Friendly Falkirk Steering Group was held in October 2021, and included service users, carers, elected members, health and social work staff, and third sector and independent sector partners. Whilst it was noted that work relating to Dementia Friendly Falkirk needs to be set within a wider strategy context, it was agreed to begin focusing on re-establishing community group work and the need to collaborate with local partners to achieve this aim.

CALEDONIA SERVICE

The Caledonia Service works with adults living with severe and enduring mental illness. The service offers community-based group activities. All activities aim to improve wellbeing, increase self-esteem, and self-confidence while giving individuals an opportunity to learn new skills or build on existing ones. Staff are always sourcing new activities and groups for service users and have weekly team meetings to discuss progress and development of the service.

Over the past three years, the service model has significantly evolved from a long-term day service to a progressive, community-focussed model. During the Covid-19 pandemic, the building closed. However, the service continued remotely and within community-based settings with service users adjusting well to the revised model.

Prior to Covid-19, discussions had been taking place around the suitability of the building. It was situated in an industrial estate, and it wasn't easy to facilitate community access and integration. Given the building had not been used since March 2020 and it had already been evidenced that services could operate successfully via a local community-based model, it was decided to co-locate the team with the Joint Dementia Initiative (JDI) service at Dollar Park and focus on delivering local community resources across the area, utilising community buildings closer to service users' homes.

The service currently offers monthly peer-to-peer support meetings to give service users a voice and a say in what activities are sourced and available for group activities, this is led by service users to encourage inclusion and participation in local community venues. Physical health is promoted in walking groups, cycling, gardening, and fitness groups which are open to all levels to allow everyone the opportunity to participate. As a result, service users can maintain their mental health and wellbeing and contribute to their physical wellbeing through local exercise groups and activities.

Service users are volunteering in their local communities undertaking several productive and beneficial tasks. The service has strong links with Forestry and Land Scotland, working in association with a ranger in the management of both Callendar and Larbert Woods. The group have been involved in the removal of invasive species, pruning, and trimming trees, and other woodland maintenance tasks. Similarly, at the Sensory Centre in Camelon, service users are working in the Sensory Garden and grounds to maintain them at a high standard.

The service is currently working in partnership with Forth Environment Link to undertake some cycle maintenance and healthy cooking groups by offering service users hands on learning and skill building opportunities. Working in partnership with Active Forth to create a referral pathway, service users are supported to access the Shapemaster Hub at the Mariner Centre. The Hub is situated in the Health and Fitness area and offers a gentle form of exercise,

relaxation, and socialising. It's ideal for those living with long-term health problems who are new to exercise or are deconditioned. Adjustable footplates and support straps enable access for people with movement restriction and their twelve power assisted exercise machines support all fitness levels.

The Upcycling Group continues to work with Grahamston Care Home, supporting them in maintaining their garden areas, with the group involved in restoring benches, fences, and general gardening tasks. The group has also created links with the volunteer programme at the Helix Park and are looking to commence fortnightly visits working on various projects to enhance the park for their array of visitors.

The Caledonia Service continues to work as part of Falkirk Users Soccer Experience (FUSE) linking in with Woodlands Resource Centre, Bellsdyke Hospital, and the Mental Health Unit at Forth Valley Royal Hospital. FUSE has maintained our working partnership with Stenhousemuir Football Club and has been able to delivery Covid-19 friendly coaching sessions throughout the last year, with the participants continuing to experience an improvement in their mental and physical health while also delivering social inclusion.

THE FALKIRK COLLABORATIVE TEAM

For many years, day support services have sought to move to person-centred models of support. The Learning Disability Day Support Collaborative is run by Healthcare Improvement Scotland Hub (ihub), and they have identified six key areas for development in Learning Disability Day Opportunities in Scotland. These are:

- Person-centred practice
- Partnership working
- Staff empowerment
- Community inclusion
- Supporting families to take a break
- Involving people in the design process

In June 2021, Falkirk HSCP was recruited to work with iHub to redesign day support for adults with learning disabilities. The Falkirk Collaborative Team includes partners from Healthcare Improvement Scotland, Falkirk HSCP, Falkirk Council, NHS Forth Valley, and Neighbourhood Networks. The Falkirk Collaborative Team is looking to explore how key areas of development in Learning Disability Day Opportunities can be applied locally.

Phase two of the project (June 2021 to March 2022) focused on gathering the views and experiences of the following stakeholder groups:

- People with a learning disability
- Families and carers of people with a learning disability
- HSCP staff who are part of the process for accessing day opportunities

- Third Sector organisations who are part of the process for accessing day opportunities

We received sixteen responses from internal day opportunities service users and carers who engaged either face-to-face, by phone, or by post. We used easy read surveys and Talking Mats to engage with service users and listen to their views. We received 32 responses from staff who provided their views either via the staff engagement survey or by attending the staff engagement event in May 2022.

Looking ahead to 2022/23, Phase 3 of the project aims to work with service users, carers, staff, communities, and key stakeholders to improve outcomes and opportunities for adults with learning disabilities in the key areas of living, learning, wellbeing, and working.

This will include hosting feedback events to share what has been learned so far in Phase 1 and 2 and the plan to use the Big Planning tool to facilitate planning sessions with a small cohort of service users. These sessions aim to establish what people want for their lives and to co-produce positive outcomes and opportunities.

DATES-N-MATES FALKIRK

As Scotland's national dating and friendship agency for adults with learning disabilities, Dates-n-Mates has sought to improve the health and wellbeing of its members in Falkirk by helping them to overcome the loneliness and social isolation to which many people with learning disabilities are particularly susceptible.

They have done this by:

- Providing opportunities and support to make and sustain friendships and close personal relationships
- Supporting people to develop the skills and abilities to make decisions about, develop, and sustain friendships and close personal relationships
- Increasing social inclusion and the presence of people with learning disabilities in everyday places, events, and activities

At the end of 2021/22, Dates-n-Mates has 40 members. The recruitment of new members has been significantly affected by the pandemic, but despite the many challenges of the Covid-19 pandemic, Dates-n-Mates have delivered a revised programme of in person and online events for members.

Online events have been developed to enable members to keep in touch during lockdown. Workshops have been delivered to members on themes of relationships and internet safety. Local events have been focused on the communities where members live, helping members get to know local people, pubs, and restaurants, which has made members feel more connected to their communities and has given them the confidence to meet

each other and visit these places without Dates-n-Mates team members in the process of developing more natural and reciprocal relationships.

CASE STUDY: DATES-N-MATES

Scotland's national dating and friendship agency, run by and for adults with learning disabilities, helps people experiencing loneliness in Falkirk.

Joining dates-n-mates following the passing of her companion two years ago, Jane* attended local social events and got to know the team. The team were then able to match her up with another dates-n-mates member, who had faced similar circumstances and had a similar outlook for life.

Originally 'friendship matched' at a bingo event, the pair have developed a strong friendship, now often meeting up for a coffee or at the tenpin bowling.

From bowling to meals out, and clubbing to bingo, Dates-n-mates creates meaningful connections, friendships, and relationships all year round with a series of regular social events.

Image 1: dates-n-mates members enjoying a day out at Glasgow's TRNSMT festival

**This case study has been anonymised and provided, with thanks, from Dates-n-Mates.*

HOME FIRST

Home First is a local initiative focussing on supporting people to avoid a delay in their discharge from hospital. Home First works with the person and their carer/relative to agree how they can support their loved one to get home, without any delays. The team consists of social work professionals, including social workers, social care practitioners, and Occupational Therapists, who carry out assessments and work in collaboration with health professionals to determine people's needs to return home.

Home First manages and facilitates discharges to Bo'ness Hospital, Summerford House intermediate care home, Falkirk Council care homes, Thornton Gardens and intermediate beds procured by the Partnership. The Home First team in Falkirk Community Hospital serves and manages the intermediate beds identified to aid downstream delays within Forth Valley Royal Hospital. Home First is also involved in discharge to assess model evolvement. The service continues to have strong links with the reablement service within Summerford House care home, working with an integrated approach to facilitate discharges to assist patient flow.

Image 2: Members of the Home First Team, Claire Duffy and Deborah Jackson

The Home First service has continued to work throughout the pandemic in parallel with our health partners to promote capacity and flow within the system. There work during this time has not gone unnoticed.

Ref	Measure	Mar-21	Mar-22	Direction of travel
54	Standard delayed discharges	15	28	▼
55	Standard delayed discharges over 2 weeks	6	17	▼
56	Bed days occupied by delayed discharges	209	662	▼
57	Number of code 9 delays, including guardianship	19	24	▼
58	Number of code 100 delays	3	3	▼
59	Delays - including Code 9 and Guardianship	34	52	▼

Table 8

The extraordinary effort and dedication of health and social care staff from Falkirk and Forth Valley was recognised in the 2021 Queen's Birthday Honours List. Almost 23% of recipients were recommended for Covid-19 service. These included recipients who have given charitable and voluntary support to communities, service in health and social care, and those who have provided critical infrastructure support.

Three members of the Falkirk HSCP's Home First Team received recognition and were awarded a BEM for services to Health and Social Care and the community during Covid-19:

- Nicola Harvey has been a valued member of the Home First team for 27 years. She was a key member of the Incident Response Team for the Partnership, while also continuing to undertake her duties as Home First Manager.
- Deborah Jackson was one of the key members of the Home First Team which supports people to return home or to a homely setting as soon as possible following a hospital visit.
- Claire Duffy has 25 years' service working throughout Falkirk Council and health and social care services. She is a Home First Practitioner within the Home First team.

The awards for Claire Duffy and Deborah Jackson were for their commitment in the hospital during the Covid-19 pandemic. The award for Nikki Harvey was for her work during the pandemic supporting the hospital team and in-house care homes. She supported and worked in external care homes throughout the pandemic. She has also been involved in supporting crisis episodes in Falkirk. For example, a gas failure in Falkirk during the winter months.

Ref	Measure	Mar-21	Mar-22	Direction of travel
85	The number of overdue 'OT' pending assessments at end of the period	226	292	▼

Table 9

DISTRICT NURSING SERVICES

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 Enhanced Community Health 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.

The past 12-18 months have been a challenging time for our District Nursing Teams due to the ongoing pandemic and the increasing emphasis on preventing hospital admission by providing care to people in their own homes. We have seen a vast increase in the frailty and complexity of those in our care and continue to see a rise in numbers of those being supported and cared for by community nurses to die in their own homes.

As well as an increase in the frailty and complexity of those in our care, we have also seen an increase in patient demand for home visits and treatment room appointments. A review of our treatment rooms between 2020 and 2021 shows a 56% rise in the number of patients seen across Falkirk. To meet this need, a request for additional staffing has been submitted to the Falkirk HSCP. We have also continued to deliver ongoing Covid-19 vaccinations to those housebound patients in our care.

Our District Nursing vision is to support people to live and die well in their own home. To ensure we have a workforce with the skills required, we have continued to support ongoing training within our service. Over the past 12 months, we have supported the training of five new District Nurse Trainees and are in the process of recruiting our first District Nurse Advanced Nurse Practitioners.

Ref	Measure	Mar-20	Mar-21	Mar-22	Direction of travel
33	Number of patients with an Anticipatory Care Plan in Falkirk	12,454	28,628	29,070	▲
34	Key Information Summary as a percentage of the Board area list size Forth Valley	8.1%	18.2%	18.4%	▲
35	Key Information Summary as a percentage of the Board area list size Falkirk	7.8%	17.8%	18.1%	▲

Table 10

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 1,730 Falkirk residents die every year. It is estimated that up to 1,300 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 six 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 six months of life.

Ref	Measure	2015/16	2020/21	2021/22	Direction of travel
86	Proportion of last six months of life spent at home	86%	89.4%	-	▲

Table 11

COMPASSIONATE COMMUNITIES: LIVING RIGHT UP TO THE END

Strathcarron Hospice compassionate neighbour volunteer programme provides practical and emotional support for people with life-limiting conditions and their carers. The volunteers at Strathcarron Hospice know that palliative care and end of life support is not just about the last days and hours of life but helping to maintain a quality of life for the person and their family at every moment from the point of diagnosis.

The Compassionate Neighbours Programme takes a de-medicalised approach to care. Its volunteers are focused on 'being there' for people experiencing life-limiting conditions and their carers. By focusing on meaningful social interactions and practical advice, the volunteers support people to live well right up to the end. The programme also aims to combat loneliness, which is known to be damaging to physical and mental health, contributing to lower quality of life.

While these volunteers are known as 'compassionate neighbours', many of the people supported by them simply refer to them as friends. As well as providing a friendly listening ear and welcoming conversation, the volunteers offer:

- Support and advice in a comfortable and non-clinical environment, such as the person's home or while out and about over a cup of coffee or a walk
- Open conversations about planning for the later stages of their life, including anticipatory care planning
- Helping people with long-term conditions, and their carers, to connect with community activities
- An opportunity for the person's full-time carer to take a break
- Practical support with small tasks, which can be as simple as changing a lightbulb

The compassionate neighbour volunteers are trained by Strathcarron Hospice and are matched with people based on interests, suitability, and location. The match-up system is designed to make friendships natural so that both sides of the relationship benefit. Anyone can refer themselves to the programme or be introduced by a friend, family member, or GP who thinks they might benefit.

CASE STUDY: COMPASSIONATE NEIGHBOURS

A lady was referred to Strathcarron Compassionate Neighbours for community support following multiple bereavements over the course of the pandemic (husband and two sisters). She had been accessing counselling from the Strathcarron Bereavement Service. Both the lady and her counsellor felt she would benefit more from connecting with her community.

She was introduced to a compassionate neighbour who was much younger than her, but they shared an interest in needlework. The lady reports that she feels she can talk to the volunteer in a way she could not talk with her family. They chat while they carry out needlework projects, sharing knowledge and tips.

**This case study has been anonymised and provided, with thanks, from Strathcarron Hospice.*

JOINT LOAN EQUIPMENT SERVICE (JLES)

Funded jointly by NHS Forth Valley, Falkirk Council, and Stirling Council, the Joint Loan Equipment Service (JLES) offers a range of equipment and aids to enable people to remain in their own homes across Forth Valley. The service primarily operates from a store in Falkirk, with small satellite stores geographically dispersed across the area. The Living Well Service compliments the JLES service as it allows service users to access equipment and aids to self-manage some conditions.

Teams across the Partnership assess patient needs and use the loan service to provide access to almost 200 different pieces of equipment, including:

- Grab aids and handles
- Kitchen, bathing, and toilet aids
- Large recliner chairs
- Hoists
- Hospital style beds

The service operates 52 weeks a year, providing evening and weekend on-call services too. Illustrating the important role that the service plays in supporting people to continue living in their own communities, the service remained fully operational throughout the pandemic.

Over the last year, the service achieved:

- On average, 1,500 items loaned out each month (18,809 in total)
- Delivered to over 6,000 clients across three local authority areas
- Over 10,500 orders processed
- An average three-day waiting period for non-urgent items
- 93% of items delivered within standard 7-day period and 59% delivered on the same day as the order was placed
- A 24% increase on items loaned compared to previous year (18,809)
- Over 6,500 items delivered to 23 local buffer stores across Forth valley (14% increase)
- Over 1,600 pieces of equipment serviced by our technicians and over 400 repairs completed
- 3,400 walking aid items uplifted, inspected, cleaned and 1,800 returned into the supply chain
- Over 15,700 pieces of equipment collected back from clients (25% increase on previous year)

Over recent years, funding partners have acknowledged that the Joint Loan Equipment Service must be refocused, to better meet the needs of current and anticipated future demands. To assist this process, an independent review of the service was commissioned via the Improvement Service.

The Review sought views from key stakeholder groups, including service users and carers, practitioners, senior manager, and JLES staff. Positive feedback included the response to urgent requests, dedication of staff and flexible access arrangements. Areas for improvement include dissatisfaction with delivery times, complex ordering processes, potential waste, or inefficiency through non-return/low reuse of existing stock, performance reporting issues, inconsistencies in processes, and a lack of investment in the service.

After careful evaluation of the Review, the Panel agreed that wider investment into a Forth Valley wide service is the best option to improve the service. Moving forward, a short life project group has been established to oversee the technical and financial developments of this option.

RETURN AND REUSE OF WALKING AIDS

Over 8,000 walking aids are supplied annually by NHS Forth Valley. There was no clear pathway for patients to return walking aids leading to them being discarded inappropriately in clinical areas causing a significant infection control and Health and Safety risk or ending up in landfill sites. The aim of the project was to create a sustainable pathway for walking aids to be safely

returned for use in NHS Forth Valley and prevent inappropriate discarding and waste.

A sustainable pathway was established by utilising QI tools and identified multi-agency partners. A sustainable pathway was then designed for the return and reuse of walking aids across all three local authority areas. We established recycling centres as drop-off points with the Joint Loan Equipment Services (JLES) to collect, safety check, decontaminate, and return walking aids fit for reuse back to NHS Forth Valley.

The project was promoted through local and social media, websites and posters of the return pathway, and ongoing support to staff involved in the process. There was signage at recycling centres, updates on websites, and labelling of walking aids with return information. As a result, 2,073 walking aids returns became fit for reuse. This has saved £8,155 and avoided the environmental impact of 12,894kg CO2E.

To sustain the change, we are providing continued support to Falkirk and Stirling local authority partners, as well as rolling out and promoting the pathway in Clackmannanshire. The analysis of monthly PECOS spends and data collection on returned walking aids is ongoing. We are obtaining user experience of the new pathway from staff and patients and will continue to support and communicate to sustain the pathway moving forward.

Image 3: JLES and NHS Forth Valley staff encourage the public to return unused walking aids and equipment.

Outcome 3:

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

A NATIONAL CARE SERVICE FOR SCOTLAND

On 1 September 2020, the First Minister announced that there would be an Independent Review of Adult Social Care in Scotland as part of the Programme for Government. This review, chaired by Derek Feely, was published on 3 February 2021, where several recommendations were made to improve the quality of social care in Scotland, including introducing a National Care Service.

The Scottish Government launched the consultation of a National Care Service (NCS) for Scotland on the 9 August 2021, which sought public views ahead of the proposed creation of a National Care Service accountable to Scottish Ministers.

In response to the consultation, the Integration Joint Board (IJB) held a workshop with the Strategic Planning Group on 22 October 2021 to consider their response. The focus of the workshop discussion was on four themes from the consultation, of priority to the members. These included:

- Reformed IJBs: Community Health and Social Care Boards (CHSCBs)
- Scope of the National Care Service
- Valuing people who work in social care
- Improving care for people

Three staff and partner engagement sessions were held to seek views on the consultation. The consultation was also widely circulated, with people encouraged to submit views individually and/or as teams or professional groups. The Council also considered their response to the consultation at a special council meeting on 2 November. The HSCP response was submitted to the Scottish Government on the 2 November.

Nearly 1,300 individuals and organisations took part in the consultation. A significant proportion of the responses came from individuals with lived experience, or bodies that represent them. The Scottish Government has published their analysis of responses to the consultation.

PARTICIPATION AND ENGAGEMENT

During 2021/2022, we have continued to adapt the way we involve people as we recover from the Covid-19 pandemic. Though we were able to conduct one consultation event in person, most engagement and consultation activity has continued online.

As outlined in our Participation and Engagement Strategy, involving people with lived experience to improve service delivery ensures they remain at the heart of provision, and that we are taking a person-centred and human rights-based approach to engagement. This approach to engagement was highlighted in the Independent Review of Adult Social Care (IRASC).

In anticipation of the introduction of the National Care Service and new legislative requirements, the Partnership is focusing on enhancing our involvement of people with lived experience to participate in activities across the Partnership. This includes providing training to service users and carers to support meaningful participation for people with lived experience.

Work is currently underway to develop training for staff so they can effectively involve and support carers and service users to participate. The Community Empowerment Team in Falkirk Council delivered community engagement training in 2021 for Tier 5 and 6 Managers. A total of 16 HSCP managers attended the training sessions. In collaboration with the Community Empowerment Team, we are currently developing a pilot training package for staff to support and allow meaningful participation for people with lived experience in strategic and operational-level meetings. This will be delivered sometime in September 2022.

The table below shows some public engagement activity that has taken place during 2021/2022:

Activity	Who was involved?					Outcome or impact on transformation
	Service users	Carers	Community	Staff	Partners	
BSL Plan	✓	✓	✓	✓	✓	
BSL Working Group	✓	✓	✓	✓	✓	
Voices Off	✓	✓	✓	✓	✓	
See Hear Strategy		✓	✓	✓	✓	
Carer Representation on the IJB and Strategic Planning Group		✓			✓	Direct opportunity to inform and direct strategic direction and decision-making process
Carer Representation on the Carers strategy Implementation Group		✓		✓	✓	Ensure appropriate and supported representation

Activity	Who was involved?					Outcome or impact on transformation
	Service users	Carers	Community	Staff	Partners	
Carer Representation on Flexible Respite Panel to agree funding of support to carers				✓	✓	Ensure appropriate decision making.
Carer Representation on group to develop easy read version of Short Breaks statement		✓		✓	✓	Ensure the final document was as accessible as possible.
Partnership approach taken to training delivery.				✓	✓	By training mixed groups from health, social work, care delivery teams, and training teams, staff could share experiences, form relationships, and consider jointly how the approach will benefit the people who use our services.
PPC Providers Networking Group formed.				✓	✓	Care coordinators and trainers from the Falkirk Council care-at-home service and private providers can come together to share best practice.
Monthly service user meetings at the Caledonia Service	✓			✓	✓	Service users have a voice to be heard by the team. It is an opportunity to discuss any issues or new opportunities available to the service.
Presentation on Caledonia service to health partners in Woodlands Resource/Social Work locality teams meeting presentation			✓	✓	✓	To allow our partners in health an opportunity to see what the service delivers, how to refer and what resources are available to new people considering attending.
Local venues resourced to engage in group work/keep well nurse visits.	✓		✓	✓	✓	Inclusion in community areas and groups, looking at overall health and wellbeing for service users.
Partnership working across HSCP within the Caledonia Service.	✓		✓	✓	✓	Partnership working and volunteering increased self-esteem in Caledonia service users and a sense of belonging within a community.

Activity	Who was involved?					Outcome or impact on transformation
	Service users	Carers	Community	Staff	Partners	
Support at Home consultation	✓	✓				Consultation findings support the HSCP and partners to develop the contract strategy and service specification for Support at Home services.
Joint Dementia Initiative (JDI) consultation	✓	✓		✓	✓	Gathered views from staff and service users to improve outcomes and opportunities for service users and re-establish links to enhance partnership and collaborative working.
Diabetes Prevention pathway Engagement activity using Scottish Model of Service design engagement tools	✓		✓	✓	✓	Lived experience shaped pathway development and ongoing Quality Improvement
Gestational Diabetes pathway Engagement activity using Scottish Model of Service design engagement tools	✓				✓	Lived experience is supporting pathway development and ongoing Quality Improvement (PDSA)
Diabetes Education development	✓	✓		✓	✓	User experience of previous diabetes education, desired learning and health need informed programme philosophy and content, including re adult literacy (health, digital, educational)
Prisons work	✓		✓	✓	✓	Content for each group is shaped by desired outcomes at session 1
Why Weight Service	✓			✓	✓	Continuous improvement through feedback from service users, staff, and partners

Table 12: Participation and Engagement Activity

Outcome 4:

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

FALKIRK COMMUNITY HOSPITAL MASTERPLAN

A new masterplan has been developed for Falkirk Community Hospital which will set out the vision for how existing services could be developed, improved, and expanded across the site. This will be taken forward in partnership with local staff, GP practices, NHS Forth Valley, Falkirk Health and Social Care staff, and Falkirk Council.


The Falkirk Herald

Health check for hospital

NHS Forth Valley reveals plans for Falkirk Community site

FULL STORY: PAGES 8 & 9

Bairns get their man


Health

Falkirk Community Hospital: Transformation will create 'seamless' care for patients

Plans to transform Falkirk Community Hospital will create "more joined up and seamless care" for people in the district, it has been promised.

By Kirsty Paterson, Local Democracy Reporting Service

Friday, 4th June 2021, 5:03 pm

Building work that had been due to start on older inpatient units - after they were identified as being a fire risk - has now been put on hold as more ambitious plans for the entire site are explored.

Since December, admission to four of the units had been paused, the number of patients gradually reduced and staff redeployed.

Now, the number of patients remaining in the block is in single figures and it is expected they will all have been discharged by the end of June.

The hospital was identified as one of several community facilities in the Scottish Government's new capital investment programme for upgrading or renewal. Plans to develop a new intermediate care facility will be explored as part of the wider review of the hospital site and there are plans to introduce additional theatre sessions at the hospital to carry out thousands of extra eye operations each year.

Work is underway to transfer outpatient physiotherapy services for people with musculoskeletal issues from Forth Valley Royal Hospital to Falkirk Community Hospital. This will free up space with the acute hospital to expand the new Urgent Care Centre which provides advice, care, and treatment for people with urgent, but not life-threatening illnesses and injuries. Many patients have been successfully discharged or transferred to other community-based facilities which are able to provide short and longer-term care, assessment, and rehabilitation support.

Several workshops took place in September and October to support the development of the Falkirk Community Hospital Master Plan. These workshops were well attended by a wide range of stakeholders including staff, public representatives, and sector specialists. The workshops have been built around the following aspects which will be included within the masterplan:

- Bedded Care
- Ophthalmology
- Audiology and Diabetic services
- Outpatients including community-based screening, continence, and audiology
- Non-clinical and support services including office accommodation, decontamination unit and technical services

The discussions through the workshops have identified the potential of a wellness centre as part of the overall master plan, creating a hub for self-management and wellbeing, bringing together a range of sectors including third sector which could sit at the heart of the Falkirk Community Hospital ambition.

COMMUNITY BED BASED CARE PROVISION

As we start to emerge from the challenges of the Covid-19 pandemic, there has been a significant improvement in the number of cases and outbreaks in our care homes. Over the winter period, the flow challenges across the system in terms of care at home availability have been supported through the commissioning of care home beds as interim and intermediate placements while suitable longer-term care has been sourced.

When looking at the demand for bedded care, including care that requires to be delivered in a community hospital setting, care that requires reablement and rehabilitation, and other residential complex care requirements, it has been identified that there are potential improvements that can be made in relation to our overall provision to match the different types of demand.

While work is ongoing to develop the Falkirk Community Hospital Masterplan, this development is a considerable time away from being delivered, and there is a need to ensure that our current bed-based care provision is fit to meet our needs in the short to medium term. Thus, a review of our bed-based care has begun.

In the meantime, one care home that has been used to support intermediate care placements is Thornton Gardens. In April 2019, the IJB agreed to relocate the respite/short breaks provision for younger adults with learning disabilities from the Rowans to Thornton Gardens, including increasing the capacity from three to four beds for short breaks. In response to the pandemic, it was agreed to temporarily change the purpose of the facility to provide accommodation for both older and younger adults and to increase the number of beds from four to fourteen to provide planned and emergency short breaks.

New intake to interim beds in this facility has now ceased and since April 2022, the Care Inspectorate Registration has been formally changed to support use of the facility for respite for all adults and adult support and protection respite. Two beds at Thornton Gardens have been unavailable throughout this time

due to reprovisioning to support storage and office accommodation. Alternatives are being considered as part of the interim bed-based care review to maximise our available bedded care provision.

This arrangement will ensure sufficient capacity is available to meet the current levels of demand while the wider review is being carried out, and medium-term recommendations developed.

PRESCRIBING PROPORTIONATE CARE

The Falkirk Health and Social Care Partnership joined with the Clackmannanshire & Stirling Health and Social Care Partnership and NHS Forth Valley to provide training to Occupational Therapists, Physiotherapists, Moving and Handling Trainers, and Care Coordinators from Falkirk Council and private providers' care-at-home teams that will allow us to modernise our approach to how we support people who need help with transfers and with moving in bed.

Modernising our approach and introducing new equipment will help us meet the growing demand for care-at-home. We have called the approach 'Prescribing Proportionate Care'. This new approach will ensure a person-centred assessment of moving and handling needs, ensuring the right amount of care and treatment is provided in an appropriate environment. The approach ensures care is not over prescribed and is proportionate to assessed needs. This prevents individual's becoming dependent on care they do not need which can negatively impact a person's independence and wellbeing.

The approach also creates capacity across the whole system as many organisations have reduced the number of care packages requiring two carers by upwards of 40% by implementing this approach. This will free up capacity and allow services to address growing demand and reduce delays safely.

There was joint working with a range of NHS Forth Valley departments to set up and kit out training rooms within Falkirk Community Hospital. We ensured that the limited spaces on each training cohort were filled, swapping places to fill vacancies that arose during a time of significant service challenge due to sickness absence, and high demand on services. We contributed to creating processes and paperwork to guide staff with the implementation at service level and in their work with individual people.

The training is already impacting outcomes for service users as the new approach avoids the need for people to have two carers where equipment plus one carer is appropriate. Thus, facilitating people who can stand, even for short periods, while transferring to do so, and offering increased opportunity for families to care for their loved one if they wish to do so.

MENTAL HEALTH AND WELLBEING IN PRIMARY CARE SERVICES

The Scottish Government has announced funding to support the formation and implementation of the Mental Health and Wellbeing in Primary Care (MHWBPC) Services Model, as proposed in the Mental Health and Primary Care Short-Life Working Group Report.

MHWBPC services are required to be established within an area served by a group of GP practices (locality or cluster area). The service should include a multi-agency team providing assessment, advice, support, and some levels of treatment for people who have mental health, distress, or wellbeing needs. The guidance states that every MHWBPC service should ensure that it provides access to a link worker to support wellbeing, with every GP practice having access to a community link worker who, through their role, will support mental wellbeing. The guidance also covers how individuals should be able to access the service, digital and self-help approaches, and pathways for people who require urgent care.

The services are expected to be developed incrementally by Spring 2026, and funding has been confirmed to support its delivery, building on the funding already in place to support mental health in primary care through Action 15 of the Mental Health Strategy and Primary Care Improvement Funding.

Local planning groups are required to be set up by Integration Authorities, and these groups will be responsible for developing and implementing the MHWBPC services in line with the Scottish Government guidance. For Forth Valley, it is intended, at least for the early planning process, that a single local planning group will be established covering Falkirk and Clackmannanshire and Stirling IJB areas.

PRIMARY CARE MENTAL HEALTH NURSES

Between 2019 – 2022, the Primary Care Improvement Plan aimed to embed a Primary Care Mental Health Nurse model which gave every GP practice access to a mental health nurse for individuals over aged 18 experiencing mild to moderate mental health problems. Since early 2022, this objective has been achieved. The service offers a weekly capacity of 1,157 appointments across all GP practices in Forth Valley (on average over the year). However, this capacity does not meet the needs of all mild to moderate mental health demand in general practice. The demand is variable and waiting times of up to four weeks are common for an appointment with a Primary Care Mental Health Nurse (PCMHN). The demand for mental health appointments seems to be higher because of the pandemic.

Between March and November 2021, there were 15,247 PCMHN appointments in Falkirk. Of these, 81% were attended, 7.1% were unfilled, and 11.9% were not attended. Service evaluation showed that most patients present with concerns relating to anxiety, low mood, or stress. Almost half of PCMHN appointments are new appointments, and half are returns. The primary

outcome for PCMHN appointments is to support patients to engage in self-help. Over 96% of patients referred fit the criteria and less than 2.5% of patients are returned to GP care. Service user feedback completed in July 2021 by 79 respondents showed that 96% of service users felt they had an appointment with the right person and 86% felt the appointment was as soon as they needed it to be.

THE SENSORY TEAM

The Sensory Team is part of the Health and Social Care Partnership and is based in the Forth Valley Sensory Centre in Falkirk. The team work closely with Opthalmology and Audiology colleagues, as well as the Social Work Locality Teams and a range of third sector specialist services to meet the outcomes of clients with sensory impairment.

The team offers support to both adults and children and have good links with local specialist schools and children's services. The team aims to promote independence, reduce risks by making the home and external environments safer and to reduce isolation and anxiety. The focus is on early intervention and prevention to prevent a decline in health and wellbeing and to reduce the impact on frontline social work and health services. The team offers a support service and staff are trained in British Sign Language, Hands on Signing, Deaf Blind Manual, and Lip Reading. The team offers BSL and Sensory Awareness training to colleagues throughout the Partnership and the wider council to meet the aims and objectives of the National and Local BSL plan.

During 2021/2022, the team have provided information and signposting as well as a range of equipment, training, advice, guidance, and support to keep people safe at home and within their local community. They have focused on meeting the agreed quality of life outcomes of feeling safe, having things to do, seeing people, staying as well as you can be, and living where you want and as you want. They have encouraged independence and improved confidence, morale, skills, mobility, and reduced symptoms.

REDESIGN OF RESIDENTIAL CARE: TORWOODHALL

There was significant engagement with residents, their families, and staff to support the transition to new care arrangements, following the decision to close Torwoodhall Care Home. This included collaborative working with Localities Teams to ensure that all residents were well supported by their key workers. All residents and their families participated in individual reviews to ensure that their individual care needs were being met and wishes and concerns were being actively listened to and documented in their care assessment and support plans.

Other agency partners were involved in supporting each resident. This included family members, independent advocacy, psychiatric nursing, and

Care Inspectorate. Regular individual meetings took place with residents in a variety of ways, including face-to-face, Teams and Skype calls.

Social stores and video footage were taken of our in-house residential care homes to enable residents to have a virtual tour of the care homes to minimise unnecessary footfall whilst adhering to Scottish Government and Public Health Guidelines. As everyone's journey progressed, visits were arranged and agreed, with PCR testing carried out. Residents were encouraged and supported to decorate their new rooms to enable and empower them to feel positive about the move and feel fully included at all stages of the process. Most of the residents from Torwoodhall chose to live in Cunningham House or Burnbrae Care Home. Staff were deployed to these homes to support residents with the move and to ensure continuity of care.

Staff engagement took place between January and March with HR and Trade Unions. All staff were supported into social care worker, domestic and cook roles in other establishments within residential care settings. Senior management ensured that all staff choices, work life balance and rotas were considered to support the staff team during a sensitive time, recognising that many staff had worked in Torwoodhall for more than twenty years. Following the residents move, Torwoodhall Care Home closed on the 30 April 2021. The building has been vacated and handed back to Falkirk Council as part of the strategic property review.

STAYING CONNECTED AT CARRONDALE CARE HOME

At Carrondale Care Home, we pride ourselves on our work within our local community and strive to give our best to encourage individuals and local groups to participate in our activity programme. During the Covid-19 pandemic, community participation has been crucial. We have used digital tools for communication to provide residents the opportunity to share their lives with family regardless of the distance and miles that separate them, especially for those who are unable to leave the home.

The main aim of the project is to bridge societal and generational gaps, to promote inclusion, diversity, and equality within the community. Throughout the activity programme, we aim to bring generations together by working with each other, for example, we are recreating a post office at Carrondale for our residents to access with the help of S4 students at Larbert High School Art Department. Plans are ongoing to erect a bus shelter with a seating area for residents and a train station with moving scenery via projector to recreate memories as a meaningful and purposeful activity.

By adopting an intergenerational approach, communities come together by creating meaningful and purposeful connections between generations whilst tackling loneliness and mental health issues. It creates more varied activities and as part of the younger generation's development, they are learning as well as socially interacting, respecting, and understanding the needs of the elderly. This is improving quality of life and eliminating age related barriers.

Adopting an intergenerational approach aims to bring young people and adults together to address social issues which in turn builds relationships and mutual respect by learning from each other. We have found families and the wider community are building lifelong friendships.

The community has come together to help us raise funds for a minibus, which is something the home has never had and would be beneficial to residents, families, staff, and community wellbeing, bringing generations together on reminiscing trips and visiting the local communities to show our support. We have used digital technology to host virtual concerts in aid of our Wheelchair Adapted Minibus Appeal.

Digital technology has been a great way to connect to the community, family, and friends. We have used our giant tablet as a tool to connect to the local primary school performing a pantomime to spread Christmas cheer and to interact with our residents. The residents love to hear from children and staff from local schools, which has been difficult due to the pandemic. However, the residents enjoyed the recorded virtual pantomime, and every child involved wrote Christmas cards for the residents as a thank you.

We have online Arts and Crafts classes hosted by a resident's daughter. We use Facebook live for singers and bands in the garden so that the residents indoors can watch and feel included allowing families to watch along with them and commenting during the live stream. We use an interactive screen for residents with hearing impairments during window and pod visits to aid in communication as masks obscure expression and thus prevents lip reading.

Digital technology has prevented loneliness by sustaining regular contact and communication with loved ones. Tablets are used to rekindle memories and encourage engagement. Laptops and iPads connect friends and family via video apps. Most of the residents own tablets and this allows them to connect with their families and friends whenever they wish.

Image 4: A local resident learning how to use a digital device to keep in touch with family and friends.

A year is a long time to miss out on new grandchildren and great-grandchildren as babies grow up too fast. Using technology, residents have kept in constant contact with their families and felt included with the new-born babies. Our Facebook page is updated daily with activities and

photographs of the residents so everyone can keep up to date with their loved0020ones and observe their overall health and wellbeing, thus giving families peace of mind. The residents at Carrondale Care Home have benefited greatly from using digital technology for family times as it has allowed them to stay connected with their family and friends.

Outcome 5:

Health and social care services contribute to reducing health inequalities.

CHANGING PLACES

Changing Places toilets are different to standard wheelchair accessible toilets, as they come fitted with additional equipment to help people with severe disabilities use toilets safely and with dignity. All Changing Places will include a height-adjustable changing bench, an overhead track or mobile hoist, a peninsular toilet, privacy screen, and enough space for up to two carers.

Image 4: Changing Places Toilet

The Changing Places Consortium estimates that around 230,000 people in the UK with a range of disabilities benefit from these facilities. This includes people with severe and multiple learning disabilities, such as Cerebral Palsy, Motor Neurone disease, Multiple Sclerosis, people recovering from a stroke, and some older people.

Falkirk HSCP is currently working to install a minimum of 12 new Changing Places across the Falkirk area. The Partnership's Changing Places working group includes members of Falkirk Council, Falkirk Town Centre, Falkirk HSCP, local service user representatives, and Changing Places advocates. Current Changing Places in the Falkirk area include:

- Carronbank
- The Mariner Centre, Camelon

- Grangemouth Sports Centre
- Forth Valley Royal Hospital
- Forth Valley College
- Helix Park Falkirk
- Oswald Avenue Day Centre, Grangemouth
- Dundas Resource Centre, Grangemouth

THE HERBERT PROTOCOL

Police Scotland has adopted a single national process to help officers quickly obtain information about a vulnerable missing person who has dementia, saving vital time in the early stages of an investigation. The national implementation of the Herbert Protocol has been developed in partnership with Police Scotland, Health and Social Care Scotland, Alzheimer Scotland, and the Scottish Government.

The Partnership supports The Herbert Protocol by sharing the news release of the national launch of the Protocol and promotion of the App on the HSCP website, social media, and newsletter. Continued promotion of the Protocol will support awareness raising and information sharing on these important initiatives. This work linked closely with the promotion of Power of Attorney (POA). The Partnership participated in POA day and took part in national media and social activity.

RECONNECT

Produced by the Scottish Chamber Orchestra, ReConnect is an interactive music-making project which aims to bring people living with dementia and their carers together through music to improve wellbeing and quality of life, whatever a person's age or stage. People are invited and supported to sing, play instruments, improvise, and listen. Since 2013, in partnership with NHS Lothian and the University of Edinburgh, ReConnect has been developed for specialist use in healthcare settings, helping people with dementi a through the creation of improved pieces that draw upon people's moods or movements.

500 DVD copies of the ReConnect series were made available to Falkirk's care homes, community groups, individuals, and their carers. The DVDs have been provided as part of the Partnership's ongoing Covid-19 action plan, aimed at supporting groups and communities affected by the impact of the pandemic.

FOOD TRAIN

Food Train is a charity that provides lifeline shopping and befriending services for older people. It is highly acclaimed for its work to tackle malnutrition and loneliness among older people, already operating in nine other Scottish local authority regions.

Image 5: Food Train Delivery Service

The service has been commissioned by the Partnership to help residents aged 65 and over to live better lives in their own homes. This includes its award-winning home shopping and delivery service as well as household support, meal sharing, and befriending schemes. With the vital support of its volunteers, Food Train helps people to reconnect with their local communities and provide a friendly helping hand with everyday tasks, which can be on a regular or as-needed basis to suit people.

In its first six months, the new Falkirk branch has established four new services: the grocery shopping service, hospital discharge food support service, befriending service, and household support service. So far, 68 older people are being supported on a regular basis with the support they feel best meets their needs.

Food Train currently have 20 active volunteers working across the services, with volunteer recruitment ongoing to steadily grow their volunteer team to match growing customer numbers. Food Train have been working with the Falkirk Council Disabilities Team and have recruited two volunteers with additional support needs, who are being supported to play a vital role in the delivery of Food Train's shopping service.

CASE STUDY: FOOD TRAIN

Before joining Food Train's Befriending service, *May, who provides care for her partner, Jack, was anxious to leave him at home alone.

Food Train helped May and Jack to find a 1:1 befriender match to support them. The befriender now visits the couple regularly to help May to get out and about without worrying about Jack.

This provides regular short breaks from caring for the couple and the opportunity to do some tasks outside the home that May would otherwise not be able to do.

**This case study has been anonymised and provided, with thanks, from Food Train Falkirk.*

DIGITIAL INCLUSION

The Partnership has participated in Digital Inclusion Schemes, including the Fairer Falkirk Digital Inclusion Fund and Connecting Scotland, where a small number of devices were acquired for individuals who were isolated or digitally excluded. We worked with Community Learning and Support and AbilityNet, a volunteer group who acted as digital champions to support individuals who received the devices.

A series of digital inclusion events called "Tech Tea Parties" are being planned for 2022/2023. These informal events will help individuals to learn some basics about technology with support from AbilityNet volunteers. Sessions are targeted to groups who use Health and Care services, such as Care Homes or Sheltered Housing residents, Social Work service users, and people waiting for a package of care.

HEALTH PROMOTION SERVICE COVID-19 RECOVERY GRANT SCHEME

The aim of the scheme was to support local organisations and community groups across Forth Valley in their response and recovery throughout the Covid-19 pandemic. The primary focus on the scheme was to reduce health inequalities and improve mental wellbeing. Organisations and groups could apply for up to £500 to support them to recommence activity or start new activity as a response to Covid-19.

The grants allowed communities to take forward innovative ideas to respond and recover from the impact of Covid-19, ensuring that support is there when people need it most. They also enabled groups and organisations to adapt their way of working, to reduce health inequalities, and improve mental health and wellbeing.

- 23 applications were received from the Falkirk area
- 13 organisations operating within the Falkirk area received a grant of approximately £6,500
- 16 applications served other areas in Forth Valley, including Falkirk
- 9 organisations operating within the Forth Valley area, including Falkirk received a grant of approximately £11,000

As communities need support to meet new challenges post Covid-19, including the cost of living crisis and fuel poverty, there will be a return to the Community Grants Scheme for 2022/2023. Mindful of the ongoing impact of Covid-19, we continue to welcome applications with this focus.

Outcome 6:

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and 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. 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.

The Covid-19 pandemic and subsequent national lockdown in March 2020 interrupted the work of the Carers Strategy Implementation Group, including the continued development of the Carers Strategy Action Plan. This group restarted on 16 March 2022 and are now called the Carers Strategy Group. Ensuring that Falkirk HSCP carries out the legal duties and requirements under the Carers (Scotland) Act 2016 remains one of the main purposes of this group. **The Carer's Strategy is due for renewal this year and this group will be reviewing the strategy to ensure it's aligned with the Strategic Plan and developments towards the National Care Service following the Independent Review of Adult Social Care 2021.**

Since the beginning of the Covid-19 pandemic, the Short Breaks Bureau team and the Self-Directed Support team have been working in close partnership with Falkirk and Clackmannanshire Carers Centre to offer coordinated support to carers. The pandemic has reduced or withdrawn many services, and this has increased the levels of caring by unpaid carers. Many people have become carers for the first time because of reduced service provision. This has inevitably led to increased stress for carers and an increase in their caring role.

To address this, personal assistants were eligible for up to £500 national bonus thank you payment in line with other health and social care staff. SDS Forth Valley has indicated a high uptake of payments. Carers have continued to be supported through the provision of Personal Protective Equipment (PPE) and information on the vaccination programme for carers.

Short break options continued to be delivered where pandemic restrictions allowed and Covid-19 testing was supported to enable these to happen. The team delivered flexible respite payments to expand options to carers who

were unable to access sufficient overnight breaks, e.g., purchase of laptops, tablets, garden furniture, exercise equipment, and online courses. A small working group was established to produce an 'easy read' version of Falkirk Short Breaks Services Statement, which has now been published online.

Despite the challenging circumstances, the Carers Centre has continued to provide a full range of services and support to carers. In addition, in response to feedback from local carers about the need for better communication, up-to-date information, and ongoing emotional support, funding from the Partnership was secured to employ a Digital Development Worker and two Telephone Support Workers, which has allowed the centre to extend service provision and reach.

In 2021/22:

- 1,988 adult carers received individual support by phone, email, or online
- 637 identified as new carers
- 506 carers offered or requested an Adult Carer Support Plan
- 474 Adult Carer Support Plans were completed
- 87 carers offered a Young Carer Statement
- 47 Young Carer Statements were completed
- 35 people accessed flexible respite funding
- 82 carers received a short breaks grant
- 1,158 carers were referred to the CAB 'Help for Carers' project for financial support
- 181 digital carers cards were issued to carers
- 3,239 carers are currently on the Carers Centre mailing list to receive regular information
- 940 carers attend 114 Care with Confidence sessions
- 745 carers attended 111 regular group sessions, including the Men's Group, Chair Yoga & Mindfulness sessions, and Young Carers and Young Adult Group sessions.
- 97 involvement opportunities, such as Carers Forum meetings, surveys, and consultations were promoted to 3,695 carers.

During 2021/2022, carers have been encouraged to think about their own outcomes (rather than focusing only on those of the cared for person) to improve their health and well-being during the restrictions imposed due to the pandemic. This enabled us to deliver support that created 'safe spaces' at home or in the garden where carers could relax. The use of technology enabled carers to access online contact with friends, family, groups, etc. Exercise equipment e.g., static and outdoor bikes enabled carers to exercise and spend some time on their own health and wellbeing.

Carers most in need were still able to access a limited amount of overnight short breaks either by using care home support, alternative 'holiday' type breaks, as restrictions eased, and hours of support at home in place of overnight breaks away from home.

There was a programme of online activities for carers during Carers Week in June 2021, including a daily prize draw of short breaks from local hospitality providers and various family events. During the festive period, the Carers Centre hosted an 'in-person' Carers Christmas Lunch and organised a prize draw to mark the 'Five Days of Christmas'.

Ref	Measure	2019/20	2020/21	2021/22	Direction of travel
60	Percentage of service users satisfied with their involvement in the design of their care package	99%	98%	98%	◄►
61	Percentage of service users satisfied with opportunities for social interaction	91%	89%	90%	▲
62	Percentage of carers satisfied with their involvement in the design of care package	93%	93%	90%	▼
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%	91%	◄►

Table 13

CARER REPRESENTATIVE TRAINING PROGRAMME

The Coalition of Carers in Scotland and Carers Scotland were funded by the Health and Social Care Alliance to develop and deliver a carer representative training programme in local authority areas. The Falkirk Health and Social Care Partnership was one of the five local authority areas chosen to participate in the pilot.

The training was co-produced by carers and delivered in partnership with carer representatives, local carer centres, and local Health and Social Care Partnerships. The project was originally planned to be delivered in 2020, but due to Covid-19, the training was adapted to be delivered online in March 2021.

The training has helped prepare carer representatives and increased their confidence and ability to engage and contribute meaningfully to meetings and to influence local development. Since the training, carer representatives have participated in meetings with the Coalition of Carers and local focus groups, such as the Dementia Friendly Steering Group and the Cross-Party Group for Carers. They have also been involved in engagement sessions regarding the Care at Home tender, the Joint Loan Equipment service, and Near Me.

Based on the success of the pilot training programme, we have extended the programme to include both carers and service users. The goal is to increase our representation of people with lived experience and encourage them to

get involved in a range of strategic and operational-level service redesign meetings. The training programme was designed and delivered in collaboration with the Coalition of Carers in Scotland (COCIS), Carers Scotland, Falkirk & Clackmannanshire Carers Centre, Inclusion Scotland, and Independent Living Association Forth Valley. Three sessions were delivered to eight carers and service users in April and May 2022.

SELF-DIRECTED SUPPORT (SDS)

Progress towards full implementation of Self-Directed Support has continued despite Covid-19. Due to the continued impact of the pandemic, some services are running at limited capacity, and this means individuals and carers are not able to access the same level of support and care that was available before Covid-19. Pandemic SDS Guidance from the Scottish Government and COSLA was updated in February 2022, and it encourages HSCPS *"to maximise flexibility and autonomy for the support person in meeting agreed outcomes."* It also highlights the need for worker autonomy to reduce process. We continue to be as flexible as possible and to try to ensure processes are not slowing down delivery.

The SDS team continuously links into national and local developments and organisations where practice can be shared, and continuous learning achieved to inform local approaches.

We continued to support those with care and support needs and their carers while taking a flexible approach. An example of this is the continuation of the 'Flexible Respite' budget which enables eligible carers to use up to £1,000 per year, from their overnight respite funding, to access alternatives to an overnight break from their caring role. We continue to work in partnership with Falkirk and Clackmannanshire Carers Centre to process and agree Flexible Respite requests, ensuring that these will meet the outcomes for carers. This includes purchasing items or activities to support them in their carer role, for example, exercise equipment, garden furniture, and technology.

Partnership working with the third sector was enhanced further during the pandemic, including through our work with the local support service SDS Forth Valley. Direct Payments were maintained to ensure Personal Assistants could be retained and those with support needs were able to meet their employer obligations. Personal Assistants have been able to return to work and provide the care and support required by their employers. There was some limited uptake of employment of family members as personal assistants (this is a complex area that can impact on income, including welfare benefits) particularly where individuals were shielding. All of these arrangements were supported by SDS Forth Valley to ensure the right processes (HMRC, payroll, insurance) were in place.

We have been working with SDS Forth Valley through their Support in the Right Direction funding from Scottish Government (SiRD). This consists of a pilot project with the Central Locality Social Work Team to try to identify

people early when an assessment or review is requested. The aim is to provide advice and information about what to expect at assessment, potential to access community or personal resources/networks and information about SDS Options, should there be eligible support needs identified through social work assessment. The learning from the pilot will be used to help streamline processes and support people that are waiting for assessment.

SDS Forth Valley has developed a hybrid model for meeting with service users and carers to support them with advice, information, and practical support to understand the SDS Options and to help them set up their support. Several videos are now available along with fact sheets and the opportunity to meet online or in person to go through the range of options and set up support. This has worked well for individuals, families, and carers, particularly where people work during the day and can't attend face-to-face meetings.

We continue to supply and deliver PPE to employers for their personal assistants.

We have delivered several briefings at Social Work team meetings to help staff keep up to date with developments and to support new staff to understand Falkirk processes.

Ref	Measure	2019/20	2020/21	2021/22	Direction of travel
37	SDS Option 1: Direct payments (data only)	27 (0.6%)	29 (0.7%)	-	n/a
38	SDS Option 2: Directing the available resource (data only)	101 (2.2%)	17 (0.4%)	-	n/a
39	SDS Option 3: Local Authority arranged (data only)	4,009 (88.8%)	4,128 (92.7%	-	n/a
40	SDS Option 4: Mix of options (data only)	376 (8.3%)	279 (6.3%)	-	n/a

Table 14

Requests for different SDS options continue with more enquiries in relation to Option 2, due to the more flexible approach which it brings when support/services may not have been operating as normal or with a reduced service. Lack of capacity among care and support providers has also led to an increase in Option 2 requests.

Moving forward into 2022/2023, the Short Breaks and SDS Teams will review the effectiveness of changes made with a view to learning from the experience of the pandemic and ensuring this is used to improve delivery of SDS for individuals and carers.

Outcome 7:

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

FALKIRK ALCOHOL AND DRUG PARTNERSHIP (ADP)

The Falkirk Alcohol and Drug Partnership (ADP) and the Falkirk HSCP work jointly to deliver outcomes for local communities and to relieve the burden of alcohol and drug-related harm across the Partnership. This is done through better alignment of area-wide drug and alcohol and HSCP Mental health services.

During the past year, ADP commissioned services have been able to maintain an excellent level of access to those who require support for their own or a loved one's substance use. We have seen a large increase in the number of people seeking help during Covid-19, and this upward trend has continued to be a feature as we move into the next phase of managing the pandemic.

Staff within these services, both statutory and third sector, have continued to demonstrate their resilience by managing increased waiting times and working with recruitment challenges, which decrease capacity. There have been many examples of solid partnership working throughout this period.

The Medication Assisted Treatment Standards have now been formally launched by the Scottish Government with an expectation that all ADPs work towards fully embedding standards 1 to 5 (of 10) by April 2023. Local work continues in pursuit of delivery of these service standards within the scheduled implementation timeframe.

A full and robust implementation plan is in place to underpin this work and a MAT Project Lead has been recruited to work with Clinical Leads, ADP Lead Officers, and ADP Chairs pan-Forth Valley to ensure this valuable work to address drug-related harm and service access is delivered on schedule.

Another key successful of the year was the design and development of the Forth Valley Overdose Outreach Team. This multi-agency assertive outreach team will respond to those who experience a Near-Fatal Overdose and is expected to be operational by July 2022. This is a further key element in reducing drug-related deaths across Falkirk and the wider Forth Valley area as evidence shows that people who suffer one or more NFOs are more likely to die from drug-related harm.

Forth Valley Recovery Community and the Forth Valley Family Support Service continued to offer their online services whilst gradually increasing face-to-face contact safely. This hybrid response has enabled services to maintain essential contact with service users and peers in areas where physical service access may be limited or where people traditionally choose not to engage at that level. The Recovery Cafes, SMART Recovery Groups and

Family Support Groups recommenced in a staged planned way, as did access to all other substance use services.

The investment made to Forth Valley Recovery Community and Change Grow Live through Falkirk HSCP Covid-19 Mobilisation funding has resulted in the successful pilot of Assistant Recovery Workers and Assistant Harm Reduction Workers being funded by the CORRA Foundation. The pilot venture proved to be a great success and has provided employment to those farthest from the employment market.

Finally, recruitment for a new ADP Lead Officer has been successful and he has recently joined the Partnership, after the post was vacant for more than two years. This is a key development for Falkirk ADP at a time when the national focus on drug-related deaths and how the Scottish Government's National Drug Mission is delivered locally is spotlighted.

During the interim period, the ADP has been supported by the Forth Valley wide APP Coordinator as part of their wider role. Although this support has been invaluable, there is now a considerable amount of work to be progressed to review and develop Falkirk ADP, including refreshing the current Delivery Plan.

Ref	Measure	Oct-Dec 20	Oct-Dec 21	Direction of travel
68a	Substance Use - Percentage of patients that commence treatment within 3 weeks of referral – Forth Valley Alcohol & Drug Partnership (90% target)	94.5%	90.5%	▼
68b	Substance Use - Percentage of patients that commence treatment within 3 weeks of referral – Forth Valley Prisons (90% target)	100%	100%	◄►

Table 15

ALCOHOL AND DRUG DEATH PREVENTION

From 1 January to 20 April 2022, there have been 20 suspected drug-related deaths reported across the Forth Valley area. 60% of these cases have been males with the average age being 40.8 years.

In August 2021, the Strategic Prevention Coordinator for Suicide and Drug Deaths came into post. This post has a direct remit for suicide and drug death prevention and is aligned to Public Health. At the same time, the Alcohol and Drug Partnerships were also awarded funding to support the recruitment of the Substance Use Death Reviewer post. This post brings additional capacity to support the multi-agency review of drug deaths. Both posts have a Forth Valley remit.

As well as overseeing the expansion of the Drug Related Death (DRD) review process, key tasks being progressed include the development of the Forth Valley Suicide and DRD Prevention Plan as well as the establishment of the Senior Leadership Group/Prevention Partnership.

Significant work has been undertaken to streamline the Drug Related Death (DRD) Review process so that all cases are now reviewed through a single multi-agency process. A range of partners are involved in each review including NHS Forth Valley, Social Work, Housing, Scottish Prison Service, Scottish Ambulance Service, Substance Use services, and Forth Valley Recovery Community. Across five review meetings, the team have reviewed 49 cases.

The soon to be developed Leadership Group/Prevention Partnership will be an important forum, along with the Partnerships, Alcohol and Drug Partnership's (ADP) and Community Planning Partnership's (CPPs) to highlight the outputs and findings from reviews and to facilitate learning and aid strategic planning. Moving forward, alcohol-related deaths will be reviewed using the same model.

The team supporting the DRD review process is also supporting the expansion of the suicide review process. Currently, suicide reviews take place where the individual was known to statutory mental health services/substance use services in the twelve months before their death.

Moving forward, all deaths by suicide will be reviewed to maximise opportunities for learning and to take a public health approach to prevention. Police Scotland now shares notifications of all probable suicides with the review team. This allows us to potentially identify themes and trends that may require a response such as the method and location of incidents. An agreed model for the review of all probable suicide deaths will be completed by the end of 2022.

OVERDOSE AWARENESS AND NALOXONE TRAINING

The delivery of Overdose Awareness and Naloxone training is targeted to participants and groups across Forth Valley who are most likely to be confronted by an overdose situation, predicated on the evidence that most drug-related deaths occur when other people were present who could have provided emergency life support to prevent death. Our training aims to equip participants with the knowledge, skills, and confidence of what to do in an overdose situation and how to administer naloxone.

Prior to Covid-19, this training was delivered face-to-face, however, due to the pause on face-to-face training delivery, the session was adapted for delivery on MS Teams throughout 2021/2022. A total of 50 participants from Falkirk attended the sessions.

SUPPORTING PEOPLE AFFECTED BY HOARDING DISORDER

Policy and guidance have been developed for multi-agency partners to provide supportive and effective interventions with adults who experience self-neglect or exhibit hoarding behaviours. It is important that our practice is collaborative, proactive, and informed by evidenced based practice. Where this is the case, the adult and their families receiving our interventions will have a better experience and feel empowered to make the changes they want, to live the life that they want, to feel safe, and to realise their potential.

Depending on the extent of the self-neglect and/or hoarding behaviours the adult is experiencing, there will be different levels of intervention and in some instances application of legislation will be indicated. It is important that all partner agencies are alert to the signs of self-neglect and hoarding and offer supportive early and effective interventions.

A multi-agency self-neglect and hoarding training course was delivered and developed in partnership with Fire and Rescue, Health and Social Care Partnership, Housing Services, Food Train, and Transform Forth Valley. An element of the course focuses on raising awareness of the signs and indicators, causes and effects of malnutrition in older people, that are not necessarily directly related to self-neglect.

The learning materials are kept under review and updated to ensure that all staff have access to up-to-date information, guidance, and training in this complex area of practice. The course is routinely evaluated with feedback from participants being used to inform and develop future learning and development resources.

Finance was secured to fund a part-time support worker within Transform Forth Valley to work with local people engaging in hoarding behaviours in partnership with statutory agencies. This post supports individuals while seeking to develop other services and resources for people affected by hoarding and self-neglect.

Between December 2021 and June 2022, six courses have been delivered with further courses planned for until December 2022. 100 staff from across the Partnership have attended these courses. 54% of attendees were from Corporate and Housing Services, 23% from Adult Social Work services, 12% from non-statutory services (including 6% from Transform Forth Valley), 7% from Home Care services within Falkirk Council, 3% from NHS Forth Valley, and 2% from Fire and Rescue Service.

While take up from colleagues within Corporate and Housing services is very encouraging, take up from adult services staff across the HSCP, particularly NHS Forth Valley staff and Adult Social Work staff is less encouraging. Future information about the course will be more focused and promoted to Falkirk Health and Social Care Partnership staff.

The Learning and Development Subgroup of the Adult Protection Committee is responsible for ensuring that all levels of the workforce have access to an appropriate level of Adult Support and Protection training this includes self-neglect and hoarding.

Ref	Measure	2020/21	2021/22	Direction of travel
45	Number of Adult Protection Referrals (data only)	805	1,101	-
46	Number of Adult Protection Investigations (data only)	164 (76 SW, 88 Police only)	65 (40 SW, 25 Police only)	-
47	Number of Adult Protection Support Plans at end of period (data only)	20 (at 31/03/21)	18 (at 31/03/21)	-

Table 16

COVID-19 VACCINATION PROGRAMME

The Covid-19 vaccination programme continued across the Forth Valley area. NHS Forth Valley offered everyone over the age of 18 their first vaccine, but not everyone has taken up this offer as 92% of Falkirk residents aged over 18 received a first dose of the vaccination and 82% received the second dose. To improve uptake rates in younger cohorts, NHS Forth Valley worked with Falkirk and Stenhousemuir Football Clubs to vaccinate on match days during August 2021.

All young people who are over twelve years with a neuro-disability or is immune-suppressed as well as those who live at home with someone who is immuno-compromised or suppressed were offered a vaccine from the 9 August 2021 to vaccinate them all prior to starting school after the summer holidays.

The main adult flu and Covid-19 booster/third dose programme started on 27 September 202 with the immuno-suppressed and clinical extremely vulnerable population. Community vaccination centres were established in Falkirk with temporary 'pop-up' vaccination sessions available at Bo'ness Sports Centre. Bo'ness was identified as the location for the 'pop-up' sessions due to the distance to Falkirk Community Hospital and the demographics of the community. Overall, the main adult programme was slow to start due to some staff absences. However, military personnel were recruited to aid in rectifying this.

Many Community Pharmacies were contracted to administer flu vaccine to everyone who is eligible. There was also a door-to-door transport service available to people who are without transport or who might struggle with

public transport. Dial-a-journey was used successfully during the COVID vaccination programme to support people.

For housebound patients, the district nursing teams, and the Immunisation Team administered the vaccine during home visits. Pupil-facing education staff including janitorial, admin and catering, had an opportunity to receive their vaccination in school in November. Patient-facing health and social care staff use a self-appointing portal to arrange vaccinations. These were administered either by Occupational Health Services, in community centres, or by community pharmacy (flu only).

NHS FORTH VALLEY HOSPITAL COVID-19 TREATMENT

New treatment for patients who are at very high risk of becoming extremely unwell with Covid-19 symptoms was launched across the UK on 22 December 2021. The aim of the treatment is to reduce the severity of the disease and to avoid hospital admissions for the most vulnerable people, for whom the vaccine may not have offered protection.

There are a group of ultra-high-risk patients, who are a subset of the current shielding or high-risk patient group. The criteria for inclusion on the ultra-high-risk list was determined by specialists UK wide. Public Health Scotland (PHS) have applied these criteria to patient databases and identified around 150,000 patients for Scotland. The nationally provided list was not 100% complete with up to 15% of eligible patients not identified by this national process. NHS Forth Valley established a process to identify patients who were not on this list, with specialist teams applying the criteria to their own patients and adding them to the list.

All patients identified by PHS received a letter advising them that they may be eligible for this treatment. Further criteria must also be met before treatment can be offered, i.e., the patient must have mild to moderate symptoms and have had symptoms and a positive test result for less than five days. If they have no symptoms or if their symptoms have persisted for more than five days, treatment cannot be given. Most patients identified are adults, however the ultra-high-risk group included children aged 12 to 18.

The NHS Forth Valley service is open to all patients who meet the criteria. NHS Forth Valley is proactively contacting patients. Twice daily, the positive PCR results for Forth Valley are mapped to the ultra-high-risk list to identify patients who may be eligible for treatment. They are then contacted by way of a Netcall message.

There are two treatment options currently available. The first treatment option is a one-off IV infusion of a monoclonal antibody drug. The second treatment option is a course of oral antivirals. This is used if the first option is unavailable, the patient has breached the five-day window for treatment, or they do not wish to have the IV treatment.

IV treatment is currently provided in the acute hospital, however further work is underway to explore a sustainable model for delivering the medication, which takes between two to three hours. The oral medication is taken by the patient in their own home and dispatched by taxi, given the time constraints.

There are currently 4 Ultra-High-Risk treatment pathways for Forth Valley patients:

- Adult
- Children aged 12 to 18
- Pregnant women
- Renal haemodialysis patients

The pathways follow the same criteria and processes for assessing eligibility and obtaining consent, but the delivery of treatment is different. Any children meeting the treatment criteria will only be offered IV treatment and this will be given in the paediatric unit. For pregnant women, again only IV treatment is appropriate, and this is delivered in the maternity department. As renal haemodialysis patients attend for dialysis three times a week, their treatment will be given while they are in the renal unit for dialysis.

CHANGES TO THE LAW: FIRE AND CARBON MONOXIDE DETECTION

The Scottish Government changed the law on fire and smoke alarms. The introduction of smoke and heat alarms in the Tolerable Standard guidance is in recognition of the danger fire poses to the occupants of a property and is intended to reduce the risk of loss of life or injury in the event of fire.

By February 2022, every Scottish home must have:

- One smoke alarm in the living room or the room used the most
- One smoke alarm in every hallway or landing
- One heat alarm in the kitchen
- One carbon monoxide (CO) detector if the home has a carbon-fuelled appliance, such as a boiler, fire, heater or flue

Telecare systems are provided in addition to the interlinked systems. In the context of the new legislation, telecare customers at high risk of harm from fire should receive the same level of protection from their telecare system as they do from the 'satisfactory equipment' stated in the Tolerable Standard.

The Partnership has increased the telecare equipment required and, as the only digital Council in Scotland, will be replacing all fire and smoke equipment with digital, interlinked equipment.

FRIENDS OF FORTH VALLEY FIRST RESPONDERS

Run by Falkirk Council in partnership with Falkirk Health and Social Care Partnership, Community Choices aims to provide local people with a way to

apply for public funding to improve their local area and vote to decide how public money is spent.

Image 6: Friends of Forth Valley First Responders install Public Access Defibrillators across the Council area.

Friends of Forth Valley Responders submitted a bid to the Falkirk area-wide category of Community Choices and secured £73,485 to install lifesaving equipment in each council ward.

Set up in 2013, the Falkirk-based charity supports the work of Forth Valley First Responders (FVFR), a group of volunteers trained by The Scottish Ambulance Service to attend 999 emergencies before the arrival of an ambulance. By raising funds, the charity helps cover the running costs of FVFR and supports public education initiatives and the promotion of good healthcare across Forth Valley.

It also buys lifesaving equipment and will use the Place-based Capital funding to further improve access to Public Access Defibrillators (PADs) by installing an additional 45 PADs in the local area – five in each council ward.

MOBILE EMERGENCY CARE SERVICE (MECS)

Our MECS Service continues to provide telecare to support individuals to live independently at home knowing that a response service is on call to assist should they raise an alarm. This gives individuals independence and their families peace of mind.

The Council of the Future Analogue to Digital Telecare Project became the first local authority in Scotland to go live with an end-to-end digital telecare service, securing the Gold Level 1 Digital Telecare Implementation Award in 2021. The project was one of six shortlisted in the category which aimed to shine a light on 'an individual, group, or organisation who has used technology to help their local community'.

Falkirk's MECS Service have been a frontrunner in Scotland in terms of upgrading the systems and equipment in preparation for when Scotland's telephone lines switch over from analogue to digital. This work was essential to avoid call failures, but the faster connection speeds and higher reliability also provides opportunities to explore what can be done with lines that can handle significantly more data. This potentially widens the range of monitoring data.

The set-up of new devices is quicker, offering more efficient processes for configuration and updates. It provides the service with real time visibility of the connection status of devices, meaning that faults can be detected sooner, and the service can be more responsive should an alarm go offline. Improved data capture has the potential to enable more timely sharing of user information where appropriate and, in this way, strengthen partnership working.

Image 7: Pauline Waddell and Ian Whitelaw with the digitally enabled MECS box.

The Partnership collaborated with Falkirk Council on a pilot project where Smart Speaker devices were provided to MECS service users. The outcome of

the project was very encouraging. Individuals engaged with digital technology easily using their voice and, as such, it reduced digital skills barriers.

It has enabled individuals to call MECS if they have a fall and aren't wearing a pendant alarm then they could use their voice to summon help through their device. Since the devices could be linked to smart technology such as plugs, heating, and doorbells it has provided practical solutions for individuals with limited mobility. Further work is required in 2022/2023 to upscale the project to explore the governance and potential risks.

Ref	Measure	2019/20	2020/21	2021/22	Direction of travel
48	The total number of people with community alarms at end of the period	4,087 (at 31/03/20)	3,989 (at 31/03/21)	3,811 (at 31/03/22)	-

Table 17

Ref	Measure	2018/19	2020/21	2021/22	Direction of travel
49	Percentage of community care service users feeling safe	90%	89%	88%	▼

Table 18

Outcome 8:

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

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. This has remained a key priority during 2021/22.

We continue with our ambition to be recognised as a Learning Organisation. This shapes and influences our approach to all training, learning, and development. We strive to follow the five golden rules in this respect:

- Encouraging experimentation
- Thrive on change
- Reward learning
- Facilitate employees to learn from one another
- Encourage learning from our surroundings

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

MULTI-AGENCY TRAINING FRAMEWORK

We are committed to delivering a comprehensive training framework. Evidence of this was recognised during the recent Joint Inspection of Adult Support and Protection in Falkirk. The inspection team commented in their report that: "The partnership had a comprehensive and robust multiagency training programme." (Page 7)

The report goes on to state: "The partnership delivered a comprehensive multiagency training programme accessible to all agencies. The partnership's work around supporting care homes was collaborative and supportive." (Page 26)

Joint Inspection of Adult Support and Protection Report – Care Inspectorate February 2022

We have prioritised continued delivery of our multi-agency training programme, regularly reviewed and updated to ensure that all staff have access to up-to-date information, guidance, and training. The programme reflects our approach to blended and flexible learning, providing learners with access to 'just in time' online learning as well as induction and tiered learning depending on job role and experience. All training delivery is routinely evaluated with feedback from participants being used to inform and develop future learning and development resources.

All staff across the Partnership and beyond have access to a web-based information and learning resource (Forth Valley Practitioner Pages) where they can access a full range of information across the spectrum of Public Protection, and also directly book places on adult support and protection training.

ADULT SUPPORT AND PROTECTION (ASP) TRAINING FOR TRAINERS AND CHAMPIONS FORUM

We have developed a training programme for experienced and motivated care home practitioners to assist them in the delivery of ASP training to their staff team within their own agency or setting. This training includes all the necessary materials required to deliver ASP bespoke training with individual agencies or care home settings, ensuring that residents and service users are safe from harm. This is accompanied by appropriate support from Falkirk Health and Social Care Partnership staff towards ensuring a consistent, high-quality standard of ASP practice within and across the Partnership.

One of the supports available is the development of Care Homes ASP Champion's Forum. The first Champions Forum is scheduled to take place in Summer 2022 and planned to run quarterly throughout the year.

Course participants become 'ASP champions' within their setting or organisation following successful completion of the training for trainers. The forum will provide opportunities for Champions to come together to discuss and share practice related to Adult Support and Protection concerns in a care home setting. This will include harm prevention through the implementation of early indicators of concern framework. Champions will also receive support to develop an ASP plan for their service.

14 Residential Care Providers from both the third and private sectors, along with Falkirk Council are represented.

ADMINISTRATION OF MEDICATION TRAINING FOR HOME CARE SERVICE

The rollout of the administration of medication training programme for personal carers recommenced mid-2021 in the Central Locality after being impacted by the Covid-19 pandemic. The training is underpinned by the updated Adult Services Care & Support at Home Medication Policy.

Three Pharmacy Technicians were recruited towards the end of 2021 to support the programme working alongside Social Work Training and Workforce Development Service. In 2022, the technicians took over the delivery of the training with implementation plans being developed for rollout in the other two locality areas.

Key elements of this training include a competence test and individual feedback. This supports the personal carers to carry out administration of medication for service users who require this support. They are also able to respond to and meet an individual's medication needs in their own home, which can potentially prevent hospital admission.

PRESCRIBING PROPORTIONATE CARE (PPC)

Staff from Social Work Training and Workforce Development Service contributed to the planning of a new multi-agency delivery approach to the provision of social care packages of care. This involved Falkirk, Stirling, and Clackmannanshire Councils and NHS Forth Valley.

A series of training events were arranged for health and social care workers who have responsibility for assessing for the provision of Moving and Handling Risk Assessments. This training took place between January and April 2022. The focus was to equip workers with the skills and knowledge to help them identify where a reduced carer care package would be appropriate. The approach enables care to be delivered with dignity, consistency, and supports person-centred care through appropriate encouragement of independence.

Following this training, a series of familiarisation sessions were arranged for Moving and Handling Liaison Workers employed within Falkirk Council and the Third Sector in April and June 2022. These sessions ensure that information about the new approach and additional equipment available is understood more widely by other workers who participate in risk assessment and provide carer support with moving and handling tasks.

Training and Workforce Development staff have helped to identify and meet prior training needs for staff attending Prescribing Proportionate Care (PPC) training. In-house Moving and Handling training is being revised to incorporate the new approach and additional available equipment.

192 workers attended the PPC training from Falkirk, Stirling, and Clackmannanshire Council, NHS Forth Valley, and Third Sector care providers. Of these 192, 25 places were offered to Falkirk Council Occupational Therapists, 6 places for Care at Home services, and 5 places for Falkirk Council Moving and Handling Trainers.

66 workers were nominated to attend the Familiarisation sessions delivered inhouse by Falkirk Council Moving and Handling Trainers.

RECRUITMENT AND RETENTION OF STAFF

A Recruitment and Retention Working Group was established in May 2021 made up of representatives from the HSCP and Council Social Work Services. This cross-service group was tasked with finding solutions to significant recruitment challenges and to create initiatives providing incentives and opportunities in support of staff retention and career development. A cross-

service staff reference group was also created to consult with and gather thoughts and ideas from operational managers and frontline staff.

In the last year, we have reinstated our Social Work Sponsorship programme. We have concluded the process of collaborating with the Open University to secure two places for their social work degree course which will commence in October 2022. We successfully recruited both applicants from the Health and Social Care Partnership. Plans are in place to routinely sponsor staff on this programme and to consider an equivalent programme for Allied Health Professionals.

Social Work student placements continue to be offered, giving the opportunity to recruit those who are in their final year. In the summer of 2021/22, Falkirk provided 15 student placements to Stirling University, Robert Gordon University, and the Open University. We work in partnership with Forth Valley College and attend recruitment fayres and bespoke events to secure student interest in a career in health and social care.

In 2021, we increased the number of placements offered to HNC Health and Social Care students trialling student placements across a wider range of services across the HSCP. Alongside our regular placements within Residential Care and Housing with Care services, students were offered placements in our Home Care Reablement service, Mobile Emergency Care service, Joint Dementia Initiative service, Social Work locality teams, and our Sensory Service.

An evaluation is currently underway that will be used to inform future practice in supporting college students towards a career in health and social care. This includes employment opportunities for students with us whilst undertaking their studies. In addition, we plan to develop the offer for staff who undertake placement mentoring duties as part of their career development based on lessons learned.

Work is underway in recognising advance practice, what constitutes advance practice, and how this is recognised. Roles under consideration relate to Mental Health Officer, Mental Health Officer Practice Assessor, and Practice Educator. Consideration is also being given to other areas of advanced practice such as in Dementia, Addictions, and Public Protection.

The group is also working on developing a cross service induction programme that supports consistency across services whilst also ensuring best use of time, resources, and providing an excellent overview of local integrated and partnership working.

This work sits alongside another recruitment initiative under development. We plan to roll out a programme of evening virtual drop-ins for potential future employees informed by feedback gathered over the past year. The sessions are designed to provide an opportunity for HSCP and Council staff to

engage flexibly and reflect HSCP and Council values in action, bringing to life strategic aims and objectives and sharing examples of collaborative working.

CROSS SERVICE NEWLY QUALIFIED SOCIAL WORKERS (NQSW) GROUP

A newly qualified workers group was developed as part of the support being offered to new staff in their first year post qualifying. The group was viewed as a sanctuary during the pandemic keeping workers connected and grounded.

The group continues to develop, meeting fortnightly. As well as offering peer support, it incorporates aspects of induction from colleagues and external agencies, the agenda led by the worker's needs. Activity over the last year has included ongoing work around the development of their Continuous Professional Learning (CPL). This has taken the form of directing and assisting with the expectations of the SSSC (regulatory organisation) in their first year.

The development of awareness and skills around the assessment and management of risk to protect the public in all settings has been an important piece of learning for the group, with them developing a sense of professional and corporate responsibility.

Activities around this have included group discussion, independent learning via the use of their online Microsoft Team Channel and reflective sessions. Imminent work includes working with them and subsequently their supervisors to look at the NQSW standards with a plan to encourage group members to familiarise themselves with these and incorporate them into their supervision sessions.

Team managers and supervisors will need to look at these and heighten their awareness of the requirements. It is hoped that using these will encourage the development of individual learning plans which should be reviewed on a regular basis. A sample of this can be found here.

Other work done with the group has included training and development on subjects such as The Promise, pre-birth assessment and self-directed support, and sessions on reflective practice. The importance of the group is to facilitate learning for and from all sections of the service to enable a clear understanding of each other's roles, responsibilities, and the integration of these. For example, in kinship care where multiple family members may be involved in the protection of a child or young person.

Knowledge of the Family Group Decision Making and Change Grow Live services are essential to enable change in this and other situations. The group is designed to facilitate learning and development, share knowledge, and ultimately help make a difference to the lives of the people and communities that we work with.

WEBINARS

During the past year we have delivered a series of webinars available to all staff working across the HSCP and Council services on “Prevention of Substance Use Harm” and “Keeping the Promise”. This format of online learning has enabled us to reach a wide audience and to use these opportunities to signpost participants to where they can find additional resources and training.

AHP NON-MEDICAL PRESCRIBING NETWORK

Allied Health Professionals Non-Medical Prescribing (AHP NMP) Network continues to expand and develop with continued financial backing from the Scottish Government. Throughout 2021, a further 16 Allied Health Professionals (AHP) successfully completed their NMP training and subsequent exams. We now have a total of 34 AHP NMPs in the Partnership with additional six Paramedic Prescribers who now fall under the AHP remit. A further four AHPs are currently underway with their training in 2022 and another four have applied to begin training in September 2022.

The AHP NMP Network now meets quarterly to support and mentor all AHP NMPs. The group provides Continuing Professional Development (CPD) opportunities and supports annual audit and peer supervision sessions. The group has recently contributed to the review of the NHS Forth Valley NMP Policy, allowing AHPs specific policy section reference for the first time.

Advanced Physiotherapy Practitioners in Primary Care have also commenced a national roll-out of e-prescribing in two Falkirk HSCP Practices in 2022. Close work has been undertaken with Pharmacy colleagues to achieve this improvement to patient journeys. Further implementation to another eight GP Practices is planned later this year.

AHP INJECTION THERAPY NETWORK

The Allied Health Professionals Injection Therapy Network for Physiotherapists and Podiatrists in the Falkirk HSCP continues to develop and expand. Network events have already taken place in 2022 to support peer learning and CPD training opportunities. The Network will meet again in November 2022 and has supported a further three Physiotherapists to successfully complete and pass their training this year. Training for up to a further six Physiotherapists will be undertaken as Covid-19 regulations are reduced thus enabled course dates to become available.

Advanced Physiotherapy Practitioners working in Primary Care undertook 1,000 injections in 2021/22. When compared to costs of these procedures being administered by Secondary Care Consultants, a saving of over £180,000 is demonstrated. Alongside economic benefits, the administration of Injection Therapy within AHP Primary Care and Outpatient settings can be seen to improve patient pathways and reduce already long waiting times within Secondary Care.

ALCOHOL BRIEF INTERVENTION TRAINING

The Health Promotion Service delivers Alcohol Brief Intervention (ABI) training, which has been designed in line with national ABI training to help participants learn more about the effects of alcohol, how to calculate units and the skills required when offering brief advice. The training also aims to equip the workforce with the knowledge, skills, and confidence to initiate a conversation about alcohol and to deliver alcohol brief interventions.

In 2021/2022, alcohol brief intervention training was delivered via LearnPro online learning and a total of 22 health care staff, including prison health care staff in Falkirk attended the training.

RAISING THE ISSUE OF TOBACCO TRAINING

'Raising the issue of tobacco' training aims to raise awareness of the importance of addressing smoking behaviour with anyone we come into contact with, thus it is seen as everyone's responsibility to 'Raise the Issue'. The course provides participants with the knowledge and confidence on how to discuss someone's smoking behaviour, the benefits of quitting, and refer someone for support to stop smoking.

In 2021/2022, this training was delivered via LearnPro online learning to 32 health care staff, including prison health care staff in Falkirk.

Outcome 9:

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

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.

The key features of the IJB's governance framework which were in place during 2021/22 to support best value are outlined below:

Vision and Leadership

A key statutory duty of the IJB is to develop a 3-year Strategic Plan which reflects the national health and wellbeing outcomes framework and delivery of agreed local priorities. The Strategic Plan is now set against a backdrop of the Covid-19 pandemic which has resulted in a significant and rapid change in the configuration of health and social care services across Scotland. *Work is already underway to produce a new 3-year Strategic Plan.*

It is recognised that the long-term impact and unintended consequences arising from the pandemic are uncertain and may require development of new services and enhanced support for existing services such as mental health and various local community initiatives. At the same time, demand linked to ongoing demographic change, is increasing as people are living longer into old age, often with multiple long-term conditions which require more complex multidisciplinary care and support.

Similarly, the age profile of our workforce is also rising (and this is more prominent in certain staff groups e.g., District Nursing) which presents several risks in terms of succession planning and our ability to provide sustainable services. This is also exacerbated by ongoing recruitment and retention difficulties particularly in relation to Social Work services (where staff turnover is in the region of 7.9%).

To respond to these 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.

Our detailed Delivery Plan is underpinned by an integrated whole systems approach, which identifies the specific work streams and actions required to progress our strategic priorities. The Delivery Plan has recently been reviewed to ensure it is fit for purpose in a post Covid-19 context and remains aligned with our pandemic response in terms of the current remobilisation, recovery, and redesign of services.

The IJB is confident that the Delivery Plan continues to reflect the appropriate direction of travel for Adult Health and Social Care Services in Falkirk and notwithstanding the operational disruption and financial risks arising from Covid-19, it is recognised that the pandemic presents a unique opportunity to accelerate key elements of our Delivery Plan.

Governance and accountability
Falkirk IJB has responsibility for the strategic planning and commissioning of delegated health and social care functions. 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 £254m.

The governance framework 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.

The range of IJB Board members has enabled informed decision-making through the insightful contributions from different perspectives. The voice of service users and carers have been of importance and value to the Board. During 2021-2022, all meetings have continued online.

Effective use of resources
The National Health and Wellbeing Outcomes Framework requires the IJB is 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 2021/22 financial performance is provided below, including consideration of the financial outlook for 2022/23.

2021/22 FINANCIAL PERFORMANCE (FROM UNAUDITED ACCOUNTS 2021/22)

The IJB reported total income of £253.983m for financial year 2021/22 and total expenditure of £234.066m incurred during the year. As a result, a surplus of £19.912m was reported in the unaudited Comprehensive Income and Expenditure Statement on 31 March 2022.

The reported surplus reflects delays in planned expenditure during the year, receipt of significant, late funding allocations and unused Covid-19 funding which is required to be carried forward into 2022/23 in line with Scottish Government guidance. However, the overall surplus does mask multiple key financial pressures experienced during the year including:

Large Hospital Services/Set Aside
Ongoing pay pressures within A&E and various impatient specialties reflects the ongoing use of locums and agency staff to cover key vacancies. This position was partly offset by lower-than-expected non-pay costs (e.g., surgical sundries, lab supplies, and drugs) linked to lower overall hospital activity levels because of Covid-19.

Social Care
Additional funding was provided by Scottish Government in 2021/22 to allow Care at Home providers to increase wages for direct care staff to increase Care at Home capacity and make the service more sustainable. Despite increased hourly rates, capacity remains a concern with demand for Care at Home outstripping capacity. Underspends were reflected throughout Social Care including assessment and care planning team recruitment delays/vacancies and lower activity across Day Care, Respite & Carers Support, and Community Mental Health, all associated with the Covid-19 pandemic.

Primary Healthcare
Key areas of overspend within General Medical Services related to reimbursement of locum cover costs in respect of sickness absence and maternity/paternity leave claims from independent GP Practices. With respect to Primary Care Prescribing, there has been a 4% increase in Prescribing activity combined with delays in delivering efficiency savings (in terms of both savings initiatives and agreed national tariff reductions) contributing to the overspend position.

Community Healthcare
Temporary ward closures at Falkirk Community Hospital due to fire risk issues mask overspend pressures within the Joint Loan Equipment Scheme (JLES), Night Nursing, and Complex Care.

The vast majority (77%) of IJB expenditure incurred during 2021/22 related to Primary Healthcare and Social Care Services as outlined in the table below:

Total Expenditure	2021/ 22	2020/ 21	2019/ 20	2018/ 19	2017/ 18
Large Hospital Services	31,079	29,629	27,741	26,026	25,207
Primary Care Services	81,474	83,284	81,941	75,816	70,734
Social Care Services	99,102	93,952	88,259	83,694	78,297

Community Healthcare Services	21,956	38,241	36,604	35,422	36,785
IJB Running Costs	454	469	444	410	351
Total	**234,066**	**245,575**	**234,989**	**221,368**	**211,374**
Set Aside	31,079	29,629	27,741	26,026	25,207
Integrated Budget	202,987	215,946	207,248	195,342	186,167
Total	**234,066**	**245,575**	**234,989**	**221,368**	**211,374**

Table 19

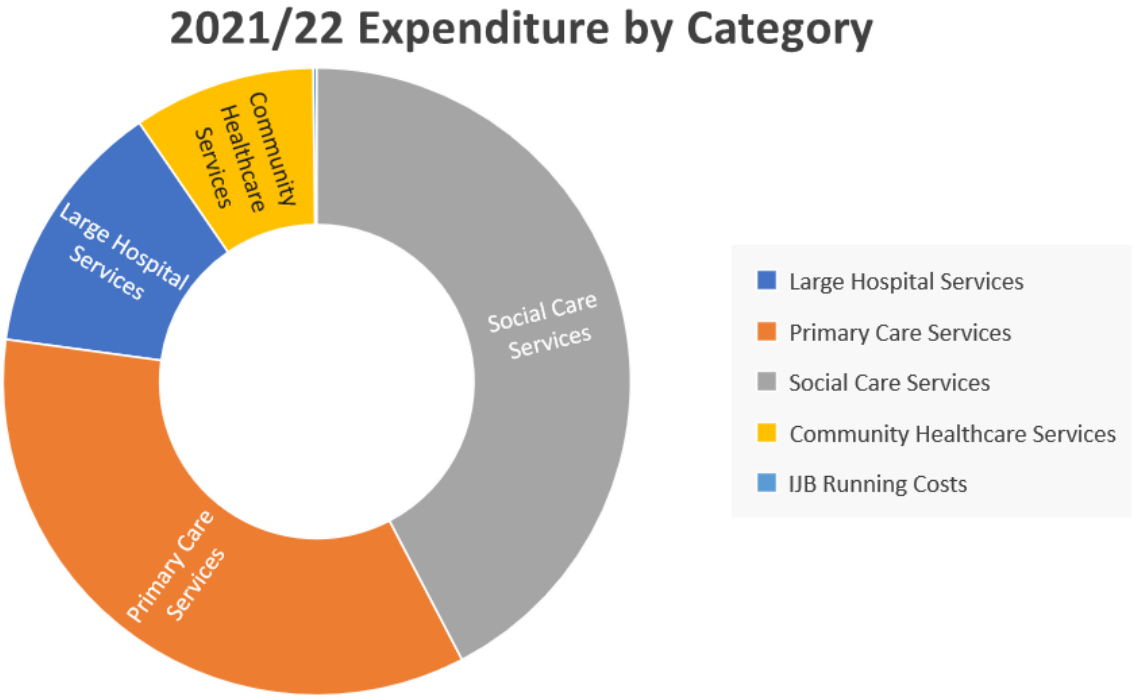


Figure 2: 2021/2022 Expenditure by Category

COVID-19 FINANCIAL IMPLICATIONS

During 2021/22, the Scottish Government provided £16.338m of Covid-19 funding to meet all additional costs and unachieved savings associated with the pandemic. This reflected the funding originally requested through the IJB's Local Mobilisation Plan submission (£1.820m) together with a further £14.518m confirmed by the Scottish Government in February in respect of ongoing Covid-19 related cost pressures. 2021/22 funding was in addition to the £6.397m Covid-19 funding carried forward through earmarked reserves from 2020/21.

Expenditure of £6.470m was incurred during the year, leaving a balance of £16.265m to be transferred to reserves in relation to Covid-19. Winter planning and winter pressure funding of £5.052m will also transfer to reserves to meet ongoing costs during 2022/23.

FORWARD LOOK 2022/23 AND BEYOND

Remobilisation, recovery, and redesign of services will continue to be a key feature of the financial year 2022/23 as we emerge from the Covid-19 pandemic.

The initial estimate of the potential cost impact of Covid-19 in 2022/23 is in the region of £9.110m (excluding unachieved savings). The Scottish Government has advised that no additional Covid-19 consequential funding has been agreed with the UK Treasury for 2022/23 and IJBs should plan on the basis that no further Covid-19 funding will be issued. Any unused Covid-19 balances carried forward from 2021/22 would therefore require to be used in the first instance to meet ongoing additional costs incurred during 2022/23.

Significant recurring investment was announced last year as part of a national funding package to address winter pressures and support longer term improvement in service capacity across the health and social care system. This funding is designed to increase multidisciplinary team working and capacity, provide further pay awards for all adult social care staff employed in direct care roles, support interim care arrangements, and enhance staff wellbeing.

To address Social Care Provider sustainability challenges, contractual rates for 2022/23 have been increased to include a pay and non-pay inflationary uplift. The rate uplift reflects full implementation of the Scottish Government's adult social care pay policy (whereby staff employed in direct care roles must be paid a minimum of £10.50 per hour) and provides a contribution towards increased non-pay costs such as business insurance, utilities, and fuel. Whilst this has been welcomed by local providers, there is ongoing concern in relation to the scale of the cost of living and inflationary pressures currently being experienced. The position will be kept under close review.

Ongoing consideration will be given to the recurring cost impact of the pandemic in terms of long Covid-19 and increase demand for mental health services, supported by Scottish Government Mental Health Recovery and Renewal funds. Plans for additional, anticipated funding in respect of mental health and wellbeing in primary care will also progress during 2022/23 while all additional £15m funding is anticipated nationally in respect of the Primary Care Improvement Programme.

The Scottish Government's medium-term financial framework and resource spending review is expected to be published in May 2022, and this will inform the revision of the IJB's medium-term financial plan, together with wider economic considerations (e.g., rising inflation, rising energy costs, and labour market challenges).

SUSTAINABILITY

Adult Social Work services are included in Falkirk Council's Carbon Management Plan. The target for the IJB is to achieve a 68% reduction in its

2019/20 carbon emissions from vehicle fuel, gas, and electricity consumption by 2030.

Adult Social Work accounted for 1,427 tonnes CO2e in 2021/22, which is not a huge increase from the previous year. The breakdown per emissions sector is as follows:

- Gas – 772 tCO2e
- Electricity (including transmission and distribution losses) – 397 tCO2e
- Fuel (fleet) – 229 tCO2e
- Staff mileage – 67 tCO2e
- Water – 4 tCO2e
- Homeworking – 3 tCO2e

Work is underway to identity how to reduce carbon emissions, especially from travel and energy use in buildings.

The NHS Forth Valley Sustainability Strategy 2019-24 sets out how the key elements of sustainability can come together to actively support and enable efficient and effective healthcare delivery. The Strategy recognises that NHS Forth Valley needs to address health challenges due to climate change as well as reducing its own environmental impact.

FAIRNESS AND EQUALITY

We know that there can be significant differences in people's health depending on where they live, whether they are socially excluded or whether they share certain characteristics (such as sex, ethnicity, or disability). The impact of such health inequalities is explained in the Joint Strategic Needs Assessment.

Promoting fairness and equality to help tackle health inequalities underpins the priorities of the Strategic Plan. We aim to work with partners to prevent and reduce the impact of poverty and promote equality of access as part of our priority to 'Deliver local health and social care services including Primary Care, through enabled communities and workforce'.

Our priority to 'Focus on early intervention, prevention and harm reduction' also recognises that there are unfair and avoidable differences in people's health and social care between different population groups.

The Equality Outcome and Mainstreaming Report 2017-21 explains what Falkirk IJB will do to address inequality in greater detail. The report defines six IJB equality outcomes and describes how equality will be built into the way that the IJB works.

One of the key mechanisms for ensuring that equality is mainstreamed into IJB decisions is the Equality & Poverty Impact Assessment. During 2021/22, we conducted Equality & Poverty Impact Assessments on the following areas:

1. Volunteer Expenses Policy
2. Participation and Engagement Strategy
3. MECS Operations Dispersed Alarm Replacement Programme
4. MECS Installation of Alexa Devices and Supportive Technology
5. Establishment of the Living Well Advice Hub
6. Proposal to establish Living Well Centres in East and West Localities
7. Relocation of service users to a new base at Burnbrae/Grahamston House
8. Review of Existing Care Package: Younger Adults
9. Proposal to close registered Support Service which runs from a room in Cunningham House
10. British Sign Language (BSL) Plan for Falkirk
11. Carer and Service User Involvement Training

BUILDING CONFIDENCE WITH SENSORY AWARENESS

The British Sign Language (Scotland) Act 2015 and the British Sign Language National Plan 2017 - 2023 required public bodies in Scotland to publish local action plans by October 2018 and on a six-yearly basis, thereafter, showing how they will promote and support British Sign Language (BSL).

Our local action plan commits to raising awareness for workers who support individuals with sensory impairment. Sessions have been developed aimed at increasing workforce confidence about sensory impairment issues with the following learning outcomes:

- how to interact with someone who has a sensory impairment
- how a sensory impairment can affect someone's communication, access to information and mobility
- how to adapt working practice to meet the needs of those with a sensory impairment and keep a positive attitude
- learn about the wide range of services within Falkirk Health and Social Care Partnership that are available to support those with a sensory impairment.

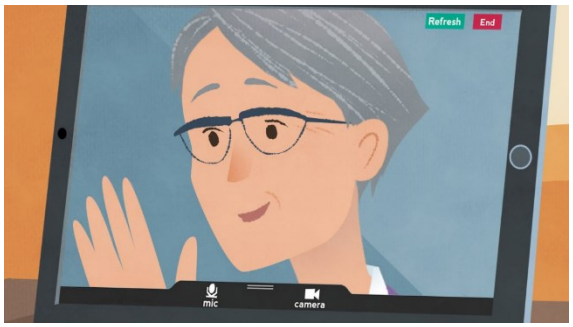
USING TECHNOLOGY

Care at Home Forecasting Tool

A Care at Home forecasting tool was developed for the Inhouse Care at Home service, making use of data to inform decision making. This report has been run and presented to Senior and Operational Management meetings on multiple occasions to identify pressure points in the system. Reports have been developed further and analysed alongside the previous year's data, the timings of the service's visit commitments and carer working patterns to support the effective and efficient use of resources.

Social Work and Near Me

During the summer of 2021, £30,000 of funding was awarded by the Scottish Government for Falkirk HSCP and a five other HSCP's to pilot a video consultancy platform called Near Me to support duty to Social Work. Near Me provides an online waiting room offering video appointments as a method of communicating with Social Work. In this way, it has the potential to widen access to the service.



The project will enable a blended approach of in-person and video interactions for Duty and other Social Work appointments where appropriate. It is anticipated that this will attract benefits such as enabling choice, widening access to our services, supporting relationship-based approaches and outcomes focussed practice. Near Me will facilitate the inclusion of family members, carers, or other health and care professionals in discussions and, in this way, the system will support integrated service delivery.

Since the project commenced, Falkirk HSCP has met multiple milestones:

- Testing has been completed
- Data Protection Impact Assessment has been completed and signed off
- Five training sessions have taken place and a small number of video appointments have been made

The next steps for 2022/2023 will focus on scaling up the use of the platform across three localities and the creation of the live online waiting room.

PARTNERSHIPS AND COLLABORATIVE WORKING

WORKING IN PARTNERSHIP WITH THE THIRD SECTOR

Community Led Support Strategy

Falkirk HSCP and third sector partners have been working together to develop an effective model of community-led support. Community-Led Support (CLS) refers to services that are designed and delivered in conjunction with people and communities. The principles of community-led support are co-production, community focus, support, and advice to prevent crises, a culture based on trust and empowerment in which people are treated as equals, minimal bureaucracy, and a responsive and proportionate system that delivers positive outcomes.

Partners agreed that a Falkirk HSCP strategy was required to ensure that community-led support remains sustainable, coordinated, and effective as our capacity increases to respond to demand on community-based services within localities. The draft strategy has been developed during 2021/2022. Our

ambition is to increase the use of community-led support to provide alternative models of care and to promote prevention and early intervention in the community.

The strategy intends to:

- Ensure that Falkirk Health and Social Care Partnership have a collective understanding of the why and how we intend to work alongside communities.
- Highlight the learning from the Covid-19 pandemic, with reference to sustainable learning for the Partnership.
- Highlight the change that is required for community led support to be effective and sustainable.
- Provide an action plan based on a theory of change model, which will enable investment and activities to be monitored and evaluated.

The strategy describes how we will develop community led support in relation to the following themes:

- Strengthening Communities
- Collaboration and Partnership
- Access to Community Resources

The Community-Led Support Strategy and action plan is still in draft format and is currently being finalised with partners. Co-production of the action plan is intended to ensure that there is an equal status amongst partners in terms of planning, design, and decision making.

To finalise and drive forward the implementation of the Strategy, a Community Led Support Programme Manager will be recruited in 2022. To ensure effective and sustainable pace of change, the Manager will be skilled in community learning and development and will work closely with third sector partners and communities. This will also include an assessment of the HSCP role in community development and consideration of resource requirements.

Winter Pressures Collaborative

The Winter Pressures Collaborative was established and funded by the Partnership to help reduce demand on Forth Valley Royal Hospital by providing a direct link to community support. The Forth Valley-wide service has successfully improved patient flow within hospital, helped to reduce admissions and promote independence at home by offering a range of supports provided by third sector partners.

The partners include:

- Strathcarron Compassionate Neighbours
- RVS
- Dial-A-Journey
- Food Train
- Falkirk & Clackmannanshire and Stirling Carers Centres

- NHS Forth Valley: Frailty Team & Rapid Access Teams, Home from Hospital & Discharge Teams
- Falkirk and Stirling & Clackmannanshire HSCPs.

Community Link Workers are employed within the hospital, helping to identify support from third sector partners to practically support the person home safely. Once discharged home, a follow-up visit involving a "Good Conversation" is conducted with the patient and, where applicable, carer. This identifies longer-term support to help maintain independence at home. The type of support available includes carers support, a shopping service, prescription delivery, befriending and links to wider community resources.

Communication between partners is aided by a bespoke app developed by Falkirk HSCP. The app allows the Community Link Workers to record the necessary personal data and patient consent securely and efficiently. The app also enables information to be shared between partners securely. The Link Worker and app provides a single point of access and coordination of resources from community partners.

Using the app helps to improve efficiency by:

- Data is entered once, but used many times (e.g., the name and address of service user may form part of a referral to more than one partner).
- Link Workers are guided through a process by advancing through the screens of the app, reducing variation and the potential for missing information.
- The app applies validation to many of the fields of data that it collects by restricting the type of data that can be entered, thus reducing the scope for error.
- Referral emails to partners are generated automatically from data that has already been collected in the app.

More than 500 people across Forth Valley used the service during the initial project period (December 2021 – 30 March 2022).

With a full project evaluation completed, the project has been a success in supporting people home from hospital and supporting hospital flow. With support from our third sector partners, Falkirk and Stirling &

Clackmannanshire Health and Social Care Partnerships have agreed to extend the project to provide year-round support.

Partners are currently identifying future service models and the potential for its expansion.

DEMONSTRATING IMPACT

The positive findings of the project's evaluation have been presented to colleagues across Scotland, with the team taking a poster to the NHS Scotland Event exhibition in Aberdeen this summer.

A virtual version of the poster, and its accompanying evaluation report, can be found on the NHS Scotland Event 2022 website.

CASE STUDY: WINTER PRESSURES COLLABORATIVE

Following her discharge from hospital, Ms C received a follow up call from the team's dedicated link worker.

Living alone with no family, Ms. C was managing her return home and recovery from hospital with assistance from friends who were visiting daily and running errands like food shopping.

The Link Worker discussed the benefits of Food Train with Ms. C, which would help take pressure off her friends, who are also elderly.

The Strathcarron Compassionate Neighbours project was also of interest to Ms. C, although she was initially unsure. A follow up call a few weeks later provided another opportunity to discuss support options, where Ms C agreed a referral to the Compassionate Neighbours, who are able to help her attend the Snowdrop Café for a chat and some company.

The range of support options available are supporting Ms C during her initial return from hospital and her recovery, as well as into the future.

**This case study has been anonymised and provided, with thanks, from the Winter Pressures Collaborative Evaluation Report.*

HOW WE WORK 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 Partnership's Strategic Plan.

Our Housing Contribution Statement (HCS) 2019 – 2022 includes the following priorities that form an essential link with the Strategic Plan and the Local Housing Strategy:

- Make the best use of technology to help people stay in their communities for as long as possible
- Recognise the importance of well-being and connectedness
- Make the most of the built environment
- Improve access to housing
- Provide housing options for homeless people

Actions that have already been achieved include:

- Review the Mobile Emergency Care Service including the transition from analogue to digital
- Explore how to further assist empty homeowners such as advice on hoarding. A Hoarding Policy is in place between Falkirk Council Housing and HSCP, officers have been trained, and 38 empty homes have been brought back into use.
- Set up a housing first model
- Increase percentage of social lets to homeless people

Of the 22 actions:

- 4 have been achieved
- 14 are ongoing
- 3 have been revised
- 1 has been delayed

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.

During the Covid-19 pandemic, the Independent Sector Lead (ISL) 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.

During 2021/22, the Independent Sector Lead (ISL) has been committed to ensuring the wellbeing of the Independent Sector workforce remains high on the agenda of many strands of the Partnership's organisational and leadership processes. The ISL holds weekly meetings with care at home and care home providers to ensure there is equality of opportunity for those who work within the independent sector in relation to support, discussion groups, and wellbeing support.

PARTNERSHIP FUNDING 2021/2022

Falkirk HSCP has operated a partnership funding programme as an opportunity for partners to establish, test, transform, and accelerate the delivery of integrated services in line with local priorities.

During the investment period 2018-2021, the IJB committed to shifting the balance of care towards integrated services and projects in the community and away from traditional models of health and social care, which have largely focussed on statutory services within centralised and/or institutionalised

settings. The IJB agreed that ongoing investment to support discharge or avoid admission should be via redistribution of current allocations rather than significant new investment. The challenge is to shift the balance of care to develop a range of community-based supports to develop supportive communities to enable more people to live at home longer.

Partnership Funding Investment Plan 2021-2024
Falkirk HSCP has operated a Partnership funding programme since 2018. The programme has provided an opportunity for partners to establish, test, transform, and accelerate the delivery of integrated services in line with local priorities.

During the period 2018-2021, Partnership Funding encompassed only four funds:

- Main Programme
- Leadership Fund
- Carers Fund
- Dementia Innovation Fund

The IJB agreed that a single partnership investment plan should be developed to provide oversight of investment, governance, and evaluation of impact for all strands of funding available to the Partnership to support in-scope services. The Partnership Funding Investment Plan 2021-2024 was developed in collaboration with partners and approved by the IJB in June 2021.

The benefits of operating a Partnership Funding Programme include the ability to:

- Respond to emerging needs across the system on a flexible manner
- Effectively and transparently allocate, monitor, and evaluate funds, using a collaborative commissioning approach
- Include people with lived experience in design and decision-making processes
- Shift resources from crisis support to earlier intervention and prevention

Currently, the Partnership Funding Programme includes eleven funds:

1. Main Programme
2. Carers Fund
3. Health Inequalities and Wellbeing Fund (non-recurring)
4. Alcohol and Drugs Partnership
5. TEC Innovation Fund (non-recurring)
6. Dementia Innovation Fund
7. Choose Life
8. Services for Survivors
9. Innovation and Invest to Save (non-recurring)
10. Locality based funding (non-recurring)
11. Mental Health Recovery and Renewal Funds (Phase 2 – Post Diagnostic Support)

The pandemic has caused a delay in progressing commissioning processes at the pace initially hoped, which has resulted in some funds accruing significant reserves. Progress is now being made to address this and align investment with the priorities of the Strategic Plan, whilst also addressing challenges resulting from Covid-19.

OUR GOVERNANCE

INSPECTION OF FALKIRK HSCP REGISTERED SERVICES

The Care Inspectorate is responsible for the regulation of care standards in Scotland. In consultation with the social care sector, the Care Inspectorate has developed a self-evaluation and quality framework model based on the Scottish Government's Health and Social Care Standards. Inspectors use the quality framework to evaluate the quality of care during inspections and improvement planning.

CARE INSPECTORATE QUALITY ASSESSMENT FRAMEWORK

The Quality Assessment Framework sets out Key Questions about the difference a care service makes to people's wellbeing, and the quality of the services that contribute to that. During 2020, the Care Inspectorate created an additional new theme of "How good is our care and support during Covid-19 pandemic?"

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?
Key Question 7	How good is our care & support during the pandemic?

RESIDENTIAL CARE HOMES (OLDER PEOPLE)

Summerford House

The Care Inspectorate visited Summerford House on 27 January 2022. This was a focused inspection to follow up on the three requirements and three areas of improvement made at their unannounced visit on 9 and 10 November 2021. There was also a follow-up visit on 1 December 2021. The Care Inspectorate also followed up on an area for improvement made as a result of an upheld complaint.

The Care Inspectorate graded the service at a three (adequate) for the quality indicator "How well do we support people's wellbeing?" The service had met the requirements and areas for improvement made in November and another made following an upheld complaint. Although one of the requirements identified in November had been met, the Care Inspectorate noted more work was needed and identified new improvements. There was no timescale given for achieving the area for improvement as the service will move back to annual inspections.

The Care Inspectorate noted that there was improvement in the cleanliness of the building and staff knowledge, and thus re-evaluated the quality indicator "How good is our care and support during the Covid-19 pandemic?" from adequate to good.

Burnbrae Care Home
The Care Inspectorate completed their follow-up inspection at Burnbrae Care Home on 17 June 2021 to focus on actions taken to address requirements. During the previous inspection on 4 May 2021, the Care Inspectorate graded the service as a two (poor) as five of the six requirements that had been issued in an inspection in October 2019 had still not been met.

Based on the follow-up inspection, the service has shown positive improvement. Many of the areas inspected were described as very good, however, given the poor grades and the need to show consistent ongoing improvement, the home was subsequently evaluated as a three (adequate) in all areas. Their report noted that each point was adequate whilst highlighting important or significant strengths. All the outstanding requirements from October 2019 have been subsequently met (out-with timescale) at the most recent inspection. The HSCP will continue to monitor improvements to ensure the standards evidenced throughout the inspection are built upon and the follow up actions are fully embedded.

At the end of the 2021/22 financial year, the percentage scores from all Homes in the Falkirk Council area were as follows, with 12 local care homes being inspected during this financial year, compared to 3 last financial year:

Key Questions	Good/Very Good/Excellent	Unsatisfactory/Weak/ Adequate	Not Inspected
KQ 1	55%	20%	25%
KQ 2	10%	0%	90%
KQ 3	10%	5%	85%
KQ 4	10%	5%	85%
KQ 5	35%	5%	60%
KQ 6	0%	0%	100%
KQ 7	50%	10%	40

Table 20

RESIDENTIAL CARE HOMES (YOUNGER ADULTS)

11 out of the 12 care homes continue to be assessed under the new Quality Assessment Framework described in the section above.

At the end of the 2021/22 financial year, the percentage scores from for the 11 care homes in the Falkirk Council area inspected under the new framework were as follows, with only three care homes inspected this year.

Key Questions	Good/Very Good/Excellent	Unsatisfactory/Weak/ Adequate	Not Inspected
KQ 1	50%	40%	10%
KQ 2	10%	20%	70%
KQ 3	10%	20%	70%
KQ 4	20%	10%	70%
KQ 5	70%	20%	10%
KQ 6	N/A	N/A	N/A
KQ 7	30%	10%	40%

Table 21

One care home continues to be assessed under the old inspection regime and was graded 100% in good, very good, and excellent, and 0% in weak or unsatisfactory.

CARE AT HOME AND HOUSING SUPPORT SERVICES

During the year 2021/22, care inspection activity across all care at home and housing support services remained reduced to create capacity in response to the Covid-19 pandemic and resilience efforts to other Coronavirus variants including Omicron.

Three services were successfully inspected in the Falkirk area between April 2021 and March 2022. For two of these services, the criteria required by the Care Inspectorate to meet the evaluation quality point scale of 4 – Good was successfully achieved. The other service inspected met the evaluation quality point scale of 3 – Adequate.

HOUSING WITH CARE SERVICES

The Care Inspectorate completed an unannounced inspection of Housing with Care Services on 30 August 2021. The inspection evaluated the quality of services in two areas.

For the quality indicator, “How well do we support people’s wellbeing?”, the inspection identified two requirements and assessed the service as three (adequate). Following a follow-up unannounced inspection, the service had made good progress and was reassessed as a four (good) for this quality indicator.

For the quality indicator, “How good is our care and support during the Covid-19 pandemic?”, the inspection identified one requirement and one area for improvement and assessed the service as a two (weak). Following good progress made, this was reassessed as a four (good).
In August, the Care Inspectorate also assessed progress against two previously identified areas for improvement. They found that insufficient progress had been made in these areas. They made a requirement around one and repeated the other as an area for improvement that would be followed up at future inspections.

ADULT SUPPORT AND PROTECTION JOINT INSPECTION

The Falkirk Adult Support and Protection (ASP) Inspection of partners – Falkirk Council, NHS Forth Valley, Police Scotland, and the Adult Protection Committee (APC) – was one of many that took place across Scotland as part of a programme of assurance activity at the request of Scottish Ministers. It was jointly carried out by the Care Inspectorate (CI), Healthcare Improvement Scotland (HIS), and Her Majesty's Inspectorate of Constabulary in Scotland (HMICS). The inspection scrutinised the quality of two important ASP indicators – the quality of our ASP Key Processes and the quality of ASP Leadership.

The partners and all others across Scotland faced the unprecedented and ongoing challenges of the Covid-19 pandemic. The report has found an engaged workforce which prioritises adults at risk of harm, and their carers. Adult Support and Protection processes in Falkirk adapted well to the challenges of the pandemic with a collaborative structure in place across all key partners. The report has identified six areas of improvement, which cover recording of key processes and further opportunities for joint-working.

The inspection report was published on 8 February 2022. The report commended the practices and processes in place to ensure adults at risk of harm are safe, protected, and supported in Falkirk. The inspection concluded that both the Partnership's strategic leadership and key processes for adult support and protection were effective with areas for improvement. There were clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement.

OUR 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 national integration indicators. This enables us to understand how well our services are meeting the needs of people who use our services and communities.

In previous years the analyses of the National Indicators have included more of a focus on direction of travel and whether performance had improved, deteriorated or the position had been maintained. Due to various changes in the 2019/20 HACE survey wording and underlying methodology, indicators 2, 3, 4, 5, 7 and 9 were no longer directly comparable to previous years. The 2021/22 survey did not see any further changes to these questions, so the aforementioned indicators are comparable to 2019/20 (but not previous years).

The impact of Covid-19 means comparisons to previous years are more challenging for all indicators. For the reasons outlined the main focus of the annual performance analysis will be on comparison to the national average.

Our performance for 2021/22 is set out in the following 'Performance at a Glance', with more detailed tables on the following pages.

INDICATOR SUMMARY

- 5.6% of indicators where Falkirk **compares well** to Scotland.
- 16.7% of indicators where Falkirk is **similar to** Scotland.
- 77.8% of indicators where Falkirk **does not compare well** to Scotland.

2021/22 performance has decreased across the country, including:

- Falkirk, 16 of 18 (88.9%)
- Scotland, 15 of 18 (83.3%)
- Comparator group, 14 of 18 (77.8%)

No.	Percentage	Outcome Indicator	National
NI-1	89.5%	Of adults able to look after their health very well or quite well.	90.9%
NI-2	70.6%	Of adults supported at home who agreed that they are supported to live independently as possible.	78.8%
NI-3	63.9%	Adults supported at home who agree they have a say in how their help, care, or support was provided.	70.6%
NI-4	47.2%	Of adults supported at home who agreed their health and social care services seemed to be well co-ordinated.	66.4%
NI-5	63.5%	Of adults receiving any care or support who rated it as excellent or good	75.3%
NI-6	60.3%	Of people with positive experience of the care provided by their GP practice	65.6%
NI-7	70.4%	Adults supported at home who agree their services and support have an impact on improving or maintaining their quality of life	78.1%
NI-8	28.6%	Carers who feel supported to continue in their caring role	29.7%
NI-9	73.5%	Of adults supported at home agreed they felt safe.	79.7%

No.	Performance	Data Indicator	National
NI-11	493 per 100,00	Premature mortality rate per 100,000 persons.	471 per 100,00
NI-12	13,945 admissions per 100,000	Emergency admission rate 2020	11,636 per 100,000
NI-13	111,984 bed days per 100,000	Emergency bed day rate 2020	109,429 per 100,000
NI-14	146 per 1,000	Readmission to hospital within 28 days – rate per 1,000 population, 2020.	110 per 1,000
NI-15	88.4%	Proportion of last 6 months spent at home or in a community setting 20202	90.1%
NI-16	24.5 falls per 1,000	Falls rate per 1,000 population aged 65+, 2020	23 per 1,000
NI-17	81.2%	Proportion of care services graded good or better in Care Inspectorate Inspections, 2020	75.8%
NI-18	65.2%	Percentage of adults with intensive care needs receiving care at home, 2020	64.9%
NI-19	1,112 per 100,000	Number of days people spend in hospital when they are ready to be discharged, 2020	761 per 100,000

NOTES ON INDICATORS 1-9

The Health and Care Experience Survey for 2021/22 was published by the Scottish Government on 10th May 2022. While core suite indicators 1-9 come from the survey the figures presented here may differ from those published due to changes in underlying methodology and not all indicators will be comparable to previous years.

Results for indicators (1, 2, 3, 4, 5, 7 and 9) may differ between the HACE and Core Suite Integration Indicator releases.

Results for indicators 1, 6 and 8 are comparable across all years.
2021/22 results for indicators 2, 3, 4, 5, 7, and 9 are comparable to 2019/20 but not to results in years prior to this* (therefore all indicators 1-9 are comparable with 2019/20 results)

*A change of methodology to focus only on NHS or Council-funded services in the core suite indicators release in 2019/20 meant that indicators 2,3,4,5,7 and 9 were not directly comparable to previous years. It also meant that 2019/20 results for these indicators may differ from HACE published results.

NOTES ON INDICATORS 11-20

Use of Proxy 2021/22 financial year data for indicators 12, 13, 14, 15 and 16
Calendar year 2021 is used here as a proxy for 2021/22 due to the national data for 2021/22 being incomplete. We have done this following guidance issued by Public Health Scotland to all Health and Social Care Partnerships. Figures presented may not fully reflect activity during 2021/22 due to the varying impact of COVID-19 at different points of the pandemic.

INDICATOR 20

NHS Boards were not able to provide detailed cost information for 2020/21 due to changes in service delivery during the pandemic. As a result, PHS have not provided information for indicator 20 beyond 2019/20. PHS previously published information to calendar year 2020 using costs from 2019/20 as a proxy but, given the impact of the COVID-19 pandemic on activity and expenditure, PHS no longer consider this appropriate.

NI	Outcome Indicator	Falkirk 2017/18	Falkirk 2019/20	Falkirk 2021/22	Comparator Avg.2021/22	Scotland 2021/22
NI-1	Of adults able to look after their health very well or quite well.	92.4%	92.4%	89.5%	90.6%	90.9%
NI-2	Of adults supported at home who agreed that they are supported to live independently as possible.	82.5%	79.2%	70.6%	76.2%	78.8%
NI-3	Adults supported at home who agree they have a say in how their help, care, or support was provided.	76.0%	78.6%	63.9%	73.2%	70.6%
NI-4	Of adults supported at home who agreed their health and social care services seemed to be well co-ordinated.	71.8%	74.6%	47.2%	67.7%	66.4%
NI-5	Of adults receiving any care or support who rated it as excellent or good	80.5%	83.6%	63.5%	74.5%	75.3%
NI-6	Of people with positive experience of the care provided by their GP practice	81.0%	76.4%	60.3%	65.7%	65.6%
NI-7	Adults supported at home who agree their services and support have an impact on improving or maintaining their quality of life	78.3%	78.8%	70.4%	78.8%	78.1%
NI-8	Carers who feel supported to continue in their caring role	37.3%	36.6%	28.6%	28.0%	29.7%
NI-9	Of adults supported at home agreed they felt safe.	84.1%	85.8%	73.5%	78.5%	79.7%
NI-10	Percentage of staff who said they would recommend their workplace as a good place to work.	N/A	N/A	N/A	N/A	N/A

	NI	Title	Falkirk Partnership						Comparator Average	Scotland
			2016/17	2017/18	2018/19	2019/20	2020/21	2021/22*	Latest	Latest*
Data Indicators	NI - 11	Premature mortality rate per 100,000 persons	466	427	449	435	460	493	459	471
	NI - 12	Emergency admission rate (per 100,000 population)	11,771	12,325	12,125	15,346	13,219	13,945	12,764	11,636
	NI - 13	Emergency bed day rate (per 100,000 population)	144,772	138,571	137,752	135,542	110,314	111,984	113,566	109,429
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	121	121	118	152	163	146	107	110
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	85.5%	86.4%	86.1%	87.0%	89.1%	88.4%	89.6%	90.1%
	NI - 16	Falls rate per 1,000 population aged 65+	19.8	21.9	23.9	24.6	22.5	24.5	23.1	23.0
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	85.8%	88.2%	83.8%	87.4%	87.0%	81.2%	84.5%	75.8%
	NI - 18	Percentage of adults with intensive care needs receiving care at home	64.6%	64.2%	64.8%	63.7%	64.2%	65.2%	66.2%	64.9%
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	1023	910	1178	1020	684	1,112	817	761
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23.4%	23.6%	23.8%	24.6%	NA	NA	NA	24.2%
	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	NA
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	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	NA

Source: Public Health Scotland

Notes:

1. NA indicates where data is not yet available.
2. NI 1 – 9: Data are presented on financial year file and 2021/22 is the most recent data available. The figures presented for the Core Suite of Integration Indicators may differ from those published due to changes in the underlying methodology. Historic figures will also not be comparable due to a change in methodology.
3. NI 11 and 18 are presented on calendar year. 2021 is the most recent data available.
4. NI 12 – 16 and 20: Calendar year 2021 is used here as a proxy for 2021/22 due to the national data for 2021/22 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships.
5. NI 17 and 19 are presented on financial year with the latest available data being from 2021/22.
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. Since moving to TrakCare in April 2019 Combined Assessment Unit (CAU) activity has been recorded in SMR01 under significant facility 11 whereas previously it was recorded in SMR00. This has contributed to an increase in the total number of emergency admissions (indicator 12) in Forth Valley areas from 2019/20 onwards. This will also have had an impact on Indicator 14.

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

LOOKING FORWARD

As we emerge from the Covid-19 pandemic, the Partnership, with support from a range of partners, remains committed to improving services available to people. We aim to increase our involvement of people with lived and living experience to help us improve how we deliver our services.

The impact of the Covid-19 pandemic will endure into 2022/2023 as we continue to manage the ongoing increased pressure on community services and the workforce. As well as the impact of the cost of living crisis and fuel poverty on people's health and wellbeing, and the widening health and social inequalities in our communities.

However, the Partnership remains ambitious. We have developed a transformation programme to enable our limited resources to be aligned to key areas of service delivery that will make the biggest impact on our Partnership.

We will also be working with the Scottish Government and fellow health and social care partnerships to help shape and prepare for a new National Care Service.

Key areas of work for 2022/2023 include:

- Establish a new three-year Strategic Plan
- Develop an Integrated Workforce Plan
- Refresh the Carer's Strategy
- Progress the Transformation Priorities
- Develop the Falkirk Community Hospital Masterplan
- Transform Primary Care
- Workforce Recruitment
- Expansion of the Community Link Work service
- Work with partners to drive forward the Community-Led Support Strategy

GLOSSARY

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
Covid-19	An acute respiratory illness in humans caused by the coronavirus, which can cause severe symptoms and in some cases death. Originally identified in China in 2019 which became a pandemic in 2020.
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	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 work 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 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
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	This is the process that informs the Integration Authorities Strategic Plan. Strategic Commissioning is a way to describe all the activities involved in: • assessing and forecasting needs • linking investment to agreed desired outcomes • planning the nature, range and quality of future services; and • working in partnership to put these in place.
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 help 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 (e.g., 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