Agenda Item
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Falkirk
Health and Social Care
Partnership

Title / Subject	**Falkirk Health & Social Care Partnership Annual Performance Report 2018 - 2019**
Meeting:	**Integration Joint Board**
Date:	**6 September 2019**
Submitted by:	**Senior Service Manager**
Action:	**For Noting**

1. INTRODUCTION

1.1. The report presents the Falkirk HSCP Annual Performance Report 2018 - 2019, which outlines how the Partnership is working towards delivering the Strategic Plan and the nine national Health and Wellbeing Outcomes.

1.2. The Board agreed at its June meeting that to meet publication timescales the draft report would be circulated to members for comments in July, with the final agreement to publish delegated to the Chair, Vice-Chair, Chief Officer and Chief Finance Officer.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1. note the publication of the Annual Performance Report 2018 - 2019

2.2. note that there will be a revision published to local performance against the national indicators once completeness issues have been resolved.

3. BACKGROUND

3.1. The Public Bodies (Joint Working) (Scotland) Act 2014 specifies that a performance report must be produced by an Integration Authority to ensure that performance is open and accountable and sets out an assessment of performance in planning and carrying out the integration functions for which they are responsible. This is to be produced for the benefit of Partnership and their communities.

3.2. The Public Bodies (Joint Working) (Scotland) Act 2014 obliges the Integration Authority to prepare a Performance Report for the previous reporting year and for this to be published by the end of July. For example, a Performance Report covering the period April 2018 to March 2019 is required to be published no later than the end of July 2019.

3.3. The required content of the Annual Performance Report is set out in the Public Bodies (Joint Working) (Content of Performance Report) (Scotland) Regulations 2014. The regulations and associated guidance set out the minimum expectations on the content of these reports. There is particular reference to the reporting of the core integration indicators to support assessment and performance in relation to the National Health and Wellbeing Outcomes. The report should include data for both the reporting year and the previous years since integration, i.e. from 2016 - 2017, where this is available.

3.4. It is for Partnerships to decide the layout of their Annual Performance Report. Partnerships are expected and encouraged to include additional relevant information beyond the minimum set out below in order to build as full and accurate an assessment as possible as to how the integration of health and social care is delivering for people and communities. This should be presented in a way that is clear for non-experts and should include:

- Financial Performance and Best Value
- Reporting on localities
- Inspection of services
- Review of Strategic Plan.

3.5. Timescales to produce the Annual Performance Report have been challenging. The timeframe coincides with the production of the Annual Accounts and verified data from the Information Services Division (ISD) and Social Care systems have become available as the report has been drafted.

3.6. NHS Forth Valley is currently experiencing a SMR01 hospital data completeness issue meaning it is not possible at this time to present full year data for national indicators 12, 13, 14, 15, 16 and 20. Once full year data is available this will be presented to the Board in the Performance Report and a revision to the Annual Performance Report will be published.

3.7. However, there is a statutory deadline to publish the report and therefore the best information available has been utilised.

4. ANNUAL PERFORMANCE REPORT 2018-19

4.1. The Annual Performance Report has been developed with input from colleagues across the Partnership. It reports on performance against the Partnership's local outcomes as required by the legislation, and highlights achievements throughout the year, with some case studies included.

4.2. The HSCP Annual Performance for 2018 -19 is attached at Appendix 1. This reflects the Partnership's activity in relation to the Strategic Plan 2016 – 2019 outcomes and local priorities, and the national outcomes. The first annual performance report for the new Strategic Plan 2019 – 2022 will be July 2020.

4.3. The report provides an opportunity to describe the numerous service developments and redesigns being taken forward. Many of these changes will take time to become established given the complexity of the whole health and social care system and recognising the current position of the Partnership with the phased integration of health services. It is anticipated that over time these changes should start to demonstrate impact and benefits for people and have a positive impact on Partnership performance.

4.4. In reviewing the Partnership's performance, there are no changes to national indicators 1-9, as these are populated by the bi-annual Health and Care Experience Survey. As this survey runs every 2 years the most recently available data relates to 2017 - 2018 and is the same as presented in the Annual Performance report 2017 - 2018.

4.5. As previously noted, it is not possible to present full year data for indicators 12, 13, 14, 15, 16 and 20. However, complete data is available for April 2018 to December 2019 and allows like for like comparisons against the comparator group and Scotland. These figures do not represent full year figures and are intended as a proxy only. For the following indicators there was some local improvement evident from the partial year data, although performance remains below comparator and Scottish position:

- 12: Emergency admission rate (per 100,000 population)
- 13: Emergency bed day rate (per 100,000 population)
- 14: Readmission to hospital within 28 days (per 1,000 population).

4.6. Performance against indicators 20 - percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency – has been maintained. There has been a slight reduction in performance for indicators:

- 15: Proportion of last 6 months of life spent at home or in a community setting
- 16: Falls rate per 1,000 population aged 65+ years.

4.7. Further work will take place with services to develop local indicators that will better represent the performance across a wider range of services and service user and carer experiences.

4.8. The Board is asked to note the publication of the Annual Performance Report. This has been published online and widely disseminated across the Partnership through existing networks.

4.9. As a key part of the monitoring arrangements for the Partnership, the Annual Performance Report will be reported to:

- NHS Forth Valley Board on 24 September 2019.
- Falkirk Council on 25 September 2019
- Falkirk Council Scrutiny Committee (External) on 10 October 2019

- Community Planning Executive Group on 17 October 2019
- Community Planning Strategic Board on 21 November 2019

5. CONCLUSION

5.1. The Partnership's Annual Performance Report is an opportunity to reflect on the varied activities and improvements that have been achieved over the year, and consider how well the Partnership is delivering the Strategic Plan.

Resource Implications
There are no resource implications arising specifically from this report. The Annual Performance Report includes information on the use of the Partnership Funding and other funding.

Impact on Strategic Plan Outcomes and Priorities
The Annual Performance Report 2018 -2019 will help to measure the impact of progress against the Strategic Plan local outcomes and priorities.

Legal and Risk Implications
The Annual Performance Report is a statutory requirement. This report ensures that the Partnership has met its statutory obligations to publish an Annual Performance Report by 31 July 2019 and illustrate our performance against our local and national outcomes.

Consultation
There has been ongoing engagement during the year which has already informed the Partnership's activity and core business.

Equalities and Human Rights Impact Assessment
The Annual Performance Report is a review of the previous year of Partnership activity. As such there is no requirement to carry out an assessment.

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Approved for submission by: Patricia Cassidy, Chief Officer, Falkirk HSCP

Author: Suzanne Thomson, Programme Manager, Falkirk HSCP
Date: 27 August 2019

Appendix 1: Falkirk Health and Social Care Partnership Annual Performance Report 2018 -2019

Falkirk Health and Social Care Partnership

Annual Performance Report 2018 – 2019

Falkirk
Health and Social Care
Partnership

Introduction

Welcome from the Integration Joint Board (IJB) Chair

Welcome to our third Annual Performance Report. The report summarises the progress made by the Health and Social Care Partnership over the past year.

With our new Strategic Plan 2019 – 2022, the Integration Joint Board is ambitious and enthusiastic about the opportunities that integrating health and social care services can bring and seeing the difference this will make to people.

The Board is committed to creating the environment, space and capacity to support the Chief Officer to establish the integrated management team that will enable the phased transfer of services under the Partnership. The Board acknowledges the Partnership is in the early stages and is working hard to increase the pace of change, recognising that there is huge complexity in our services, and challenges, including increasing demand and workforce pressures. This is all the more reason to look at ways to deliver services in a different way, making sure that they are responsive to people's needs and improve their outcomes.

On behalf of the Board, I would like to extend thanks to our workforce, Third and Independent Sector partners, Community Planning Partners, communities and volunteers for their commitment to delivering services. This has sometimes been under challenging circumstances, and you continue to do this with professionalism, commitment and passion. Importantly thanks to people who have used our services for sharing their thoughts with us about what we have done well that we can build on, and ways that we can improve. We will listen to this feedback and take the appropriate actions.

I would like to extend thanks to the Strategic Planning Group (SPG) for their invaluable contribution to the refresh of the Strategic Plan and the review of this going forward. More information about services is available online through the HSCP, Falkirk Council or NHS Forth Valley websites.

I hope you find this report informative.

Fiona Collie
Falkirk IJB Chair

Welcome from the IJB Chief Officer

Welcome to our Annual Performance Report.

The report provides an overview of our progress to transform the way we deliver Health and Social Care services for people living in the Falkirk area. This is reflected in the case studies that show how we are reshaping our services to better support people to achieve their personal outcomes. The report also provides information of our performance against the national integration indicators.

During the last year we have made progress with the development of new services to support adults with a learning disability. The highlight of my year was attending the Dates n Mates St Valentines disco and enjoying a dance with young people and their families. Through the review of day services we have been able to work with younger adults and their carers to improve access to a range of community based activities.

We are making key appointments to the senior management team to support the development of integrated locality teams. NHS Forth Valley has agreed to transfer some operational services and planning is underway to establish the integrated teams by winter 2019.

We have built strong foundations to collaborate with local communities to transform the way we provide support and meet local need.

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

Patricia Cassidy
Chief Officer

Our Partnership

Strategic Plan 2019 – 2022

Our vision for Falkirk, set out in the Strategic Plan, is:

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

The Health and Social Care Partnership (HSCP) has published a refreshed Strategic Plan. This sets out how the Integration Joint Board (IJB) will plan and deliver local adult health and social care services over the next 3 years. We will use the integrated budgets under our control to deliver the national outcomes for health and wellbeing, and achieve the core aims of integration to:

- improve the quality and consistency of services for patients, carers, service users and their families
- provide seamless, integrated, quality health and social care services in order to 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.

Since we produced our first Strategic Plan, there has been significant change to the local and national policy context. This includes the Community Planning Partnership Single Outcome and Local Delivery (SOLD) Plan; Primary Care Transformation Programme and General Medical Services (GMS) Contract; Carers Act; Ministerial Strategic Group integration indicators; Regional Planning; and the national strategies for Mental Health and Dementia.

We have worked with the IJB and Strategic Planning Group (SPG) members to develop the refreshed Strategic Plan for our local area. This approach recognised that the key messages from the first plan remain relevant given the short period of time since it was prepared.

There have however, been some minor changes made to the vision and local outcomes. Our local outcomes continue to align with the Scottish Government's national health and wellbeing outcomes, the National Health and Social Care Delivery Plan and the Falkirk Community Planning Partnership Strategic Outcomes and Local Delivery (SOLD) Plan.

The Strategic Plan describes how the Partnership will continue to make changes and improvements to health and social care services for all adults. The plan details how the partnership will prioritise services in response to the key issues for the Falkirk area. This is supported by a Strategic Needs Assessment (SNA). We will focus on delivering high quality health and social care services with Third and Independent sectors and our Community Planning partners providing a valuable contribution.

The changes to the Strategic Plan vision and outcomes from the original plan are set out in table 1 below:

Strategic Plan 2016 - 2019	Strategic Plan 2019 - 2022
To enable people in the Falkirk Council area to live full and positive lives within supportive communities	To enable people in the Falkirk HSCP area to live full and positive lives within supportive and inclusive communities
Self Management Individuals, their carers and families are enabled to manage their own health, care and well being	**Self Management** (merge with Autonomy and Decision Making) 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
Autonomy and Decision Making Where formal supports are required, people are enabled to exercise as much control and choice as possible over what is provided	
Safe Health and social care support systems help to keep people safe and live well for longer	**Safe** High quality health and social care services are delivered that promote keeping people safe and well for longer
Experience People have a fair and positive experience of health and social care	**Experience** People have a fair and positive experience of health and social care, delivered by a supported workforce that are skilled, committed, motivated and valued
Community based Supports Informal supports are in place, accessible and enable people, where possible, to live well for longer at home or in homely settings within their community	**Strong Sustainable Communities** Individuals and communities are resilient and empowered with a range of supports in place, that are accessible and reduce health and social inequalities

Table 1

The following page sets out the national health and wellbeing outcomes and the national integration priority areas for IJBs.

National Health and Wellbeing Outcomes

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

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

Integration Priorities

1	Reduce occupied hospital bed days associated with avoidable admissions and delayed discharge
2	Increase provision of good quality, appropriate palliative and end of life care
3	Enhance primary care provision
4	Reflect delivery of the new Mental Health Strategy
5	Support delivery of agreed service levels for Alcohol and Drugs Partnerships work
6	Ensure provision of the living wage to adult care workers and plan for sustainability of social care provision
7	Continue implementation of Self Directed Support
8	Prepare for commencements of the Carers (Scotland) Act 2016 on 1 April 2018

Locality Planning

The development of localities lies at the heart of the integration legislation – the Public Bodies (Joint Working) (Scotland) Act 2014. It is also reflected in the Community Empowerment (Scotland) Act 2015.

The Partnership has identified its locality areas for service planning purposes. There are three localities within the Falkirk Council area, which are illustrated in Figure 1 and are:

1. **West**
2. **Central**
3. **East**

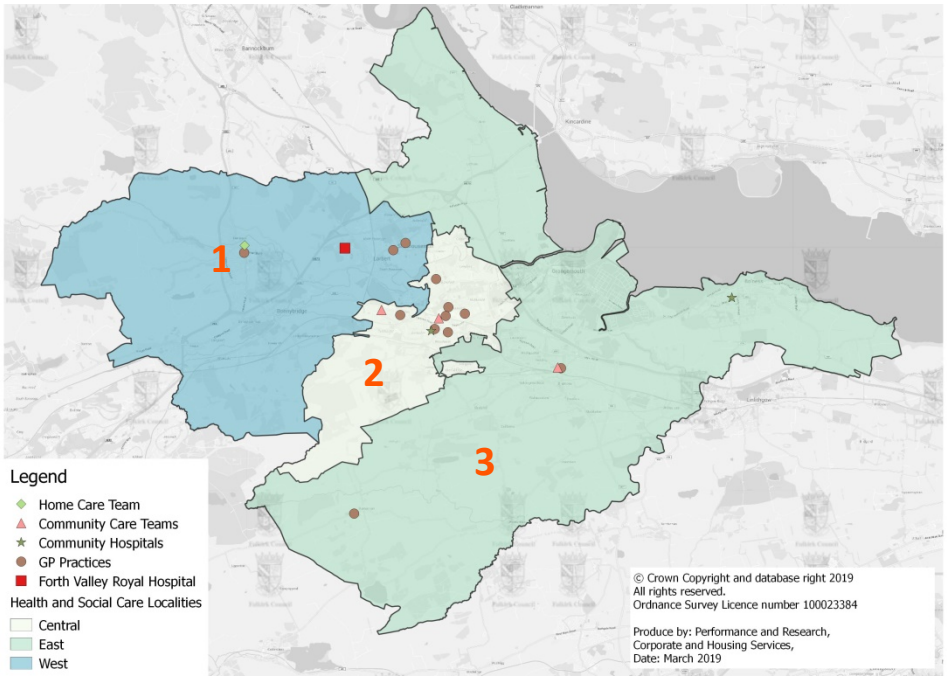

Figure 1: Falkirk HSCP Localities

Locality working provides the opportunity for the Partnership to design integrated services and realign resources to deliver the Strategic Plan. This will also include working alongside our partners and their plans. This includes the Community Planning Partnership (CPP) Strategic Outcomes and Local Delivery (SOLD) Plan.

The Partnership has appointed two Heads of Integration and two of the three Locality Managers, with recruitment ongoing for the third post. The Locality Managers will have a key role to establish integrated locality teams including assessment and care planning, Home Care and community nursing teams. They will also lead on the development of Locality Plans that reflect the Strategic Plan priorities and local priorities.

In developing our locality plans we will align with the work of our partners to:

- co-produce locality plans with partners, communities and people who use services
- design integrated and localised services, including health improvement and prevention support

- build community capacity to improve health and wellbeing outcomes and address health inequalities.

These locality plans will show how the Strategic Plan is being implemented at a local level to ensure services respond to the priorities, needs and issues of communities.

The following table summarises information taken from the Locality Profiles for each of the locality areas.

POPULATION	Central Locality	East Locality	West Locality	Falkirk HSCP
Total Population	44,500	67,136	47,744	159,380
Percentage over 65 years old	18.9%	18.6%	17.3%	18.3%

EQUALITY				
Ethnicity (ethnic minority population)	5.1%	3.3%	3.3%	3.6%
Physical Disability (per 1,000 population)	74.9	70	64.3	69.7
Learning Disability (per 1,000 population)	5.3	3.9	5.6	4.8

CIRCUMSTANCES LIFESTYLE & RISK				
Population Income Deprived	14.3%	10.8%	10.1%	11.6%
Drug related hospital stays (per 100,000 population)	158.5	73.4	83	100.8
Alcohol related hospital stays (per 100,000 population)	697	460.8	514.9	543.7

MENTAL HEALTH Quality Outcomes Framework				
Dementia Count	360	460	361	1,181
Mental Health (rate per 1,000 population)	11	7.7	6.2	8.1
Psychiatric Hospitalisation (rate per 1,000 population)	389.1	248.4	281.1	297.6

Table 2: Locality Information, extracted from the HSCP Locality Profile produced in 2019

How We are Making a Difference

Our Strategic Plan sets out the Partnership's vision, outcomes and priorities for people who live in the Falkirk area.

In this section of the report we have provided an update on our progress. This is over the year 1 April 2018 – 31 March 2019. This means we are reporting progress on the outcomes and priorities of the first Strategic Plan 2016 – 2019. We will report progress on our new Strategic Plan next year.

In this report we have merged the outcomes *Self-management* and *Autonomy and Decision-making* and provided an update on both these areas. This reflects our new Strategic Plan *Self-management* outcome.

Local Outcome 1: Self-management, autonomy and decision-making

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	
What will this mean for people? People, their carers and families will be at the centre of their own care by prioritising the provision of support which meets the personal outcomes they have identified as most important to them. Services will encourage independence by focusing on reablement, rehabilitation and recovery. People are able to access services quickly by an accessible point of contact. Information that enables people to manage their condition is accessible and presented in a consistent way. This will include a range of information on services and community based supports. In addition, services are responsive and available consistently throughout the year, on a 24/7 basis, if appropriate. Health education and information is accessible and readily available to people, their carers and families, which allows them to make informed choices and manage their own health and wellbeing. Person-centred care is reinforced, acknowledging family/carer views. Care and support is underpinned by informed choices and decision making throughout life.	**What will this mean for our communities?** Communities will feel they are involved in decisions that affect them. Their views are gathered and they are listened to. They know what services we are able to provide and have confidence in them. Communities are enabled to continue to develop and manage a variety of good quality local services to meet community need.
Examples of work progressed during 2018 - 2019 1. Living Well Falkirk Website 2. Living Well Falkirk Centre 3. Supporting carers 4. Redesign of day services for younger adults 5. Specialist Dementia Services 6. Unscheduled Care and delayed discharge	

Table 3 Local Outcome one

1. Living Well Falkirk

Living Well Falkirk (www.falkirk.gov.uk/livingwell) launched in May 2018. It is a guided self management web based service. It offers people an opportunity to find support, advice and solutions about their health, well being and self-management.

The tool gives people choice and control by providing a wide range of information about local and national health and social care services. It also helps people to connect in to local groups and services. People can use it on behalf of someone they live with or who they care for. If people need assistance using the tool, staff at local libraries can help. An information leaflet is available in NHS and Social Work offices as well as libraries and information hubs across Falkirk.

Research underpinning the website shows that prevention and early intervention strategies can mean that people stay well and independent for longer. This in turn can lead to less need for health and social care services. The average age of people accessing the website is 65 years.

The website has also offered an alternative route to contacting services such as the Duty Social Work Team. People are able to access information quickly, solving their issues, rather than waiting on a list to be visited by the team. The system also has inbuilt assessment features that mean if someone needs to be seen by a professional, the system tells them who they need to contact. This could be their GP, Community Nurse or Social Worker.

In the first year of the website, over 2250 people have used the site, with a total of 3792 visits. The following summarises what areas of the site were most used by people.

Figure 2 Living Well Falkirk

2. Living Well Falkirk Centre

When people identify that they have difficulty with daily living tasks, for example bathing or managing the stairs, it is important that they receive the right support at the right time. The aim of the Living Well Falkirk Centre is to assess people quickly and where there is a need, provide equipment or adaptations to help maintain independence. This work has taken place over the year and has in turn, improved our waiting times.

The introduction of the Living Well Falkirk Centre means we are able to reduce the waiting time for new referrals for this type of assessment to 2-3 weeks. The first Living Well Falkirk Centre was launched on 9 April 2019, within the Forth Valley Sensory Centre.
The service runs three days a week, and people are offered an appointment with an experienced worker. Using the Living Well web based assessment, people can get personalised advice on healthy ageing and on keeping active and independent for longer.

3. Supporting Carers

Over the year we have been working with carers and carer organisations to implement the Carer's (Scotland) Act 2016. The Partnership's Strategic Plan 2016 - 2019 (and 2019 – 2022) has prioritised support for unpaid carers as a key issue. We recognise the need to support carers in a range of ways to meet the projected increase in the older population and people with complex needs. The work we have being doing is consistent with the main direction of the Act.

The Act extends and enhances the rights of unpaid carers. It aims to ensure that carers are supported more consistently, so they can continue to care if they wish, and are able to do so in good health and with a life alongside their caring responsibilities.

The Act introduced a number of duties on local authorities and the NHS, some of which are delegated to IJB's. One duty was to develop a Carer's Strategy. This was agreed by Falkirk Council and the IJB in April 2019 and covers both young carers and adult carers.

Working with carers, we have agreed a shared local vision:

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

The Partnership has also published a Short Breaks Services Statement. This sets out information about local short breaks provision. It describes a variety of ways carers can access short breaks through funded support from the local authority or through access to community based support. We will review this every year to make sure the information it contains is kept up to date.

We have also put in place arrangements to support carers through the completion of Adult Carer Support Plans (replacing Carers' assessments) or Young Carers' Statements.

There is ongoing work to maintain services for carers that provide information and advice about carers' rights, income maximisation, education and training, advocacy for carers, health and wellbeing, bereavement support, and emergency planning and future care planning. This also involves carers in hospital discharge planning for the person they care for.

In 2018 – 2019 the Carers Centre has:

falkirk & clackmannanshire carerscentre
Inform | Support | Involve

- supported 1069 individual carers
- provided 73 health and wellbeing sessions
- provided 94 carers with a grant to purchase a short break. We also provided an additional 74 grants funded by the Short Breaks Fund.
- delivered 152 Care with Confidence sessions
- provided 24 carer involvement opportunities
- delivered carer awareness sessions to 311 professionals
- participated in 46 meetings with external organisations
- represented the views of carers at 36 planning group meetings
- offered 447 Adult Carer Support Plans
- completed 372 Adult Carer Support Plans.

4. Redesign of Day Services for Younger Adults

The Partnership has continued to take forward a programme of work to redesign day services for younger adults. This involved engagement with people who use services, their carers and staff about what changes should happen to develop alternative community based services.

The redesign work reflects Self-Directed Support principles to empower and enable people to have choice and control over the design of their own support. People identify through their reviews and reassessments opportunities to use their existing care differently. For example, people can access more community based activities, rather than in-house care, with day service staff supporting them where this is needed. People can use their hours of support more flexibly and have control over their personal outcomes. This promotes and supports personal independence and social inclusion.

The Partnership hosted a successful event on 23 April 2018. The purpose of organising the "Believe and Achieve" event was to demonstrate the many opportunities there are for people with a disability and their carers in the Falkirk area.

On the day 179 people attended the event where there was information available from 25 exhibitors. These covered a range of services from Falkirk Community Trust, Third Sector organisations and other services.

The Partnership has invested in a range of community based supports to provide alternative choices to people. We have been able to reinvest money from the closure of Camelon and Bainsford Day Centres to do this.

These community supports include dates-n-mates in Falkirk (Dates n Mates Falkirk). This is Scotland's national dating and friendship agency run by and for adults with learning disabilities. People can become members and will have opportunities to make new friends through invitations to social events and activities. These could be from cinema and shopping trips, bowling to Halloween Parties and much more. There are also volunteer opportunities to help other members. Dates-n-mates launched in Falkirk in early 2019, and held a pre-launch Christmas Party at the Falkirk Stadium on 20 December 2018.

The Partnership has funded the set up of a Neighbourhood Network project Neighbourhood Networks. The service supports adults mainly with learning disabilities, physical disabilities and mental health issues to live an independent life within their own homes, have a better quality of life and be fully involved within their local communities.

In the Denny and Bonnybridge area, a Community Living Worker will support up to 10 people (called members), who will have knowledge of the local area and the facilities available. The support they deliver is responsive and flexible, available day, evening and weekend. It is tailored to the individual needs to each member.

Members are supported to develop their own personal growth plan which focuses on areas such as independent travel, money management, life skills, employment, building friendships and relationships. Members are encouraged to share life skills and offer support to other members within their own networks, and also across the organisation. It is hoped that as members will be able to spend more time with friends, they will be less isolated and less likely to suffer the problems associated with isolation and loneliness and rely less on paid support.

The project hopes to inspire people, create a feeling of acceptance and belonging, a sense of involvement and to re-energise neighbourly connections.

5. Specialist Dementia Services

During 2018 - 2019, work has been progressed to support the transformation of services for Post Diagnostic Support (PDS), and to deliver the commitment in the National Dementia Strategy to provide a continuum of support for patients, their carers and families, after diagnosis. The service improvement includes the integration and co-location of the NHS Dementia Outreach Team (DOT), Alzheimer's Scotland Post Diagnostic Link Workers and Social Worker support.

The integrated team will operate on a Forth Valley basis. Nursing staff, supervised by a Consultant Psychiatrist, will work along with locality based support provided by the PDS Link Workers and dedicated Social Work support. The team will provide enhanced support for the shared assessment and ongoing support for people with dementia and their carers.

Case Study

Mrs A is an 85 year old woman who lives alone. She has been living with Alzheimer's Disease for a few years. Unfortunately over recent months there was deterioration in how Mrs A was managing, to the extent that she was forgetting to eat. Her daughter who is her main carer was visiting every day but was finding this increasingly stressful. Mrs A's daughter contacted Social Work Services to ask for help. Given the concerns about Mrs A's lack of adequate nutrition, and the health and well being needs of her daughter in the carer role, Mrs A's case was allocated as a priority.

The Community Care Worker completed an outcomes focussed assessment with Mrs A and her daughter to work out what was important for them. The collaborative assessment identified that Mrs A was socially isolated; couldn't remember to eat her lunch and that the daughter was worried about her mum.

A plan was put in place whereby a carer from a local care provider now comes in at lunchtimes and sits with Mrs A to encourage her to eat her lunch. Mrs A also now has a support worker to go out and about within her local community. Mrs A is less socially isolated because she has joined a community day care group in her area.

Mrs A's daughter is less stressed because she is reassured that her mum is eating regularly and has gained weight. She feels the quality of her relationship with her mum has improved and likes to hear from her mum how much she enjoyed the community day care group.

Mrs A's daughter reported that as a result of the support she is "now much more confident that we can manage mum at home for a longer time".

6. Unscheduled Care and Delayed Discharge

The Partnership continues to focus our approach and services to prevent unplanned admissions to hospital as well as to support people's discharge home when they are ready to leave hospital.

In addition to core health and social care services, there are a range of initiatives funded by the Partnership. These aim to tackle and improve various aspects of the pathways in and out of hospital care and the community.

We are investing 54% (£2,399,458) of Partnership Funds in the prevention of admissions to hospital and supporting discharge. These funds support a range of initiatives including:

- Enhanced Community Team is a team of ANP, Senior staff nurses, Health Care Support Workers, Allied Health Professionals and GPs. The team operates over 7 days and works closely with ReACH and the Out of Hours Nursing team. They provide support to people who would otherwise be referred for hospital assessment or admission. This may be because they are unwell or are uninjured after a fall. The team aims to provide an immediate response, normally within 2 hours. The team will complete comprehensive medical, social and environment assessments that enable people and carers choice in their place of care through Anticipatory Care Planning.

Case Study

Mrs B is a 76 year old lady who was referred by her GP with shortness of breath. She was keen to avoid hospital admission. She lives alone and her relatives live some distance away. She had a background of Chronic Obstructive Pulmonary Disease (COPD), cognitive impairment and vascular disease. She had been feeling progressively unwell over the last month.

On first assessment her oxygen saturation levels were reduced. Her blood pressure was low and she appeared dehydrated. Blood investigations confirmed this.

Mrs B had extensive intervention and daily visits by members of the team. She was treated for an exacerbation of COPD with antibiotics and steroids, both a nebuliser and oxygen were provided which improved oxygen saturation levels.

Medications were reviewed and changes made. A temporary package of care was provided by the team to assist with personal care and she was referred to the ReACH team for further assessment of her functional ability with activities of daily living.

Mrs B was successfully supported by the team for 11 days and able to remain at home independently at the point of her discharge.

When asked what difference the team made during this episode of illness, her daughter said: "*Reassurance and support when needed. Talked through and set up a plan for caring for/supporting mother in the future. Has provided the family with more confidence in dealing with any problems".*

- Rapid Access Frailty Clinic – the clinic is able to rapidly assess a person who is at risk of crisis admission to hospital. People have access to a Consultant Geriatrician and a full range of diagnostic tests can be done as needed. A person specific treatment plan by a multi disciplinary team will be completed and wherever possible, people can return home on the same day.

£607,497 of Partnership Funding is used to provide additional support for reablement and intermediate care services. This includes Summerford Intermediate Care Home, and reablement posts in each of the Community Care Locality Teams, Falkirk Community Hospital and the ReACH team.

Winter planning monies have also been released through the Unscheduled Care Programme Board to assist with work on delayed discharge.

The Partnership has engaged the Institute of Public Care (IPC), based at Oxford Brookes University, as a key partner in setting the strategic direction on reablement and bed based intermediate care services. These services are a key enabler in the implementation of a "Maximising Recovery, Promoting Independence" approach. This model aims to prevent hospital and care home admissions and support Falkirk citizens to remain living at home independently for as long as possible.

Local Outcome 2: Safe

High quality health and social care services are delivered that promote keeping people safe and well for longer	
What will this mean for people? People will be supported to live safely in their homes and communities. People will be involved and consulted on decisions about their care, treatment and support. People will have timely access to services, based on assessed need. Services will improve quality of lives and be joined up to make best use of available resources.	**What will this mean for our communities?** Communities are confident that systems are in place for the identification, reporting, and prevention of harm.
Examples of work progressed during 2018 - 2019 1. Free Personal Care 2. Support at Home (Home Support and Supported Living) Contract 3. Pharmacy First 4. Power of Attorney Campaign	

Table 4 local outcome 2

1. Free Personal Care

Free Personal Care is available to all adults who are assessed by Social Work Adult Services as needing this service. This started from 1 April 2019.

The Partnership has responded to the Scottish Government statutory guidance issued in December 2018. This guidance outlines the provision of free personal care to those both over and under the age of 65. Since the guidance was issued, we have done work, including the implementation of revised eligibility assessment and criteria, to prepare to introduce these changes.

2. Support at Home (Home Support and Supported Living) Contract

Care at Home services have an important role in supporting people to remain at home.

The Partnership spends significant amounts of money on these services therefore we need to have a contract in place. This ensures the quality of care provided and we can demonstrate value for money.

Our new contract started on 1 April 2018 for a period of 2 years. There is an option to extend for up to a further 2 years. The estimated value of the contract over the 4 years (including extension period) is £100m.

The new contract provides an opportunity to work collaboratively with a smaller number of providers. This will enable stronger processes for contract and performance management to be developed. The objectives of enhanced collaboration are to:

- ensure levels of care are reviewed to deliver personalisation and improved outcomes
- increase provider capacity, reducing delays in provision of care packages
- support locality planning
- implement operational efficiencies, reducing service delivery costs.

This approach will also enable commissioners to develop stronger partnership working with providers, to build more effective relationships that will be central in taking forward:

- reablement
- SDS and outcomes approach
- individual budgets
- integrated working.

3. Pharmacy First

The aim of the Pharmacy First Service is to enable people to access treatment for uncomplicated common conditions from a community pharmacy. These include urinary tract infections, impetigo, bacterial conjunctivitis, skin infections and minor skin conditions.

People can get a consultation with the community pharmacist, who will provide advice and treatment if required. The Pharmacy First Service is free to anyone registered with a Forth Valley GP surgery. It is available both within GP opening hours and out of hours through 33 community pharmacies in Falkirk.

This service has a number of benefits to people, as they have quick and convenient access to the service and do not have to wait for a GP appointment for minor conditions. In turn this frees up GP appointments and promotes a different way of working with other professionals supporting people.

4. Power of Attorney (PoA) Campaign

The Partnership is part of a national campaign to promote the uptake of Powers of Attorney. The campaign is about giving people the power to make decisions that will protect them, their family and those they care about should they ever lose capacity to make decisions.

A PoA is a written, legal document giving someone else (your Attorney), authority to take actions or make decisions on your behalf (the granter). You choose the person(s) you want to act as your Attorney and what powers you want the Attorney to have. A PoA is intended to ensure that your financial affairs and personal welfare can still be dealt with/protected in the event of you being unable to act on your own behalf.

This is important because when a person who lacks capacity and does not have a PoA is admitted to hospital, discharging them to a care setting can only take place once a legal process to appoint a guardian has been completed. This can mean people stay in hospital for longer than they need to where they could be settled in a more homely environment.

More information on the campaign can be found at
https://www.mypowerofattorney.org.uk

Local Outcome 3: Experience

People have a fair and positive experience of health and social care, delivered by a supported workforce that are skilled, committed, motivated and valued	
What will this mean for people? People feel services are responsive to their needs and are available to them before reaching a point of crisis. These services are joined up and improve quality of lives. People are engaged and involved across the Partnership. People will receive feedback and understand what their contribution has influenced.	**What will this mean for our communities?** Communities will have the opportunity to be engaged and involved in service redesign and delivery within their local areas. This will be based on a clear understanding of local needs and available resources.
Examples of work progressed during 2018 - 2019 1. Good Transitions – Improving Transitions Planning 2. Palliative and End of Life Care 3. Improving mental health and wellbeing 4. National Health and Social Care Standards	

Table 5 Local Outcome 3

1. Good Transitions – Improving Transitions Planning

Young people with additional support needs and their families told us how we can improve the way we support them as they move from children's to adult services. This involves coordination within and across services including Education, Children's Social Work, HSCP, Health, Housing, Employment Services and the Third Sector. There is optimism about the future and enthusiasm around how good transitions can be achieved.

As part of a new model a Transitions Coordinator will work alongside social workers in children and adult services, who remain the case holders. The coordinator will ensure that young people are identified early, and that plans are in place for a smooth and appropriate move into adulthood. This is a new post and will be advertised later in 2019.

In the interim, adult services have ring fenced the time of a community care worker to plan for S5 and S6 young people and begin development of a transitions data base. Alongside this Children's Services are using Attainment Funding, which is aimed at closing the attainment gap, to fund a social worker post in Carrongrange School until 2021. Once in place, one aspect of the remit of this worker will be transitions not only into adult services but also from primary to secondary education.

The HSCP has adopted the Principles for Good Transitions to guide service delivery and practice and signal our commitment to excellence in transition planning.

2. Palliative and End of Life Care (P&ELC)

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. Care often involves a range of health and social care services for those with advanced conditions who are nearing the end of life.

Approximately 1600 Falkirk residents die every year. It is estimated that up to 1200 of these people are likely to have palliative or end of life care needs. Our ageing population means that the number of projected deaths is expected to rise, which will also increase demand for palliative and end of life care services.

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

Our key priorities include:

- Update models of P&ELC care to support the provision of services that will meet future needs. This will include the delivery of more care closer to home and in community settings, reducing unnecessary hospital admissions, and ensuring that everyone that needs palliative care is provided with a high quality of care and support.

- Improve communication and care planning to improve identification of people with P&ELC needs, including people with a non-cancer diagnosis or frailty. This will include enhancing communication, coordination and care planning.

- Develop P&ELC skills for staff to have a balanced workforce with the right capacity, knowledge and skills to ensure that people have timely access to the support they need.

Key areas of activity over the last year have included:

- **Anticipatory Care Planning** (ACP) is about people thinking ahead and understanding their health. There is growing evidence that ACP increases the likelihood of people dying at home and reduces hospital readmission rates. We have continued to raise awareness about ACP and embed this in day to day practice, including a large local stakeholder workshop event in February 2019. We will work with care homes to ensure ACP's are in place.

- **Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Process** creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about a person's care and treatment. The ReSPECT process can be complementary to the wider process of anticipatory care planning. A variety of ReSPECT workshops and education sessions were delivered to a range of staff. An evaluation of ReSPECT was undertaken, which has now been published on the Scottish Patient Safety Programme (SPSP) website. We are developing tools to support the proactive identification of patients in need of ReSPECT/ ACP and communication prompts.

- **Health Crisis in the Community** - we have worked with the Scottish Ambulance Service (SAS) to evaluate feedback from paramedics and first responders about their access to emergency care planning documentation in a crisis and the impact on patient care. As part of this work, and linking in with ReSPECT, we will be working with the SAS and MacMillan Cancer Support to improve how we manage a health crisis in the community for people with palliative care needs, who may not wish or be appropriate for hospital admission.

- **Quality End of Life Care for All (QELCA) programme** - care homes within the Falkirk area have been participating in the QELCA programme delivered at Strathcarron Hospice. This aims to create sustainable improvements through attitudinal change, and results in active problem solving and facilitates change in practice to deliver high quality care to patients and families

- **Extension for Community Healthcare Outcomes (Project ECHO) -** utilises telemedicine links to deliver education to care homes in an effective and high quality manner. Care home staff have formed the first local cohort of Project ECHO, which improves care by gathering a community of practice together for learning and support

- **Advanced Nurse Practitioners (ANP) with a specialist interest in P&ELC** are supporting practices in various areas of care with an evolving model that will be evaluated and inform future developments

- **Macmillan Healthcare Support Worker (HCSW) project** is a two year project to test a new model of care for people in the community. This model involves HCSW providing support to Community Nursing to support people to remain in their own homes for as long as possible. There is already evidence that early intervention is enhancing patient and carer experience and that crisis admission near the end of life is likely to be avoided.

- **Hospice at Home Service**, provided by Strathcarron Hospice, has operated over the last 5 years, supported mainly through Big Lottery funding. It supports people in their own home who are in the last weeks of life through practical, emotional and personal care. A core element of the service is flexible support to family carers as death approaches. An external evaluation (working with ISD) has evidenced this intervention enabled more people to die at home, has high user satisfaction, and achieved an excellent rating from Care Inspectorate.

- **Living Right Up to the End: ** Using a community development approach, this Strathcarron Hospice project is developing volunteers to support people with advanced long-term conditions and their carers, right up to the end of their lives. It is person focused, and supports self management and community connection as well as facilitating a ground-up approach to thinking ahead and making plans for the end of life. The project offers:
    - One to one support (befriending)
    - Short breaks for carers
    - Support to connect to community
    - Local volunteers with in depth knowledge of community resource
    - Lunch group
    - Community well being café
    - Thinking ahead support
    - Information stands.

HSCP funding has supported Strathcarron Hospice with this development in Falkirk Central and Falkirk West.

3. Improving Mental Health and Wellbeing

The Partnership will continue to work with partners to deliver and redesign services in line with the national Mental Health Strategy. The Falkirk Mental Health Planning Group (MHPG) brings together service providers from statutory and third sector organisations to analyse data, identify areas for improvement and deliver on Community Planning Partnership, IJB and Children's Commission priorities on mental health and wellbeing. These priorities include suicide prevention, emotional regulation, trauma and substance use and mental health.

Decider Skills Training Programme

The Partnership has funded Decider Skills Training programmes to teach adults and children the skills to understand and manage their own emotions and mental health. This is in response to a gap in early intervention services for people and in training for staff in skills based interventions for distress tolerance, mindfulness skills, emotion regulation and interpersonal effectiveness. It will give communities the opportunity to develop life skills and give everyone a shared language and set of tools to use.

The Decider Skills training is based on cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT) informed skills under four core skill sets. It has the potential to be adapted for a range of service settings including adult mental health, child and adolescent, learning disability, substance misuse and prisons.

There have been 4 cohorts of staff training aimed at health, social care, Police, Fire and Rescue service, Scottish Ambulance Service, pastoral teachers and third sector mental health services. We have trained up 6 authorised trainers, who will continue to deliver Decider Skills, starting training later in 2019.

Mental Health Acute Assessment and Treatment Service (MHAATS)

Since 31 January 2019, MHAATS have been providing pre-hospital triage for people who come to the attention of Police Scotland or the British Transport Police (within the Forth Valley area). The service is available where there is a suspicion that the person is suffering from a mental disorder, or where the individual discloses symptoms which warrant an emergency mental health assessment, for example reporting suicidal intent.

The aim of providing this service is to:

- reduce unnecessary ED attendances
- reduce the time spent by Police Officers waiting in the ED
- improve the experience of patients accessing mental health assessment.

During the time from 31 January to 7 July 2019, a total of 264 referrals have been made to MHAATS by Police Scotland. There have been 22 cases where redirection to ED has been necessary. The provision of the Pre-Hospital Triage Service has helped avoid 242 ED attendances (91.7% of all referrals to the service). This means that people are receiving access to the right service. Exact figures are not available to demonstrate efficiencies for Police Scotland, however it is estimated that there are significant benefits to the Police by minimising time taken to attend ED.

Community Based Provision

In addition to the range of statutory services provided, Partnership Funding supports projects delivered through Falkirk's Mental Health Association (FDAMH). These include:

- Immediate Help Service - aims to provide people with the opportunity to get immediate access to speak to an experienced mental health practitioner either on the telephone or in person. **1,177 people used the service**

- Social Prescribing Service – has 3 staff. One is based in a GP practice taking referrals from the GP's and accepting self referrals from patients of the practice. One is based in FDAMH taking referrals primarily from the Immediate Help Service and the other provides a range of therapeutic groupwork. **461 people engaged with the service**

- Social Spark – is a modern approach to befriending that helps people who use the service form friendships in a safe environment. The impact of the service has been
    - reduction in social isolation and loneliness
    - forging new friendships outwith group meetings
    - supporting and learning from one another
    - supporting early intervention / prevention of deteriorating mental health and wellbeing
    - providing some respite for carers.

4. National Health and Social Care Standards

The Partnership has implemented the new human rights based Health and Social Care Standards. The standards set out what people should expect when using health, social care or social work services in Scotland. This means empowering people to know and claim their rights. The objectives of the new Standards are to drive improvement, promote flexibility and encourage innovation in how people are supported and cared for.

The Health and Social Care Standards describe both the headline outcomes, and the descriptive statements which set out the standard of care a person can expect. Not every descriptor will apply to every service. The headline outcomes are:

- I experience high quality care and support that is right for me
- I am fully involved in all decisions about my care and support
- I have confidence in the people who support and care for me
- I have confidence in the organisation providing my care and support
- I experience a high quality environment if the organisation provides the premises.

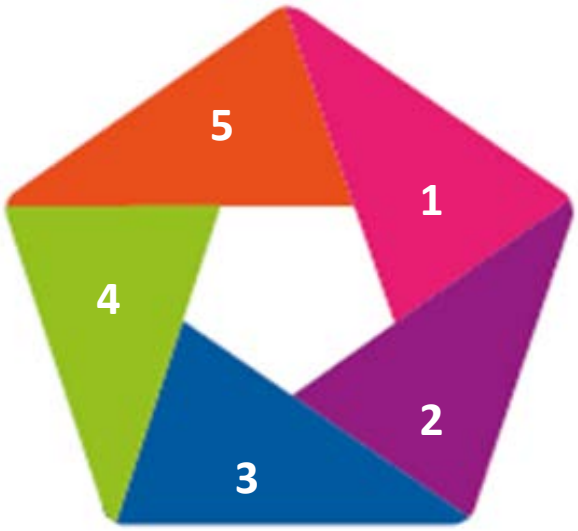

Figure 3 National Health & Social Care Standards

Each Standard is underpinned by five principles:

1. **Dignity and respect**
2. **Compassion**
3. **Be included**
4. **Responsive care**
5. **Support and wellbeing.**

These principles reflect the way that everyone should expect to be treated.

Local Outcome 4: Community Based Support

Individuals and communities are resilient and empowered with a range of supports in place, that are accessible and reduce health and social inequalities	
What will this mean for people? People are more confident, reliant and able to access local services and support to improve and maintain their health and wellbeing and be more independent. There will be a focus on early intervention and prevention.	**What will this mean for our communities?** Communities are informed, involved and supported to work cohesively to develop and manage community based supports**.**
Examples of work progressed during 2018 - 2019 1. Primary Care Transformation Programme 2. Changing Places Toilet Facilities 3. Supporting discharge from Loch View 4. Developing strong and resilient communities	

Table 6 Local Outcome 4

1. Primary Care Transformation Programme

Primary Care Improvement Plan

Falkirk IJB and Clackmannanshire and Stirling IJB have collaborated to produce a single Primary Care Improvement Plan for Forth Valley. The plan aims to enhance Primary Care workforce capacity and capability, for example, with Advanced Nurse Practitioners (ANPs) and Advanced Practitioner Physiotherapists. This will support a person centred, safe, effective and sustainable shift of workload from GPs and will release capacity for their Expert Medical Generalist role.

There has been significant engagement and work with all GP clusters to consider their needs and priorities and to help plan the phasing of new services over the next 3 years in support of practices. A number of public awareness sessions have been well attended with individual practices also highlighting the changes to their patient populations.

The Primary Care Improvement Plan has a number of priorities, and each has a detailed plan. These priorities are:

- **Pharmacy Support -**The Primary Care Improvement plan sets out a strategy for transformational change in the way we provide Primary Care NHS services for the population of Forth Valley.

Part of this plan is to deliver on a number of new services to support the new GP contract. For 3 of our 5 Falkirk clusters, the focus has been on developing primary care pharmacy services, called the Pharmacotherapy Service. This service will include pharmacists and qualified pharmacy technicians supporting GP practices. Activities include assessing and authorising acute and repeat prescriptions and ensuring that when patients have been discharged from hospital any medication changes that have happened during their hospital stay, are accurately updated in the patients GP record.

The Pharmacotherapy Service will also offer pharmacist led clinics and appointments for patients to discuss their medicines. For example, pain medication or for those patients who are taking multiple medicines who may need a medication or 'polypharmacy review'.

In March 2019, the Pharmacotherapy Service started to be rolled out across some GP clusters, including central Falkirk. The next phase will be across the Stenhousemuir and Larbert GP cluster and Denny/Bonnybridge GP cluster.

The intended outcomes are that new service will free up GP to focus on more complex care whilst reducing medicines related hospital admissions and improve patient safety through polypharmacy review.

- **Additional Professional Roles** - practitioners, such as Physiotherapists, Mental Health Practitioners and Advanced Nurse Practitioners (ANP's) will work closely with GPs. They will be a first point of contact to assess and direct care for urgent health issues, muscle and joint problems and mental health issues. In Falkirk Partnership there are 9 practices with Advance Practice Physiotherapists. We are also training ANPs to work in practices to deal with urgent, same day appointments. We have introduced Primary Care Mental Health Nurses (PCMHN's) in 19 practices in Falkirk. There is alignment with the national Mental Health strategy and work being done in Primary Care.

- **Community Link Workers** – will work directly with people in our most deprived communities, who need support because of their health and social care needs to help them navigate and engage with other services.

- **Vaccination Transformation Programme** - this will mean the development of a community vaccination team who will maintain the highest levels of immunisation and vaccination uptake

- **GP Out of Hours Service (OOH) -** The GP OOH service has been changing to meet people's needs and to create a sustainable and cost effective workforce model. The aim is to have a multidisciplinary OOH service across Falkirk, Clackmannanshire and Stirling.

The OOH service is making good progress towards a stable multidisciplinary workforce and service delivery model which delivers a quality service for people whilst providing a good working experience for staff. The service will scale up the multidisciplinary workforce with a rolling programme of training for ANP and Paramedic Practitioners whilst also seeking to build better connections and approaches with partner services in social care and out of hours nursing.

2. Changing Places Toilet Facilities

Within the Falkirk Partnership area we are making good progress towards having Changing Places Toilets (CPT) available at a number of locations.

The provision of CPT facilities has been identified as a gap, which leads to denial of dignity. People can feel compelled to abandon days out as they have no choice but to return home to attend to their personal care needs. Alternatively they and their carers need to deal with their personal care needs in non adapted facilities.

Over the year:

- Falkirk Community Trust has completed work to install a facility at the Mariner Centre and at Grangemouth Sports Complex
- Forth Valley College have agreed to open their facilities for use by the wider community
- Social Work is taking steps to open some facilities, for example at Oswald Avenue Day Service, for use by the wider public
- Falkirk Council's Locality Hubs are being designed with the need for CPT included as standard
- We are engaging with the private retail sector to make available CPT facilities.

These facilities can empower people who have higher levels of personal care need to be involved in their communities. Their availability also supports the objectives of the review of day services for younger people which can only deliver the shift towards more community based support if the necessary physical infrastructure is in place.

3. Supporting Discharge from Loch View

Loch View is NHS Forth Valley's Inpatient Learning Disability Assessment and Treatment Unit. Work is ongoing to support people to move from there to a homely setting when they are ready for discharge. This has involved working in partnership with health, social care, housing and providers to find suitable accommodation and community based supports to meet their needs.

This supports the Partnership's ambition that people with learning disabilities have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. People should have a home within their community,

be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

Through supporting people to move from the unit, there has been a reduction in the number of required in-patient beds. The savings from this have been reinvested to develop a proactive outreach treatment service model which will provide an alternative to inpatient beds.

Case Study
John has a learning disability, and behaviour that challenges. Over the years, John had numerous admissions to Loch View due to his increasingly difficult behaviours. He often issued verbal and physical threats of aggression to staff and threatened to harm himself.

For a time he had a placement in the community however his behaviours became more challenging and he was admitted to hospital and then moved to Loch View. John enjoyed living there but always wanted to move to his own place.

When John was ready for discharge, his family, advocacy worker, social worker, Loch View staff were all involved with John, working together to plan how best he could be supported in the community. John's support had to be individualised and bespoke to meet his needs.

A one bedroom flat and a support provider were identified. A transition plan was agreed by all, and a speech and language therapist was involved so that John could understand the plan. This had a visual time line of what John could expect from a move from Loch View to his new home.

John visited his new flat a number of times with his new support staff and he really liked it. John began spending more of his time with his support staff, planning the décor of his new flat and purchasing items. He was also supported to decorate the flat himself. John was included every step of the way and when his tenancy was ready, an easy read tenancy agreement was produced that he could sign without legal intervention.

Today John is very much in control of his support plan and discusses this with support staff every week. John's staff are vigilant and ensure he has a good balance of emotional and physical support. He has a responder system in place in his flat that he can activate if he wishes to speak to staff or requires assistance.

John can still be frustrated at times but staff training and their understanding of him have meant the frequency and intensity of any behaviour deemed as challenging has reduced.

John has a full life since he moved from Loch View that is community based. He recently participated in the kilt walk and raised money for charity. He hopes to do more charity work in the future.

4. Developing Strong and Resilient Communities

During the year, partners have worked together to establish a framework to further enable the HSCP to work with communities. The key driver for partners has been to develop and embed approaches within all three locality areas, that will help people to become actively involved in designing and delivering health and social care services that suit the specific needs of their local community.

The framework has been informed by work undertaken by the IJB and SPG during the development of the Strategic Plan 2019 - 2022. The Strategic Needs Assessment noted that there remain inequalities within our communities that have a significant impact of health and social care services. It was also acknowledged that our communities are asset rich in terms of the skills people have and willingness to get involved. The Partnership will support this by working collaboratively with Community Planning partners and establishing a framework of support within localities.

The HSCP approach to help the development of strong and resilient communities, is illustrated in figure 4, below.

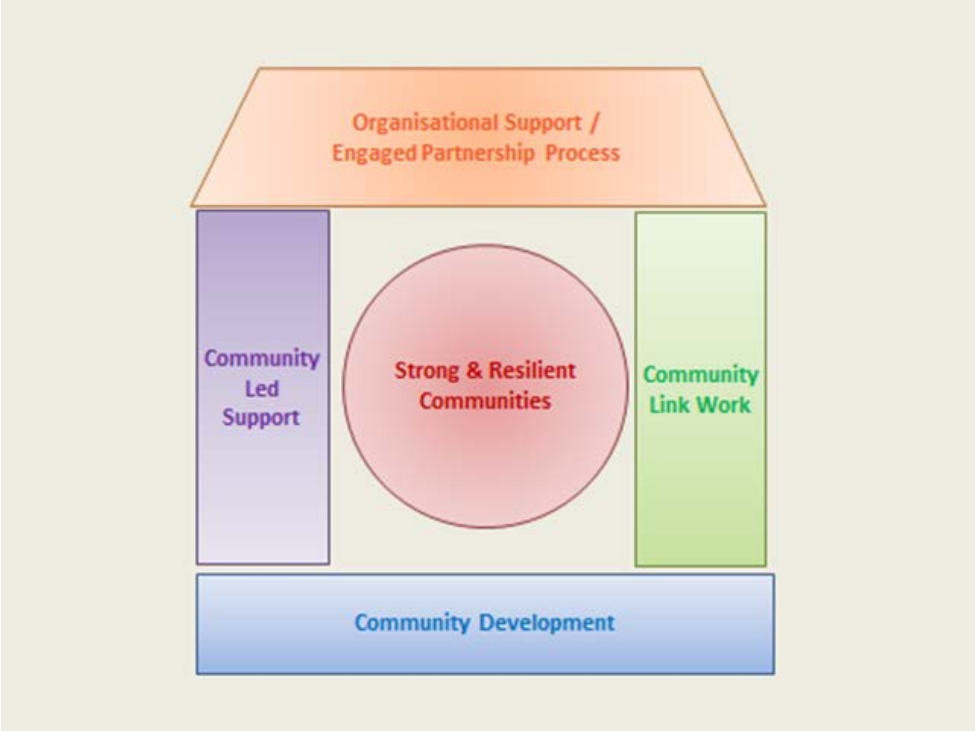

Figure 4 Strong and Resilient Communities

The components of the framework are:

1. HSCP Community Development Workers working within each locality will work with communities to identify local action plans and to support community capacity and resilience. This will include supporting individuals to form small action groups, focussing on improving and sustaining health and wellbeing. This will help create a sustainable foundation within communities.

2. Community Led Support is currently being developed to change and develop the way that services interact with services users. The focus being on 'good conversations' and providing advice and support to help people self-manage before crisis through the introduction of community led hubs. This support will be most relevant for people who have had initial contact with Social Work services due to a decline in their wellbeing.

3. Community Link Workers are generalist social practitioners generally based in a GP practice serving a socio-economically deprived community. They offer non-clinical support to patients, enabling them to set goals and overcome barriers, in order that they can take greater control of their health and wellbeing. They support patients to achieve their goals by enabling them to identify and access relevant resources or services in their community.

4. Engaged Partnership Processes: All of the areas of work described above rely on an empowered workforce supported by strong leadership. In addition, this work will be part of locality teams, to ensure that the support and services avaiable are in line with local need and integrated within health and social care provision.

The whole system described above will be overseen by a Stronger Communities Steering Group, with representatives from each area of work. The structure will be implemented during 2019 - 2020.

How We are Enabling Change

Understanding our Local Needs

The Partnership's Strategic Needs Assessment (SNA) has been refreshed and has helped us to understand and demonstrate the health and care needs which exist in our area. This has been used to inform the development of the Strategic Plan for 2019 – 2022. The latest version of the Needs Assessment was designed to provide an update to sections of the previous iteration where it was deemed there had been meaningful change, and attempts to address gaps that were identified in the period since the last SNA report was published.

The SNA brings together available data that allows us to understand the current supply of services and gaps between need and supply. The needs assessment is extensive and covers a wide range of topics including demographics, life circumstances, risk factors, population, health and service provision.

Understanding need and service provision across the Partnership will be key to future success.

As the key messages from the 2016 SNA remain relevant given the short period of time since it was prepared, a more focused update is available. This sits alongside the original document. The update includes information on population, inequalities, housing, dementia, mental health, sensory impairment, community prescribing, substance use, Primary Care, end of life care, workforce, Third Sector and Unpaid Carers.

The following key issues have emerged from the needs assessment:

- Population projections show that working age groups (16-49 and 50-64 years) make up a smaller proportion of the population in 2041 than they do in 2016. The effect of this must not be underestimated as it is two-fold; a greater proportion of the population in the older age group categories could lead to a far greater requirement for health and care service provision, while a reduction in the working age population will ultimately reduce the number of people able to provide such services.

- Projections suggest that the Falkirk population will increase over the next 25 years, with the elderly population in particular seeing a large increase. With an increased population comes the potential for a greater number of deaths in any year, and consequently a greater number of older people dying. It also predicted a greater number of individuals with multiple long term conditions (LTCs) so there is the potential for both a greater number of deaths but also greater number of more complex deaths. It is essential that palliative and end of life care services are optimised to respond with this.

- In Falkirk, all cause mortality has been increasing for the most deprived areas (SIMD 1), and declining for the least deprived areas (SIMD 5). This shows that health inequalities in Falkirk not only exist, they are widening.

- Across the health and social care services in Falkirk there is an aging workforce with many staff potentially nearing retirement. Long term workforce planning will be essential to ensure future services are sustainable. This theme is particularly relevant in primary care where there is an anticipated shortfall in newly-qualified GPs combined with the fact that GPs often retire prior to state retirement age.

- Mental health was identified as a priority in the original strategic plan, and remains a priority in the latest iteration. A large number of people experiencing minor mental health issues are unlikely to interact with services until they reach a crisis. Conditions such as depression and anxiety can have an equally negative effect on health as long term physical health conditions.

- Alcohol and drugs remain a challenge in Falkirk. While alcohol related hospital admissions have fluctuated over the years, the number of alcohol related deaths have continued to decrease. The picture for drugs is more concerning with drug related hospital admissions consistently on the rise and the number of drug related deaths has tripled in Falkirk over the past decade.

How We are Collaborating to Improve

Frailty at the Front Door Collaborative

Falkirk HSCP and NHS Forth Valley were one of five partnerships who participated in the Frailty at the Front Door Collaborative. This was facilitated by Healthcare Improvement Scotland and the iHub team.

The aims of the project were to improve outcomes and experiences of older people living with frailty and their carers who presented to acute services. We did this by:

- rapidly and reliably identifying frailty at the front door
- delivering early Comprehensive Geriatric Assessment (CGA)
- ensuring the person experiences well coordinated care and support attuned to their needs with the focus on support at home or a homely setting where possible
- improving interface and collaborative working between health and social care.

Institute of Public Care

We have started work with the Institute of Public Care (IPC), based at Oxford Brookes University. This will enable the Partnership to set the strategic direction on reablement and bed based intermediate care services, which will support a Home First approach, maximising recovery and promoting independence. The work will take place over the next year.

Developing a Priority Setting Framework

We are working with Glasgow Caledonian University and the University of Strathclyde as part of a research project to implement a priority setting framework. The focus of the framework is on the delivery of Homecare services, and "how to deliver a responsive, efficient, and sustainable Homecare provision that addresses quality, personal outcomes and reablement". This work is continuing over 2019.

How We Involve People

Falkirk HSCP Participation and Engagement Strategy sets out our commitment to effective and meaningful engagement with service users, carers, communities, staff and partners. Importantly, it also provides information about how people can participate and why participation is important.

The table below shows some examples of engagement activity undertaken by the Partnership during 2018 - 2019. This builds on activity reported in the 2017 - 2018 Annual Report

	Who was involved?					
Activity	**Service Users**	**Carers**	**Community**	**Staff**	**Partners**	**Outcome/Impact on Transformation**
Consultation & Engagement re Living Well Falkirk (presentations & feedback to targeted groups and forums)	✓	✓	✓	✓	✓	Feedback informed format and design. People informed and supported to use tool.
Engagement with young people and their families about how we support young people with additional support needs as they move from children's to adult services (Believe & Achieve event)	✓	✓				Service design and improvement
Public consultation about Adult Services Transport Policy (Online survey)	✓	✓		✓	✓	Better understand implication of policy changes
Celebration of Older People's Day - CVS Falkirk led an Older People's Day 2018 drop-in event for the Partnership.	✓	✓	✓	✓	✓	Increased public awareness of support and services. Multi-agency benefit from engagement with older people and partners to inform service design
Public consultation on local Eligibility Criteria for the Carers Act. (2 public events, an online and paper	✓	✓	✓	✓	✓	Direct input to Service development

	Who was involved?					
Activity	**Service Users**	**Carers**	**Community**	**Staff**	**Partners**	**Outcome/Impact on Transformation**
survey, information in the local press, Facebook and Twitter).						
Engagement session held with Carers Forum regarding the development of the Short Breaks Services Statement.		✓	✓	✓	✓	Direct input to Service development
Public consultation on the Carers Strategy. (Discussion with Carers Forum, 3 public events, an online consultation and information via social media).	✓	✓	✓	✓	✓	Increase local awareness and service design. Opportunity for carers and general public to raise questions and concerns which inform ongoing developments
Two joint IJB and Strategic Planning Group Development Sessions held to initiate development of the Strategic Plan 2019-2022	✓	✓		✓	✓	Inform and direct review and refresh of outcomes, priorities and action plan
Consultation on revised outcomes and priorities of the Strategic Plan 2019-2022 (Online survey & targeted presentations to local groups & forums).	✓	✓	✓	✓	✓	Wider public consultation at early stage of strategy design to enable feedback to inform further development
'Our Voice' developed and embedded within 5 residential settings for people with Learning Disabilities, including full service user involvement in recruitment, staff meetings, supervision,	✓		✓	✓		Service users and staff work together to embed an inclusive ethos across service.

	Who was involved?					
Activity	**Service Users**	**Carers**	**Community**	**Staff**	**Partners**	**Outcome/Impact on Transformation**
organising activities e.g. meetings with Royal Bank of Scotland regarding impact of changes to online services for LD community. Our Voice is led by service user group who meet monthly.						
Locality Planning work in conjunction with CPP, including community engagement and co-design of local action plan and services	✓	✓	✓	✓	✓	Community involved in planning process and supported to develop skills and knowledge to enable direct involvement in service design and delivery

Table 6: Partnership engagement activity 2017 - 2019

Listening Events

Over 2018 - 2019 we have held a number of engagement events with staff that are supporting redesign and transformational change in services. These include events with home care, day services and health and social care colleagues.

LEARNING IS A PATH, NOT A DESTINATION

Our workforce remain the single most important resource in delivering high quality services and the transformation required to ensure the delivery of health and social care integration. The Partnership has a shared commitment to continuous professional development and to support innovative working and learning across agencies and disciplines. Learning and development opportunities are responsive to needs identified during workforce planning; via employee development reviews or appraisals and through partnership working with schools and further education establishments. The current workforce plays a key role in the promotion of health and social care as a career destination. Training for mentors is available and accredited and services routinely offer work experience and support student placements, benefitting students, services and people accessing support and services.

We continue to work with Forth Valley College in the development of flexible and accessible career pathways for new and existing staff and are involved in the piloting of a number of new professional development awards.

We recognise there are many challenges currently facing the workforce. This is centred around culture, systems and practice change related to integration, financial austerity and the shift towards strengths based and risk enablement approaches. This requires working alongside people rather than doing things for and to them and shifting away from being problem focused to asset based, focusing on what really matters to people.

The resilience of the workforce, particularly in times of change is a priority. Flexible working and learning alongside collaborative leadership is supporting a shared approach to managing change. Over the past year we have piloted an evidence based programme focused on the promotion of resilience with groups of health and social care staff. This is designed to support individuals and teams to sustain and develop meaningful strategies to address the impact of change and establish a space to reflect and learn from one another. The programme is primarily accessed online and includes face to face workshops and group coaching for line managers. Evaluation of the programme will inform next steps.

We have also been working with Scottish Social Services Council who helped to facilitate an Action Learning Set focused on addressing key challenges in embedding outcomes focused practice. This involved Partnership and Independent sector frontline staff. This recently concluded and learning is anticipated to impact on a far wider audience. Of significance, all participants reported feeling more confident practitioners and said they had a much better understanding of each others, roles, responsibilities and early evidence reflected willingness towards greater integrated practice based upon a clearer understanding of the benefits. Plans are in place to sustain this approach within the Partnership building on existing capacity.

We continue to work towards the development of a training consortium involving Partnership and Independent sector workforce. We are utilising joint resource and focused on building capacity across the workforce as envisioned within the National Health and Social Care Workforce Development Plan Part 2.

Careers in Care

Nearly 100 people interested in entering the adult social care profession attended an event organised by the Partnership in March. The event held in Forth Valley College, provided high school pupils and college students an insight into the world of care.

During the afternoon representatives from across the Partnership, including Homecare, the Sensory Centre, Community Care teams, Integrated Learning Disability team, Community Hospital and Care Homes gave short talks on their roles and why they work in care. Representatives from Workforce Development, CVS Volunteering service and Falkirk Council Employment Training Unit were also in attendance.

Attendees were then invited to take part in quick informal one-to-one sessions with the professionals to gain a better understanding of the different jobs available in the sector.

To find out more about career opportunities in Social Work Adult Services email socialservicetraining@falkirk.gov.uk.

For general information about jobs and work experience at Falkirk Council visit www.falkirk.gov.uk/services/jobs-careers/.

How We are Working with Falkirk Community Planning Partnership

The Partnership is a strategic partner within the Falkirk Community Planning Partnership and makes a significant contribution to the CPP's Strategic Outcomes and Local Delivery (SOLD) Plan in a leading capacity, as follows:

- People live full and positive lives within supportive communities
- Improving mental health and wellbeing.

The Partnership also makes a distinct contribution to a number of other priorities and outcomes within the SOLD plan.

In relation to mental health and wellbeing, the Chief Officer chairs a multi-agency Mental Health and Wellbeing group. The group are refreshing the delivery plan to take account of the national Mental Health Strategy and local priorities.

How We are Working with Children's Services

The Partnership continues to work closely with Children's Services across a range of work including:

- Transitions planning for young people with additional support needs

- Supporting carers - young carers may need support from Children's Services (including Education) depending on the impact of their caring role. They may also be supported through Social Work Adult Services if they are caring for an adult. Equally, adult carers of children with disabilities may be supported by Children's Services.

- The Head of Children's Social Work Services is a member of the HSCP Leadership Team and Strategic Planning Group, and is a member of the IJB in her role as Chief Social Worker Officer.

How We are Working with Housing Services

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

There is a requirement that a Housing Contribution Statement (HCS) is in place. This provides an essential link with the HSCP Strategic Plan and the Local Housing Strategy. The HCS Steering Group scope of work includes:

- review of housing for older people,
- take account of demand for wheelchair accessible housing, disabled adaptations and advice services

- work to develop, implement and resource the Rapid Rehousing Transition Plans, including Housing First
- increase use and access to communal areas within housing complexes. This will include activities to improve and maintain health and wellbeing.

How We are Working with Falkirk Alcohol and Drugs Partnership (ADP)

The ADP oversees a broad range of activity to minimise the harms caused by substance misuse. There are on-going challenges to reduce drug related deaths as we have too many people who have died. A Drugs Related Deaths Task group has been established to bring partners together to identify issues and solutions.

The ADP priorities all support the aims and principles of the IJB:

- improve health, early intervention and prevention
- reduce prevalence of alcohol and drug use
- promote and provide opportunities for recovery
- support children and families affected by substance use
- reduce the impact of substance use on communities
- provide high quality treatment and support services.

The ADP continue to build a Recovery Oriented System of Care (ROSC), where treatment and aftercare are integrated and priority is given to empowering people to sustain their recovery. Features of a ROSC link and contribute to the work of the IJB and include:

- being person-centred
- being inclusive of family and significant others
- keeping people safe and free from harm
- the provision of individualised and comprehensive services – such as housing, employability and education
- services that are connected to the community
- services that are trauma informed.

How We are working with Community Justice Partnership

The IJB is a Community Justice partner, and engages in the planning and delivery of services. The Chief Officer represents the IJB on the Falkirk Community Justice Partnership (CJP), which sits within the Community Planning Partnership structure.

People with lived experience of Community Justice Services often have a range of needs. These require partnership working between the IJB and CJP to ensure people access and make use of relevant services to address areas of need such as physical and mental health, housing, social welfare, education and employment.