This paper relates to

Agenda Item 6

Report to:	**Integration Joint Board**
Title/Subject:	**Strategic Plan**
Date:	**5 February 2016**
Submitted By:	**Chief Officer**
Action:	**For Decision**

1. PURPOSE OF THE REPORT

1.1. The purpose of the report is to provide an update to the Integration Joint Board on the Strategic Planning arrangements.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1. consider the latest draft of the Strategic Plan which is attached at Appendix 1 for information

2.2. consider the IJB meeting timetable to enable the necessary consideration and approval of the Strategic Plan as noted at section 4.6

2.3. consider the draft Consultation and Engagement report on the development of the Strategic Plan, which is attached at Appendix 2.

3. BACKGROUND

3.1. The Board members are aware that the Integration Joint Board (IJB) is responsible for the preparation of a Strategic Plan in relation to the functions delegated to it by the Council and NHS Board. The Board is required to establish a Strategic Planning Group as part of the process to prepare the Strategic Plan for their area.

3.2. The IJB will oversee the development and delivery of the Strategic Plan for the integrated functions and budgets that they will be responsible for. The plan is to be prepared before the integration start day as defined in the Act, which will be no later than 1 April 2016.

4. STRATEGIC PLAN

4.1. The preparation of the Strategic Plan is clearly defined in the Act and includes:
- the board prepare proposals for what the strategic plan should contain, and seek the views of its Strategic Planning Group on the proposals
- take account of any views expressed to prepare a first draft of the strategic plan, and seek the views of its Strategic Planning Group on the draft
- take account of any views expressed to prepare a second draft of the strategic plan for wider consultation in line with all prescribed consultees.

4.2. The draft Strategic Plan was approved for consultation by the Integration Joint Board on 6 November 2016. The consultation period was from 16 November to 31 December 2015. Section 5 of this report summarises the consultation process.

4.3. In line with legislative requirements, the Strategic Planning Group (SPG) has supported the development of the draft Strategic Plan. The group met on 15 January 2016 to consider the feedback from the consultation on the draft Strategic Plan. This has informed the development of the plan.

4.4. The Strategic Planning Co-ordinating Group has continued to meet, now on a weekly basis, to ensure the comments from the SPG and consultation process are reflected in the production of the Strategic Plan. The group also supported the consultation and engagement arrangements.

4.5. The amended draft Strategic Plan is attached at Appendix 1 for consideration. There is a separate report on the agenda relating to the financial position. Once this is clearer the final plan will be presented to the Integration Joint Board for approval.

4.6. The Board will be aware that the plan is to be prepared before the integration start day as defined in the Act, which will be no later than 1 April 2016. In meet this requirement, the Board may wish to consider the IJB meeting timetable to enable the necessary consideration and approval of the Strategic Plan to be brought forward by the Strategic Planning Group.

5. CONSULTATION AND ENGAGEMENT ARRANGEMENTS

5.1. As noted, the consultation on the draft Strategic Plan took place from 16 November to 31 December 2015.

5.2. The plan was informed and developed through a series of information and consultation methods including:
- Seven staff engagement sessions: April to May 2015
- Transitional Board priority setting workshop: 18 June 2015
- Stakeholder engagement event for staff across all sectors: 30 June 2015
- Strategic Planning Group meetings: August and October 2015 and January 2016
- Distribution of the draft plan through global email distributions to employee groups, partner organisations and through meeting networks
- Presentation and feedback sessions - targeted: November to December 2015
- Online and Citizen's Panel survey.

5.3. A draft Consultation and Engagement report outlining the process to develop the Strategic Plan is attached at Appendix 2 for information and comments. The draft will also be circulated to the Strategic Planning Group for comments. The final consultation report and final draft Strategic Plan will be presented to the Integration Joint Board for approval.

6. CONCLUSIONS

6.1. An Equalities Impact Assessment will be required for the Strategic Plan. The partnership will use a range of information to inform the EqIA, including the equalities data being collated as part of the Strategic Needs Assessment.

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Approved for Submission by: Patricia Cassidy, Chief Officer

Author: Suzanne Thomson, Programme Manager – Integration (Falkirk)
Date: 25 January 2016

List of Background Papers:

Transitional Board report: 6 February 2015 – Planning Requirements
Transitional Board report: 1 May 2015 – Strategic Planning
Transitional Board report: 5 June 2015 – Strategic Planning
Transitional Board report: 7 August 2015 – Strategic Planning
Transitional Board report: 4 September 2015 – Strategic Planning
Transitional Board report: 2 October 2015 – Strategic Planning
Integration Joint Board report: 6 November 2015 – Strategic Planning
Integration Joint Board report: 4 December 2015 – Strategic Planning

Appendix 1

DRAFT – FEBRUARY 2016

Falkirk Integrated Strategic Plan 2016-2019

FOREWORD

To enable people to live full, independent and positive lives within supportive communities.

The integration of Health and Social Care will see the establishment of a Falkirk Health and Social Care Integration (HSCI) Partnership with its own Integration Joint Board, developed by Falkirk Council and NHS Forth Valley.

We are pleased to introduce our first Strategic Plan on behalf of the HSCI Partnership. This plan is of interest to everyone living in the Falkirk area as it describes how we will deliver services to adults who use health and social care services. The plan will be reviewed every year.

New legislation requires that a local plan is produced to ensure that people who use health and social care services get the right care and support, whatever their needs, at any point in their care journey.

In the future, we need to build on our existing partnerships and develop new relationships with people, communities, our workforce and other stakeholders. The main purpose of the HSCI Partnership is to put people at the centre of decisions about their care and support. It will build on current good practice to change the way we deliver services that are high quality and joined up to meet individual need.

This will **"enable people to live full, independent and positive lives within supportive communities**" forming Falkirk's Strategic Plan vision.

This is an opportunity for the new HSCI Partnership to use our combined resources in a more effective, efficient and person-centred way. This will mean that we can address the challenges we face. There is an increased demand on services that will exceed available resources if we do not work together in a more integrated way. This will ensure a joint contribution to encouraging, supporting and maintaining the health and wellbeing of people who live in our community.

We should celebrate that people are living longer, are active and contributing citizens, and in the main are healthier or are able to live at home with long-term and multiple conditions. However, there are inequalities within our local communities, which we aim to address by working with our partners to prevent and reduce the impact of poverty, promote equality of access, and improve health and well-being. Equality will be at the heart of everything that we do.

The HSCI Partnership will focus on prevention and early intervention. We will encourage and support self-management so that people are in control of their own health and care to be as independent as possible and enhance their quality of life.

We want to change the way we deliver services and to involve people in how services are redesigned to meet their needs. Our three year Strategic Plan is informed by a range of engagement and consultation activity and local and

national information. We will put people first and combine our resources to provide integrated support, and engage with communities and staff to deliver on locality plans.

On behalf of Falkirk Health & Social Care Partnership

Allyson Black	**Patricia Cassidy**
Chair, Falkirk Integration Joint Board	**Chief Officer**

1 SETTING THE SCENE

People will be at the centre of all decisions about their care and support. When this support is provided, the HSCI Partnership will ensure this is delivered to the highest quality and safety standards. We will work with people with a focus on prevention, anticipation and supported self-management. When admission to hospital is required, there will be a focus on ensuring people are supported to return to their home. This will be done as soon as appropriate to ensure there is minimal risk of re-admission to hospital.

The Scottish Government's *2020 Vision* is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. This vision will only become a reality by all agencies working together. To make this new way of working successful, it is essential that the views of service users, their carers and families and local communities are taken into account in shaping future services.

The *Public Bodies (Joint Working) (Scotland) Act 2014* requires NHS Boards and Local Authorities to establish Health and Social Care Partnerships. In Falkirk it has been agreed to deliver integrated health and social care services through delegation to an Integration Joint Board. The Board is established as a *body corporate*, with the appointment of a Chief Officer as the jointly accountable officer.

The Integration Joint Board was established on 3 October 2015 and has representatives from Falkirk Council, NHS Forth Valley, Third Sector, service users and carers. From 1 April 2016, the Integration Joint Board, through its Chief Officer, will have responsibility for the planning, resourcing and the operational oversight of a wide range of health and social care services.

The HSCI Partnership, consists of the Local Authority, NHS Forth Valley, Third and Independent sectors, who will work together to provide effective and joined up services. The partnership will work towards the *2020 Vision* in an integrated way and are responsible for the delivery of targets, called the *National Health and Wellbeing Outcomes*.

The HSCI Partnership will prioritise services in response to the key issues set out in Section 3 and the detailed Joint Strategic Needs Assessment. These are:

- The Falkirk area has an ageing population
- Workforce
- It is projected that the Falkirk area will have growing numbers of people living with long term conditions, multiple conditions and complex needs
- Early intervention and prevention can make a difference
- Carers
- Deprivation, housing and employment.

NHS Forth Valley and Falkirk Council are building on existing working practices that will put in place single working arrangements. These will aim to provide better, more integrated adult health and social care services. Integration of these services is driven, in part, by the following:

- People in Falkirk would like to have access to more joined up care and support near home
- More people in Falkirk are living longer with a range of conditions and illness
- Local demand for existing health and social care services is changing and there are resource constraints in terms of human and financial resources
- NHS Forth Valley and Falkirk Council must continuously improve services and contribute to achieving better outcomes for people
- There is an opportunity to make better use of public resources while creating increased public value in avoiding duplication of effort.

Falkirk HSCI Partnership and Localities

The HSCI Partnership has identified its locality areas for service planning purposes. This is required in the legislation. There will be three localities within the Falkirk Council area:

- **Falkirk**
  The Falkirk Locality is the smallest and most compact of the three Heath and Social Care Localities with a population (including Hallglen) of just under 40,000. It is centred on the ancient burgh of Falkirk itself which is the main retail and administrative centre for the Council area as well as having the main campus of Forth Valley College. Falkirk town centre is a main source of employment and other major employers are the public sector and vehicle manufacturing. Some of the most deprived areas within the Council area lie in Falkirk, in particular parts of Camelon, Bainsford and Langlees, as well as in Hallglen. The recent major projects of the Falkirk Wheel and the Kelpies have promoted the area across the whole of Scotland and beyond.

- **Grangemouth, Bo'ness and Braes**
  This is the largest of the three Heath and Social Care Localities, both in terms of area (176 sq km) and population (over 65,000). It lies along the coastline of the River Forth and extends southwards into the higher land of the Slamannan Plateau. It contains the former burghs of Grangemouth and Bo'ness as well as the villages of the Braes such as Polmont, Westquarter, Redding and the more isolated villages such as Slamannan and Avonbridge. Grangemouth is a major industrial town based largely on the petro-chemical industry and is also Scotland's premier port. The M9 motorway runs through the area and the Kincardine and Clackmannanshire bridges connect the area to Fife and beyond. The locality includes some the Falkirk Council area's most prosperous estates as well as areas of deprivation in Grangemouth, Bo'ness, Maddiston, Westquarter and Slamannan. The Braes area is a popular location for home buyers and considerable housing development has taken place and is expected to continue.

- **Denny/Bonnybridge/Larbert/Stenhousemuir**
  This Health and Social Care Locality lies in the north west of the Council area and has a population of around 53,000. It includes the towns of Denny, Bonnybridge, Larbert and Stenhousemuir and a number of smaller settlements. The population is growing with major new housing developments in Denny and Larbert. Forth Valley Royal Hospital is a major employer and is located close the motorway network with the M80 and M876 connecting the area to the rest of Scotland.

There are small pockets of deprivation in Denny and Stenhousemuir but this is a fairly prosperous area which has good commuting links.

(replace map with defined locality boundaries)
MAP
Figure 1:

This Strategic Plan describes why, what and how health and social care services will be configured. This plan presents a framework to deliver the agreed vision over the following three years and will be reviewed each year. A number of key priorities have been identified, which will help provide a direction and focus for service change and improvement.

2 A PLAN FOR FALKIRK AREA

This section summarises the vision and the connections between this and the principles, outcomes and priorities that have been identified.

2.1 Vision

The Falkirk's Health and Social Care Partnership agreed vision is described as:

To enable people in Falkirk to live full and positive lives within supportive communities

2.2 Outcomes and Priorities

The HSCI Partnership has identified five specific outcomes for the Falkirk Strategic Plan and Integration Scheme. These are in line with the Scottish Government's *2020 Vision.*

The local outcomes address the key challenges highlighted in the Joint Strategic Needs Assessment (JSNA) (as outlined in section 2.1). The outcomes are also consistent with the views of people who use services, their carers and communities. This plan is for adults and older people who have a range of health and care needs. These include physical disability, mental health, complex care needs, learning disability, long terms conditions, alcohol and substance misuse, and young people moving into adult services.

The Falkirk HSCI Partnership will focus on the identified priorities in the Strategic Plan to achieve its outcomes. There are also a number of cross-cutting priorities as detailed in the table below:

Outcomes	Priorities
Self-Management: Individuals, carers and families are enabled to manage their own health, care and wellbeing	• Information that enables people to manage their condition is accessible and delivered consistently • Support for carers
Autonomy And Decision Making: Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided	• Person-centred care is reinforced, acknowledging family/carer views • Care and support is underpinned by informed choices and decision making throughout life
Safe: Health and social care support systems are in place, to help keep people safe and live well for longer	• Technology is used in an effective and appropriate way to support care • Risk is acknowledged and managed effectively

Service User Experience: People have a fair and positive experience of health and social care	• Greater focus is given to an individual case management approach, enhanced by the provision of advocacy support • Feedback drives continuous improvement • Service users are engaged and involved across the HSCI Partnership • Co-location is pursued where appropriate
Community Based Support: Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community	• Information about community based support is accessible and presented in a consistent manner • Build sustainable capacity within all sectors • Adopt a consistent framework when commissioning services • Build on existing assets within local communities

Table 1

The delivery of these priorities will support the transformational change that will be needed to deliver integrated services.

2.3. What will be different

By services working together in a much more integrated way, the outcomes for people using health and social care services will be improved. This will also avoid duplication, improve communication and understanding of services and reduce dependency.

Current Model of Care	Future Model of Care
Disjointed care	Integrated, seamless care with a single point of contact
Reactive care	Preventative and Anticipatory Care
Hospital centred	Embedded in communities
Services are given to people	Services empower people to self-manage
Service user as passive recipient	Service user as partner
Support for carers is variable	Carers are supported
Under use of technology	Improved use of technology
Acute condition focus	Long-term condition focus

Table 2:
Illustration of old and new care model. Adjusted from Falkirk Joint Commissioning Plan for Older People 2014 - 2107

2.4 Local Outcome One

Self-Management: Individuals, carers and families are enabled to manage their own health, care and wellbeing	
What does this mean for people? People, their carers and families 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 via a single 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. **What does 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 available to provide and have confidence in them. **What does this mean for the HSCI Partnership?** Our shared vision is held across all partners. Our workforce across all sectors is highly skilled and has a focus on promoting independence and improving health and well-being. Joint working across agencies and sectors is the norm and frontline staff are empowered to take decisions, which allows them to tailor response and care to suit the needs of the people.	**What are we going to do?** We will lead the cultural change required across agencies and communities to support the change necessary to deliver integrated care We will redesign services so they are flexible and responsive, ensure feedback drives continuous improvement and are aligned to our outcomes We will continue to develop the ways in which we support carers We will support people to use technology solutions to support them to have more independence and control over their lifestyles and the management of their condition We will implement our Organisational Development and Workforce Plan to support our staff and partners though training and organisational development Communication will be central to everything that we do. We will continue to engage with stakeholders to shape our services to meet needs.

2.5 Local Outcome Two

Autonomy And Decision Making: Where formal support is needed people are able to exercise as much control and choice as possible over what is provided	
What does this mean for people? 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 does this mean for our communities?** Communities are enabled to continue to develop and manage a variety of good quality local services to meet community need. **What does this mean for the HSCI Partnership?** Information sharing is critical to good integrated care and is extended across all sectors. Information sharing includes the ability to share single assessments and care plans. These will be co-produced by service users and professionals, and can be used and updated across professional specialism. This allows the co-ordination of care, so that the right care is provided at the right time by the most appropriate service. Infrastructure, particularly IT systems, are in place to support this, and staff are able to securely access and use the system with data sharing procedures in place. Information is shared appropriately to ensure a safe transition between all services.	**What are we going to do?** ▪ We will develop a single point of contact for people and their carers to support access to a wide range of information on services across all sectors ▪ We will develop one Single Shared Assessment as standard across the Partnership ▪ We will promote the uptake of Anticipatory Care Plans that reflect the current views of people and their carers. We will ensure this information is shared where appropriate. ▪ We will continue to design community based models of care, such as Closer to Home and Advice Line For You (ALFY) ▪ Information sharing protocols are in place

2.6 Local Outcome Three

Safe: Health and social care support systems are in place, to help keep people safe and live well for longer	
What does 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 qualities of lives and be joined up to make best use of available resources. **What does this mean for our communities?** Communities are confident that systems are in place for the identification, reporting, and prevention of harm. **What does this mean for the HSCI Partnership?** The Partnership is able to identify, manage and tolerate risk, and staff are supported in being able to work in different ways, to support personal outcomes. The Partnership recognise the critical link between health and social care provision and the contribution of wider partners, for example, the Community Planning Partnership, Criminal Justice and Housing. The Partnership will continue to work together to reduce avoidable admissions to hospital by ensuring that priority is given to strengthening community based supports.	**What are we going to do?** We will ensure there is a greater focus given to individual case management, enhanced by the provision of advocacy support, where required We will ensure risk is acknowledged and managed effectively and risk based support is in place We will continue to work across the partnership to ensure adults at risk of harm are supported and protected. We will implement our Clinical Care Governance framework We will continue to invest in Technology Enabled Care as an effective and appropriate way to support care. We will pursue co-location of staff and services where appropriate to support integration

2.7 Local Outcome Four

Service User Experience: People have a fair and positive experience of health and social care	
What does 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 HSCI Partnership. People will receive feedback and understand what their contribution has influenced. **What does 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. **What does this mean for the Partnership?** The Partnership will enable its workforce to be motivated to come to work, feel supported by colleagues and management, and valued by colleagues and people for whom they provide care. We will encourage continuous improvement by supporting and developing our workforce.	**What are we going to do?** ▪ We will ensure consistent high quality services are delivered, informed by a robust service evaluation framework ▪ We will ensure our decision-making processes are consistent, fair and transparent, and are based on reliable information and evidence based good practice ▪ We will complete Equality and Poverty Impact Assessments for all subsequent changes to policies and services to ensure we identify and address inequalities ▪ We will implement our Participation and Engagement Strategy

2.8 Local Outcome Five

Local Outcome Five **Community Based Supports:** Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community	
What does this mean for people? People are more confident, reliant and able to access local services and support to improve and maintain their health and well-being and be more independent. There will be a focus on early intervention and prevention. **What does this mean for our communities?** Communities are informed, involved and supported to work cohesively to develop and manage community based supports. **What does this mean for the HSCI Partnership?** The Partnership will work pro-actively with the Community Planning Partnership and the Third Sector and Independent Sector to plan and deliver solution based and community focussed services to support the delivery of our priorities.	**What are we going to do?** ▪ We will establish locality planning structures within the three local areas agreed which will align with the Community Planning Partnership ▪ We will adopt a consistent framework when commissioning services that will build sustainable capacity within all sectors ▪ We will build on existing strengths within local communities

2.9 Summary table showing the links from the national Health and Well-being Outcomes to local priorities

National Health and Wellbeing Outcomes

Local Outcomes	Evidence	What People Said	Priorities
Self-Management: Individuals, carers and families are enabled to manage their own health, care and wellbeing	↑ Population, with +75 expected to double by 2037 ↑ People with multiple conditions ↑ Life expectancy for people with conditions ↑ Lifestyle risks such as obesity, smoking and substance misuse • +15,000 Carers in Falkirk area of which 37% provide 35hours care per week	'More prevention work and dealing with the underlying causes of poor physical and mental health. A co-ordinated approach.' '….working with a range of agencies including education […]physical activity providers and retailers to educate on healthy lives.' 'A framework for dealing with medication in the community'	• Information that enables people to manage their condition is accessible and delivered consistently • Support for carers
Autonomy And Decision Making: Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided	• 2.3% patients account for 50% health expenditure - most with 2-4 conditions. ↑ Emergency admissions to hospital ↑ Delayed Discharges, with 1,034 bed days lost in July 2015	'IT communication should be improved to allow sharing of information easier.' 'better sharing of information - relatives often have to articulate care needs over and over again' ' More consideration is required for the transition from childrens services (health) to adult services (social work) where disabled are concerned' 'The process of links between the different services has been a great success so far and helped keep my father and mother in law at home longer. It made their lives better and ours too.'	• Person-centred care is reinforced, acknowledging family/carer views • Care and support is underpinned by informed choices and decision making throughout life
Safe: Health and social care support systems are in place, to help keep people safe and live well for longer	• An average of 6,848 items of equipment are provided per annum to support people to live at home ↑ In 2014, 4,353 people received telecare services • 990 adults with Learning Disabilities in Falkirk area, 51.1% live in mainstream accommodation • 10,868 adults with physical disability, 53% aged 50-74.	'more emphasis placed on technology enabled care to help people self manage their conditions at home.' 'Not all people needing help or re-homing are elderly […] More communication between staff might make a difference' 'Use of technology to support people to articulate their needs, provide feedback and influence services and	• Technology is used in an effective and appropriate way to support care • Risk is acknowledged and managed effectively

Local Outcomes: What They mean and what we're going to do (Section XX)

				plans and improve care'		
		Service User Experience: People have a fair and positive experience of health and social care	⬇ In working age population, which is mirrored in Partnership workforce • Heath & Care recipients survey 13/14 found – 94% respondents felt ' treated with respect' and 85% felt 'health & social care services seem well co-ordinated'	'It's taken me a year to find out where I can find support to cope […]a single point of contact for me would really have helped me during the year since diagnosis.' 'dialogue between client and service staff should be open and honest at all times' 'There also needs to be a culture of open feedback mechanisms, where errors or mistakes and not punished, but seen as learning opportunities for the individuals and the systems'	• Greater focus is given to an individual case management approach, enhanced by the provision of advocacy support • Feedback drives continuous improvement • Service users are engaged and involved across the HSCI Partnership • Co-location is pursued where appropriate	
		Community-based Supports: Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community	Community engagement over 2 years to inform Falkirk's Community Learning and Development Action Plan found: • People do not always know what services and support is available to them in their communities • Impacts on health and wellbeing include not feeling safe within community, isolation, issues regarding housing and employment • There are 18 datazones in the Falkirk Council area fall within the 15% most deprived in Scotland (SIMD)	'Where to get information on how people can get more involved.' 'Isolation and malnutrition need to be addressed. Incentive social activities /lunch clubs etc' 'We…get together and run a self help group, which I think is very important, since most GP's are just learning about it. I feel we have a lot to offer!'	• Information about community-based support is accessible and presented in a consistent manner • Build sustainable capacity within all sectors • Adopt a consistent framework when commissioning services • Build on and signpost to existing assets within local communities	

Table 3:

3. WHY CHANGE?

The demand and expectations on health and social care services is changing. The challenges highlight a need for changes to service delivery that is driven by increasing complexity of need, greater demand for services, reducing resources coupled with greater public expectation. We therefore need to change the way we deliver services to respond. We also need to continue to deliver services to people in most need within the available resources.

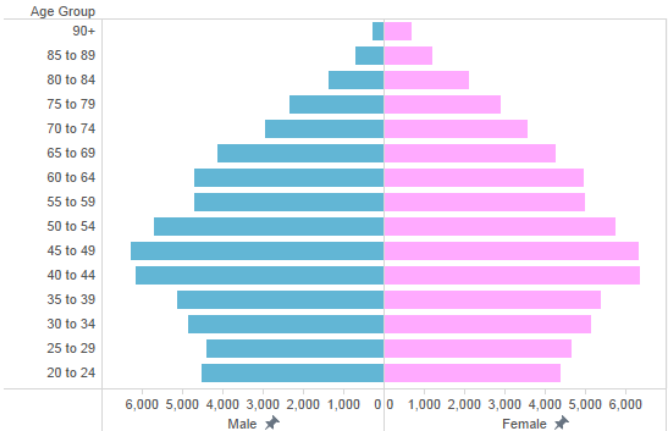
The more traditional ways in which health and social care and support services have been structured and delivered has not always led to improved outcomes for people. Health care and social care systems have traditionally focussed on a reactive approach. This means that care is provided for people rather than supporting people to live more independently in their communities. A reactive approach can lead to unnecessary, expensive and prolonged hospital admissions and to a dependency on care services. This approach is unsustainable and fundamental change is required.

This section outlines the main drivers for the Falkirk Health Social Care and Integration Strategic Plan.

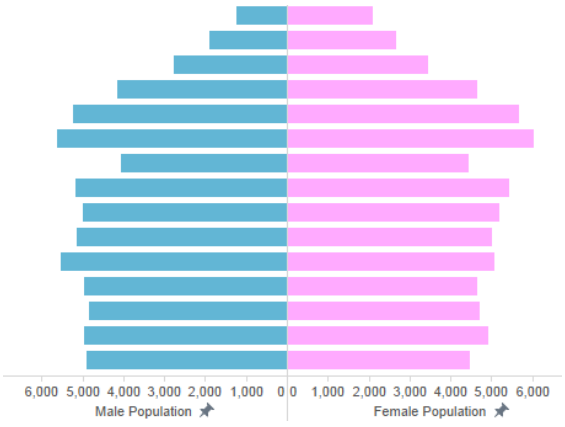
3.1 Local Population

The Falkirk Council area has a population of approximately 157,640 (2014) and is increasing. The population has been increasing for over 20 years after some years of little change. The area has grown by almost 12,500 since the Census in 2001 (8.5%) compared to an increase in Scotland of 5.6%. We had the ninth fastest growth rate of all Scotland's councils.

Falkirk Population by Age/Sex 2012



Falkirk Population by Age/Sex 2037



75+ population expected to nearly double by 2037
Older Population = Heavy users of services
Increased Older Population = Increased demand for services
Need for Service Re-design

Figure 4

3.2 Multiple and long-term conditions

Multiple morbidity is common, increases with age, and by age 65 years most individuals will be living with more than one diagnosed condition. It should be noted that currently the number of individuals with multi morbidity is actually higher in those younger than 65 years. This highlights the need for proactive anticipatory care planning and adequate focus on prevention and positive lifestyle interventions.

There are clear links between the onset of long term conditions and mental health problems, deprivation, negative lifestyle factors and the wider determinants of health. People living with a long term condition are likely to be more disadvantaged across a range of social indicators, including employment, educational opportunities, home ownership and income.

Individuals living in a disadvantaged area are more than twice as likely to have a long term condition and more likely to be admitted to hospital because of their condition. Furthermore, the onset of multiple morbidity occurs 10–15 years earlier in people living in the most deprived areas compared with the most affluent.

People living with long term conditions are also more likely to experience psychological problems. Prolonged stress alters immunity, making illness more likely and recovery more difficult, especially for those who are already unwell. Mental health disorders, particularly depression, are more prevalent in people with increasing numbers of physical disorders.

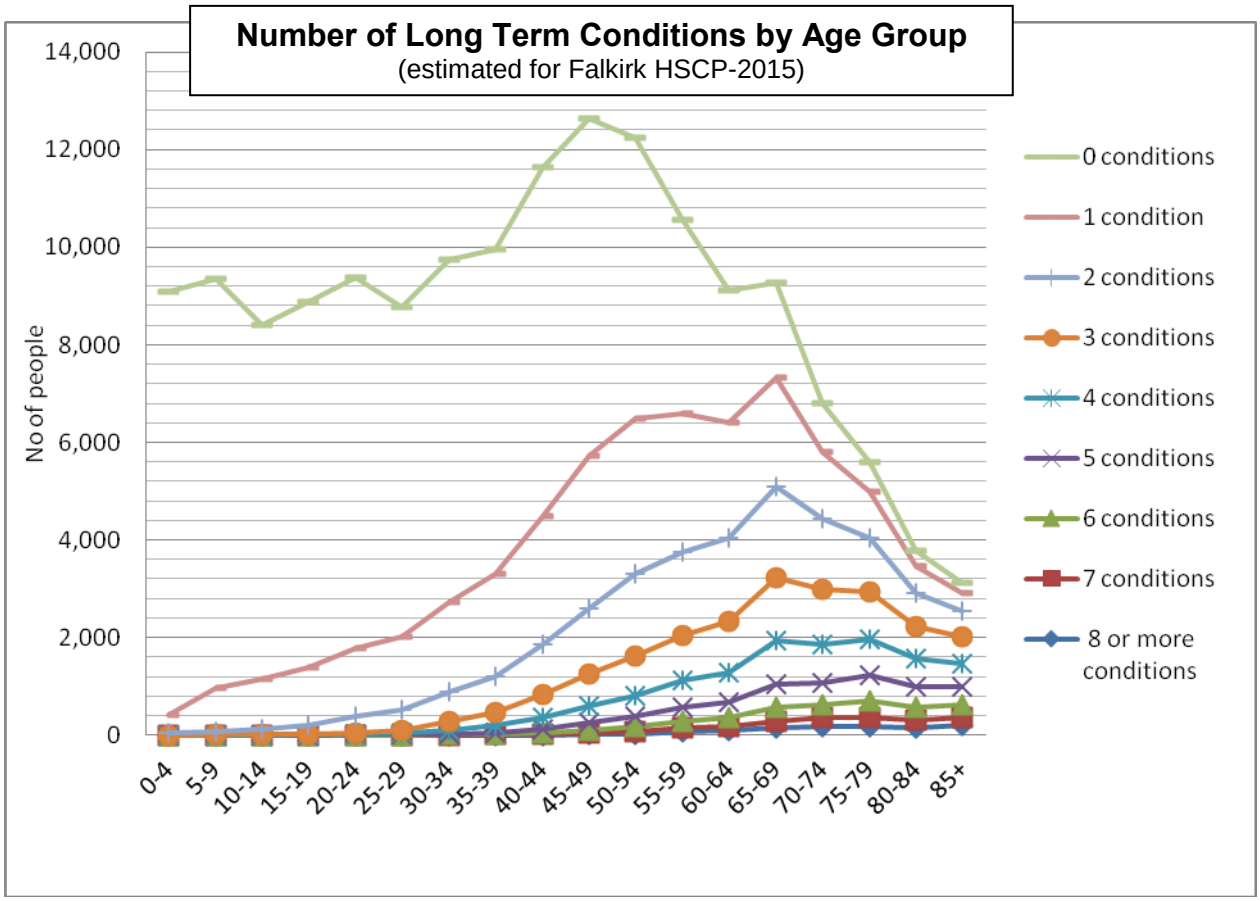


Figure 5:
Estimated number of people within Falkirk with various numbers of long-term conditions - 2015. *Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk*

3.3 Carers

The role of carers is widely recognised as being fundamentally important in supporting people to continue to live in their own homes and communities. Carers often live with the consequences of caring: poor health and wellbeing, financial hardship and the inability to participate in activities that others take for granted, such as work, learning, leisure and family life. The provision of unpaid care is a key indicator of care needs and has important implications for the planning and delivery of health and social care services.

There are an estimated 492,231 carers in Scotland (Census, 2011). The Census estimated 28,014 of these carers are within the Forth Valley area. An overview of carers in the Falkirk area is presented below:

- 15,056 people providing unpaid care in Falkirk, 9.7% of the local population
- Approx. 2/3rds 35-64 years and nearly 20% over 65 years
- 35.7% of carers in Falkirk provide in excess of 35 hours unpaid care
- 29% of those providing in excess of 35 hours care are aged 65 and over.

The chart below builds on the idea that the health of carers is worse than the population who do not provide unpaid care. There is a clear pattern showing that the health status of the carer deteriorates as the level of care provided increases. Less than 60% of those providing the highest level of care (50+ hours a week) consider themselves to be of good or very good health, compared to over 80% who do not provide unpaid care.

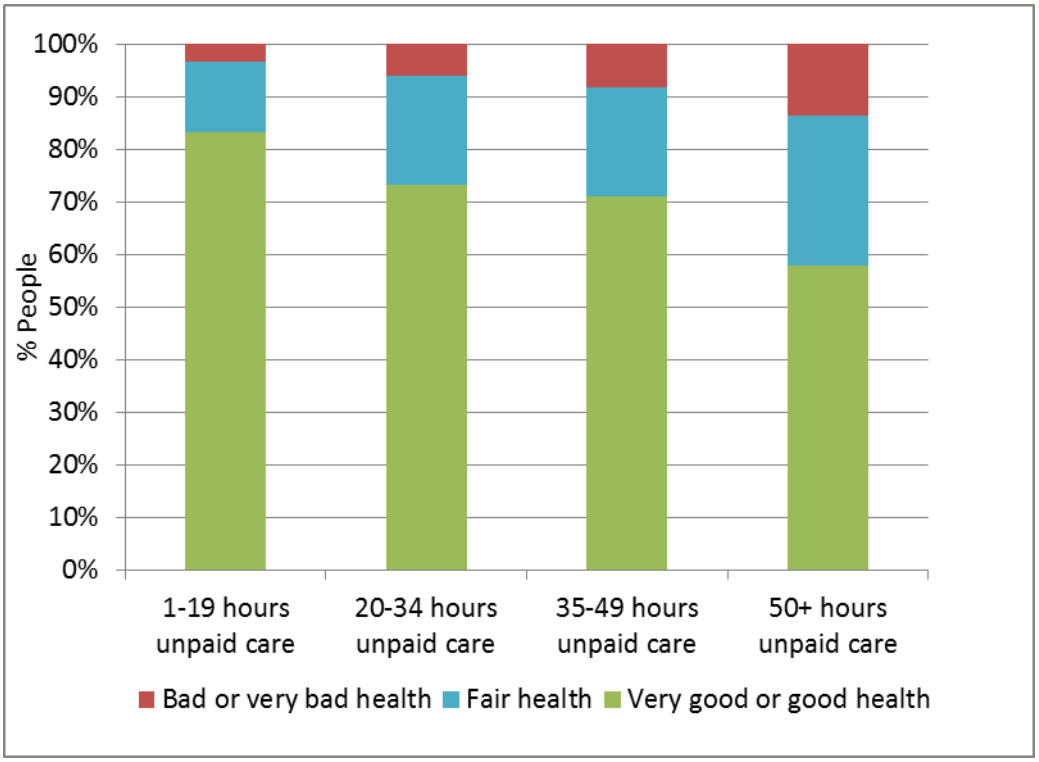


Figure 6:
General health by level of unpaid care provision - Falkirk, Scotland's Census 2011

We will:

- Recognise and value carers as equal partners in care
- Support and empower carers to manage their caring responsibilities with confidence, in good health and enable them to have a life of their own outside of caring
- Fully engage carers as participants in the planning and shaping of services required for the service user and the support for themselves
- Ensure that carers are not disadvantaged, or discriminated against, by virtue of being a carer
- Recognise and support the needs of any young carers who are caring for an adult.

3.4 Deprivation

Deprivation is a risk factor for the vast majority of conditions and we must continue to reduce health inequalities through positive health and social outcomes for those experiencing deprivation.

Within the deciles, 1 is the most deprived and 10 the least deprived. Figure 7 illustrates the number of people and data zones in each decile in Falkirk. The population in Falkirk can almost be split right down the middle, half of the population live in the lowest five deciles, and the other half in the highest five deciles.

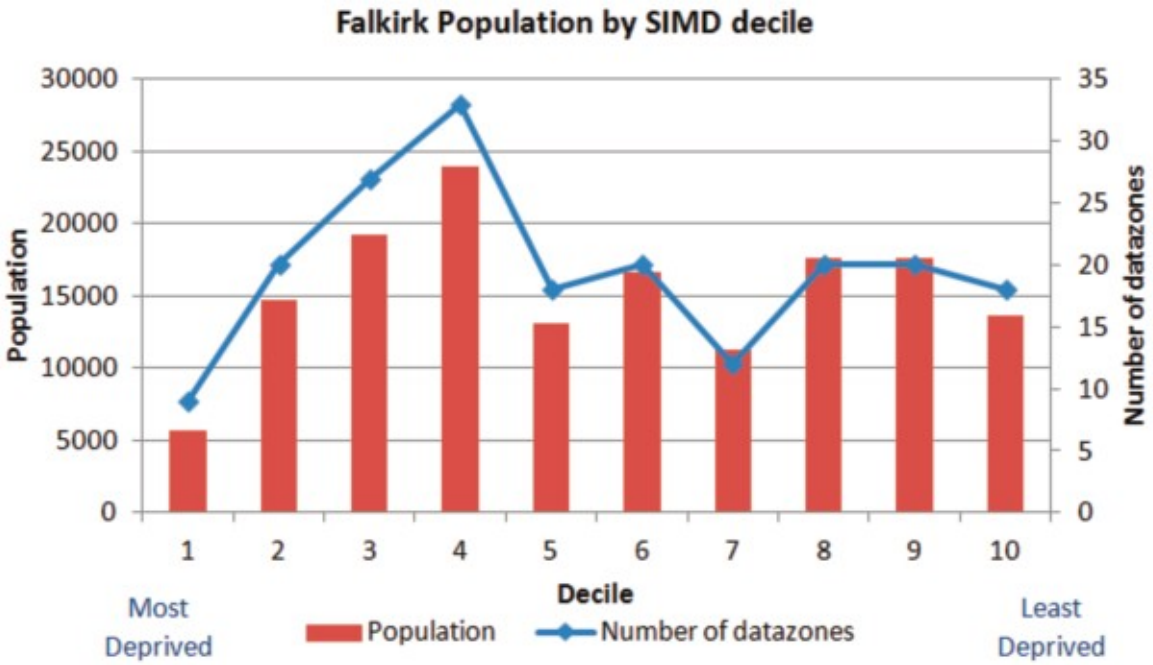


Figure 7:
Falkirk area population by SIMD decile. *Source: SIMD 2012*

3.5 Workforce

The local demographics demonstrate an ageing workforce; subsequently the Falkirk Partnership must consider the workforce to ensure that planned future services are sustainable. The raising of the retirement age also emphasises the need to develop strategies which meet individual and the Falkirk Partnership's expectations; enabling people to work longer with both energy and good health so that vital skills are retained.

The Falkirk Partnership aims to improve working lives through provisions to create better work/life integration. Flexible working practices can enable people to be refreshed and committed throughout their working lives.

The Partnership will support the delivery of new ways of working for services providing health and social care. A Staff-side Framework is agreed and working to achieve positive involvement with staff-side organisations and with all staff. The Partnership continues to work together in developing effective integrated health and social care teams working across systems. Joint Organisational Development work is well positioned and is already supporting the development of joint planning and working.

Mapping the workforce with all partners is key to the delivery of the integration agenda and partners are committed to working together to support this process. A framework of Human Resources metrics has been agreed and in time, integrated workforce plans in support of new and emerging models of care will be developed.

The continuing focus is on the development of relationships and working arrangements with partners which will deliver the conditions required for success in the Integration of Health and Social Care agenda.

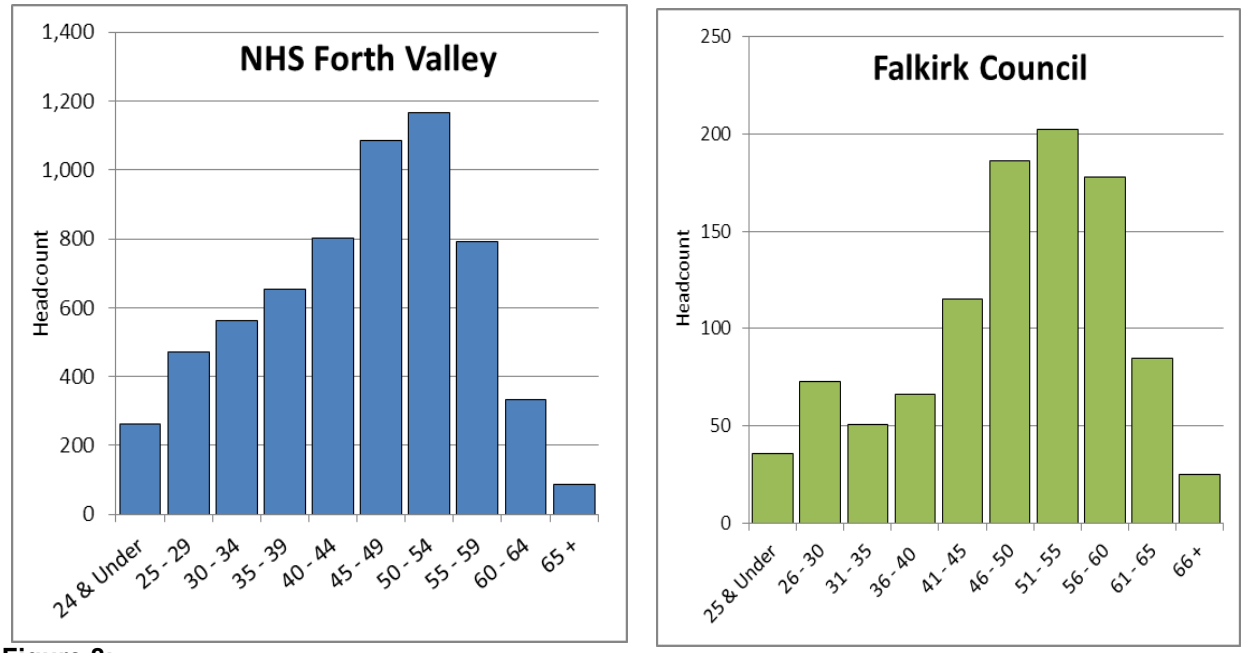


Figure 8:
Workforce age profiles for NHS Forth Valley and Falkirk Council – September 2015 Source: Scottish Workforce Information Standard System (SWISS) & Falkirk Council
Note – NHS Forth Valley figures represent the entire workforce, not just those in scope for integration, it is assumed that the relevant staff will share a similar age profile.

3.6 Emergency Hospital Admissions

The delivery of emergency and urgent care is becoming increasingly challenging due to a range of factors such as the ageing population, increasing numbers of people with complex conditions and changes in the availability of the workforce to deliver care (CSR, 2015). Figure 9 demonstrates that the rate and number of admissions remains below the Scottish average. Figure 10 shows the number of emergency hospital admissions for patients aged 65+ from 2004/5 to 2013/14 which has increased.

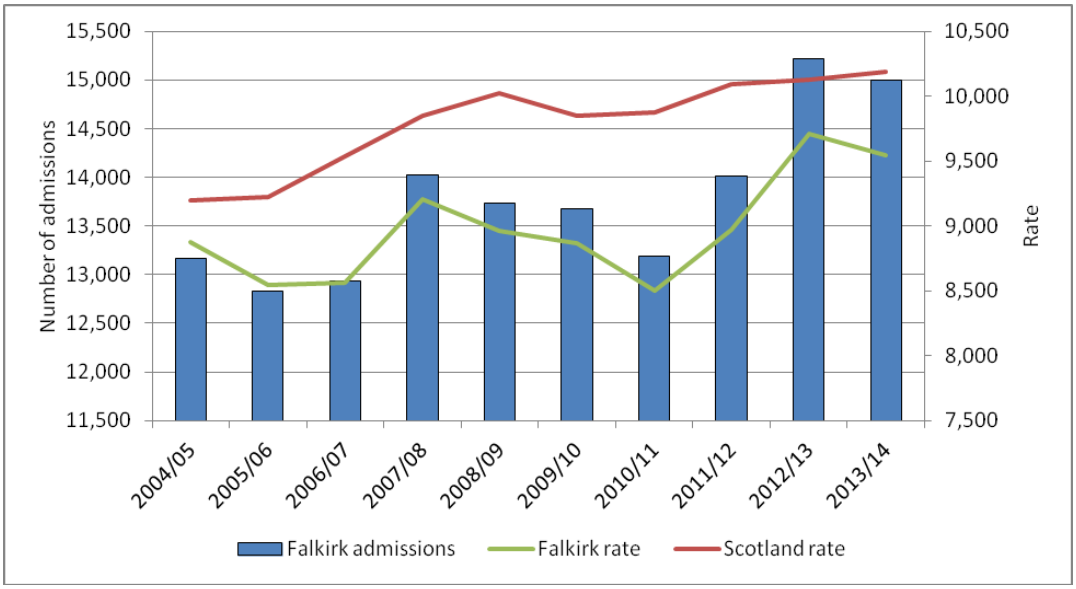


Figure 9:
Falkirk emergency admissions to hospital - 2004/05 to 2013/14. *Source: ISD Scotland*

As the numbers of older people increase, the number of hospital admissions is likely to increase. For example, Figure 10 demonstrates that 65+ year olds represent over a third of emergency admissions. Therefore, there is a need to reduce the rate of avoidable admissions.

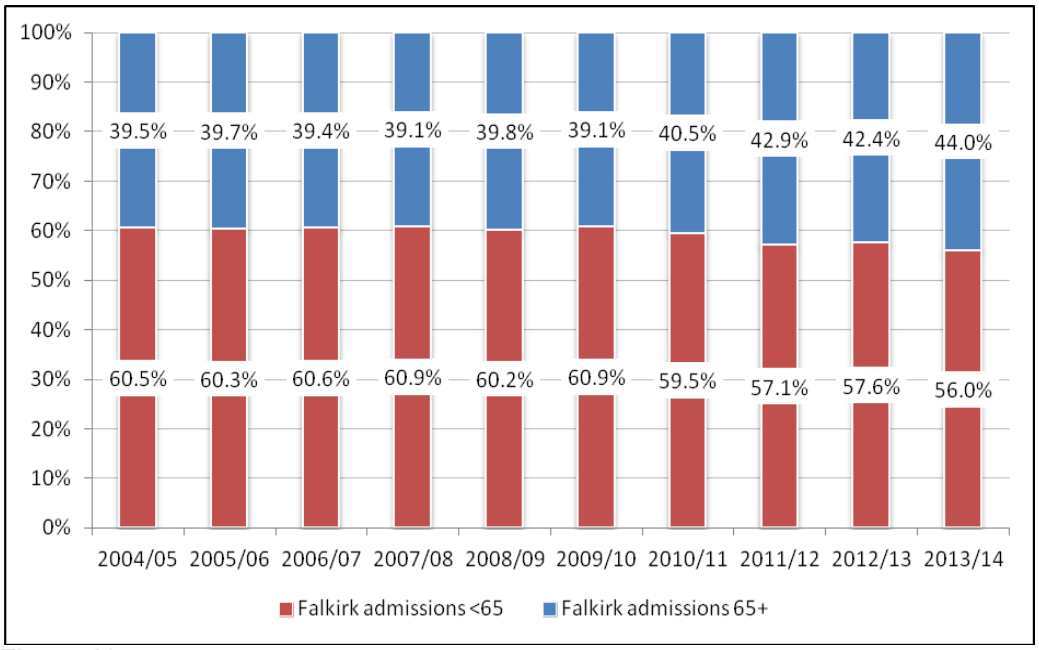


Figure 10:
% Emergency admissions by age group, Falkirk. *Source: ISD Scotland*

3.7 Delayed Discharges

People do not want to stay in hospital longer than needed. The Scottish Government target is that no one should wait longer than 2 weeks to be discharged. Unnecessary delays can lead to deterioration in an individual's health and consequently a potential loss in their ability to remain independent. Delays in a person's discharge can occur for a variety of reasons.

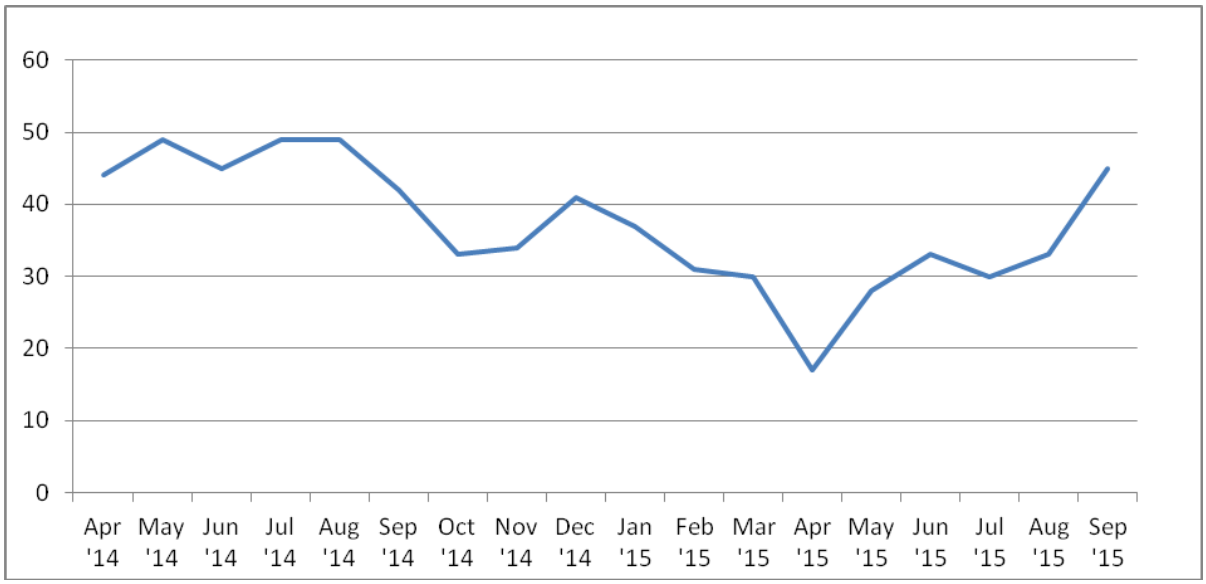


Figure 11:
Delayed Discharges in Falkirk LA, April 2014 – September 2015. Source: ISD Scotland

Figure 11 represents the number of people within Falkirk with Delayed Discharges over the time period April 2015 until September 2015. The figure represents all delayed discharges, from and beyond one day delay.

The Falkirk Partnership is working towards the target of ensuring that no one stays in hospital for more than two weeks beyond their agreed discharge date and will work through a number of actions identified which will support timely and appropriate discharge and support people returning home with appropriate care wherever possible.

3.8 Key Issues

A detailed Joint Strategic Needs Assessment (JSNA) has been completed. This provides a comprehensive description of health and social care information for the Falkirk HSCI Partnership.

The key issues for the Partnership are:

- **The Falkirk area has an ageing population.** The 75+ year population is projected to increase by 98% by 2037. This has significant implications for service provision as over 75's are generally intensive users of health and social care. Corresponding with the growth in the older population, the working age population is expected to decrease. This has the potential to affect the ability to provide services. However, it is important to note that people are living longer and healthier lives. Many people aged over 60 years are contributing to society through volunteering within their community and caring for relatives.

- **Workforce.** The local demographics demonstrate an ageing workforce; subsequently, the Falkirk Partnership must consider the workforce to ensure that planned future services are sustainable. The raising of the retirement age also emphasises the need to develop strategies which meet individual and the Falkirk Partnership's expectations; enabling people to work longer with both energy and good health so that vital skills are retained.

- **It is projected that the Falkirk area will have growing numbers of people living with long term conditions, multiple conditions and complex needs.** There is a need to redesign services to better meet the needs of people with complex needs. People with several complex long term conditions are currently making multiple trips to hospital clinics to see a range of specialist services that are sometimes uncoordinated. This would suggest that a focus should be on the holistic needs of people and developing new pathways and guidelines rather than the current disease specific models.

- **Early intervention and prevention can make a difference.** If current disease trends continue then there are likely to be increasing numbers of people requiring support for their disease or condition. These trends could be influenced positively through a continued focus on health improvement, early intervention and prevention.

- **Carers.** One of the aims of Health and Social Care Integration is to keep people living independently in the community for longer. The projected increase in the older population and people with complex care needs is likely to mean there will be an increasing need to support carers.

- **Deprivation, housing and employment.** High levels of public resources are spent each year on alleviating health and social problems related to people and families who are trapped in cycles of ill health *(Christie, 2011)*. Consideration will be given to other important factors, such as housing, unemployment and poverty. The Partnership will adopt a whole-systems approach to improve health and social care outcomes and will work alongside Community Planning partners to address these wider issues.

In summary, the key issues described can have an impact on the delivery and availability of services at a time of reductions in public spending. For example, services associated with emergency hospital admissions and delays in discharge, care at home and community based services. This plan will take account of these issues and address them through integration and new models of service delivery. Further detail on the priorities and how we will achieve this are described in later sections of the plan.

3.9 Policy Context

The challenges described in this section are recognised across Scotland. The Scottish Government has initiated a major legislative programme of reform of public bodies to address these. The Integration of Health and Social Care ensures that those people who use services get the right care and support whatever their needs, at any point in their care journey.

The Falkirk Health and Social Care Integration Strategic Plan is a high level strategic framework. It sets out the reason for change and how we will begin to make the transformational changes and improvements to develop health and social services for adults. This will be over the next three years.

Key national legislation that has been considered in the development of Falkirk's Strategic Plan, and its outcomes and priorities include:

- Public Bodies (Joint Working) (Scotland) Act 2014
- Community Empowerment (Scotland) Act 2015
- Children & Young People (Scotland) Act 2014
- Community Learning and Development (Scotland) Regulations 2013
- Carers Bill
- Criminal Justice Bill
- Audit Scotland - Health & Social Care Integration report, December 2015

This plan takes account of the Clackmannanshire and Stirling HSCI Partnership Strategic Plan and priorities. There are a number of NHS and Local Authority services which will continue to be planned and delivered across Forth Valley where this makes sense to do so and will meet local needs. Consideration has been given to specialist services out with Forth Valley that Falkirk residents may need.

In the development of our Strategic Plan we took into account the existing plans that relate to health and social care.

These include for example:

- Falkirk Single Outcome Agreement 2013 - 2023
- Falkirk Strategic Outcomes and Local Delivery Plan 2016 - 2020
- NHS Forth Valley Healthcare Strategic Plan 2016 - 2021 (draft)
- NHS Forth Valley Clinical Services Review 2015
- NHS Forth Valley Local Delivery Plan 2015 - 2016
- NHS Forth Valley Winter Plan 2015 - 2016
- Falkirk Council Corporate Plan 2012 - 2017
- Poverty Strategy: Towards a Fairer Falkirk 2011- 2021
- Falkirk Joint Commissioning Plan for Older People 2014 –2017
- Forth Valley Integrated Carers Strategy 2012 - 2015
- Drug and Alcohol Strategy 2015
- Integrated Children Services Plan 2010 – 2015
- Local Housing Strategy 2011 – 2016
- Falkirk Council's Community Learning & Development Action Plan 2013-2018.

There are a number of national strategies, including:

- Mental Health Strategy
- Keys to Life Strategy (Learning Disabilities)
- Dementia Strategy 2012
- Physical Activity Strategy 2007 – 2017

4. PEOPLE'S VIEWS

The Strategic Plan has been developed using information about the Falkirk area, population and their needs. The HSCI Partnership will produce a Consultation and Engagement report on the process to develop the Strategic Plan. In addition, the HSCI Partnership will produce a detailed Falkirk Participation and Engagement Plan. This will outline how we will continue to engage with people and partners to develop integrated models of service delivery.

4.1. Wider Engagement

The HSCI Partnership has listened to the views of people living in and providing services within the Falkirk area to shape the plan. We have also acknowledged the legislation and national and local policy and planning arrangements.

Locality planning will put people and partners at the centre of developing current and future services, which includes setting local priorities. The Falkirk Participation and Engagement Plan will describe how people can be involved.

In the development of the Strategic Plan, we have:

Informed	**Engaged**	**Consulted**
Staff Newsletter Local Media Social Media Website Banner Posters in public venues/GP surgeries	Staff engagement sessions *(7 in total April & May 2015)* Transitional Board priority setting workshop *(18 June 2015)* Stakeholder engagement event for staff across all sectors *(30 June 2015)* Strategic Planning Group meetings *(August and November 2015 & January 2016)*	Citizens Panel Survey *(November 2015, with 493 responses)* Online Survey *(November & December 2015, with 73 responses)* Targeted presentation and feedback sessions *(23 in total throughout November & December 2015)*

Table 4

The process to date has been sequenced, with information from each event helping to inform the next. The Strategic Planning Group then refined and agreed the priorities. Wider consultation has taken place through the Citizens Panel and online surveys, during November and December 2015. This was also supported by 23 targeted presentation and feedback sessions to a range of stakeholder groups within the Falkirk area. These included:

Target Audience	Group/Forum
Communities	Community Council Forum Carers Forum ALFY Public Education Events Patient Participation Forum Friends of Dundas
Staff	Occupational Health Forum GP Sub Committee NHS Forth Valley Corporate Management Team Community Care Service Managers Meeting Playing to your Strengths Event
Partners	NHS Forth Valley Board Falkirk Council Falkirk Community Planning Partnership ICF Project Leads Alcohol and Drugs Partnership Community Care and Health Forum Scottish Care Providers Make it Happen Forum Fife and Forth Valley Community Justice Authority Board

Table 5

4.2 What people said future services should be

Consultation and engagement events have informed the HSCI Partnership about what future services should look like, **to *enable people in Falkirk to live full and positive lives within supportive communities*.** The responses from engagement on the draft plan are summarised below.

Respondents said future services should be:

- **Person-centred** – Good services are outcomes focused, centred round the needs of people. People are able to make informed decision regarding their own care pathway and are supported to self-manage, where possible. The transition process will be seamless and well-co-ordinated. For example, young people transition from children's to adult health and social care services will begin at a point that allows sufficient time to plan for new arrangements to be in place. Single care plans should be 'owned' by the service user, their carers and family. Information about services is co-ordinated and communicated in an accessible way.

- **Improved Access** – People are able to access services quickly via a single point of contact, particularly those with multiple or long-term conditions. Transition between services is supported with a back office infrastructure that facilitates smooth transfer via effective communication and information sharing. In addition, services are responsive and available consistently throughout the year, on a 24/7 basis, if appropriate. People said transport to services should be available, when appropriate.

- **Focused on Early Intervention** – People are supported by responsive, proactive services before reaching crisis. 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. The HSCI Partnership recognises the critical link between traditional health and social care provision and the contribution of wider partners, for example, the Community Planning Partnership, Criminal Justice & Housing.

- **Enhanced Information Sharing** – Information sharing is critical to good integrated care – and is extended across all sectors. Information sharing includes the ability to share single assessments and care plans, which are co-produced by services users and professionals, and can be used and updated across professional specialisms. This allows the co-ordination of care, so that the right care is provided at the right time by the most appropriate service. Infrastructure, particularly IT systems, are in place to support this, and staff are able to access and use the system with data sharing procedures in place.

- **Skilled Workforce** – A shared vision is held across all partners. The workforce across all sectors is highly skilled. Joint working across agencies and sectors is the norm and frontline staff are empowered to take decisions, which allow them to tailor response and care to suit the needs of individuals. The HSCI Partnership is able to identify, manage and tolerate risk, and staff are supported in being able to work in different ways to help people achieve their personal outcomes.

4.3 Further information on the consultation and engagement process to develop the Strategic Plan are described in the Consultation and Engagement report on the process to develop the Strategic Plan. The information from the Joint Strategic Needs Assessment and the consultation has helped shape the priorities for the partnership. These are described in the following sections.

5 HOW WILL THIS PLAN BE DELIVERED?

5.1 The Falkirk HSCI Partnership is committed to continuing our engagement with individuals and communities to develop high quality, responsive and effective services that improve outcomes for people. This section sets out how we will deliver the Strategic Plan. We will do this by:

- Working with communities and our staff to develop locality plans for each of the three areas
- Continue to engage with our workforce to develop services and to provide appropriate training and support
- Working with Community Planning Partners and the Third and Independent sectors to develop local services and support.

The Strategic Plan sets a direction for the next 3 years and will continue to develop in response to the changing environment and emerging feedback from communities and partners. In order to work towards the outcome and priorities, the following section outlines the required actions.

5.2 Localities

The Strategic Plan will be realised within three different localities, namely

- Falkirk Town
- Bo'ness, Grangemouth and Braes
- Denny, Bonnybridge, Larbert and Stenhousemuir.

The Falkirk HSCI Partnership will work alongside Falkirk Community Planning Partnership, including NHS Forth Valley and Falkirk Council, to implement a locality planning framework that will mean that local communities are involved in the design and implementation of new services; provided by statutory agencies and by communities themselves. This will also support the Community Empowerment (Scotland) Act.

Although three health and social care localities have been identified, the Community Planning Partnership will work with a greater number of smaller localities across the Falkirk area, with a particular focus on areas with high levels of deprivation. Local action planning that has previously been undertaken, in line with the local Community Learning and Development Action Plan 2015-2018, have highlighted challenges and need within communities based on 'lived experience'. Information has been gathered relating to health and well-being and health inequality. The Partnership will use and build on this intelligence when considering future community based provision.

5.3 Community Engagement

The HSCI Partnership will implement our Participation and Engagement Strategy. This will be in line with the National Standards on the Principles of Community Participation and Engagement, the Council's Principles of Community Involvement and the NHS Participation Standard.

This will mean that engagement with communities and the providers working within the areas will generate information which will set the scene for holistic provision. It will link to the work of the Community Planning Partnership to target health improvement activity and actions to reduce health inequalities and support people to live more independently in supportive, safe communities.

5.4 Services

The HSCI Partnership has responsibility for the planning and operational delivery of health and social care for adults within the boundaries of the Falkirk Council area.

There is a range of social care, primary and secondary healthcare and public health improvement services. There are also several examples of integrated working arrangements in place, such as the Community Mental Health and Learning Disability Teams. These provide valuable resources to continue to develop integrated services and ways of working.

Many initiatives are currently being tested and are contributing to local outcomes. Some of these initiatives are specific to certain localities and could be rolled out across the Falkirk area. Initiatives and service redesign have been, and will continue to be, developed consistent with the outcomes and priority areas.

The adult health and social care services, including those provided by the Third and Independent sectors, which will be within the agreed scope for planning and delivery are:

Current Community Health Services	**Current Local Authority Services**
• District Nursing • Services related to substance addiction • Services provided by AHPs in outpatient clinics or out of hospital • Primary medical services/ Public dental service/General dental, Ophthalmic and Pharmaceutical services • Community Mental Health and Learning Disability services.	• Social work services for adults and older people • Services and support for adults with physical disabilities and learning disabilities • Mental health services • Drug and alcohol services • Adult protection and domestic abuse • Carers support services • Community care assessment teams • Support services • Care home services • Adult placement services • Health improvement services • Aspects of housing support, including aids and adaptations

Current Hospital Services	
• Emergency Department • Inpatient hospital services (General Medicine/Geriatric Medicine/Rehab Medicine/Respiratory) • Hospital based Mental Health services • Psychiatry of Learning Disability.	• Day services • Local area co-ordination • Respite provision • Occupational therapy services • Re-ablement services, equipment and Technology Enabled Care.

Table 6:

5.5 Housing

Housing has an important role to play in the delivery of coordinated, joined up and person-centred health and social care services. Successful integration of health and social care services will require that more people will be cared for and supported in a homely setting.

Falkirk has an ageing population, it is estimated that people over 65 years will increase by 72% from 2012 to 2037 (National Records of Scotland 2012 population projections). Over the same time period there will be an increase of 32% in single person households. The majority of the population (65%) in Falkirk live in owner occupied housing (2011 Census) which is above the national average (62%). In relation to older people, they are more likely to own properties than younger people.

It is estimated that there is a need for disabled adaptations in 2% of dwellings locally, equating to around 1, 380 properties (Scottish House Condition Survey 2011-13). Applying local information to national research, it is estimated that there may be a need for 510 all tenure wheelchair properties locally (Watson et al 2012).

The Housing Contribution Statement (HCS) is informed by consultation with stakeholders and the analysis carried out for the Housing Need and Demand Assessment. This Assessment identifies the contribution that specialist provision plays in enabling people to live well, with dignity and independently for as long as possible. It is important to target funding to plan the delivery of need from specialist groups; further information is available in the Housing Contribution Statement which has highlighted a potential need for Extra Care Housing for older people, advice and information for specialist groups and the importance of streamlining procedures for disabled adaptations.

The Housing Contribution Statements is an integral part of the Strategic Plan and provides a link between the Strategic Plan and the Local Housing Strategy.

5.6 Workforce

Effective leadership is crucial in providing direction and delegation, enabling staff at all levels across the HSCI Partnership to fully adopt a person-centred approach to care. In addition, a systematic review and evaluation of current services will provide the basis for the necessary transformational change.

Robust accountability is necessary to ensure that there is clarity around roles and responsibilities regarding reporting structures that ensure actions are delivered. This links backs to effective leadership and the ability to make informed decisions.

This workforce plan sets out our commitment to ensure a workforce that is responsive and skilled and is able to provide care and support that is local and of a high quality consistent with the Partnership ambitions.

The workforce plan also sets out the commitment to working across the wider health and social care sector, not just those employed by the NHS or the Council. This will support the ongoing joint commissioning of services and the approach to delivering services integrated at local level.

This plan will be a 'live' document and will be supported by more detailed workforce and organisational development action plans for localities and will reflect the ongoing Integration Joint Board corporate and national priorities.

5.7 Strategic Plan and other plans

In section 2.2, we describe the range of partnership and service plans in place. Importantly, public views and evidence based approaches informed their development, and there was wide consultation and research on these. The partners have individually and/or collectively agreed to work towards these and are at different stages of completion.

These plans are a helpful starting point to focus future HSCI Partnership activity. This Strategic Plan takes account of the legislative strategic planning requirements and how future local plans must align with the integration agenda and a whole system approach.

The Strategic Plan is supported by key documents which are available as annexes.

These are:

- Joint Strategic Needs Assessment
- Financial Plan
- Performance Management Framework
- Participation and Engagement Strategy
- Housing Contribution Statement
- Market Facilitation Plan

5.8 Resources - Financial Statement

Financial statement to follow - including position for IJB and budget savings targets.

5.9 Risk Management

The Strategic Plan will be underpinned by a Risk Management Strategy. This will provide staff with the necessary structure to assess and manage risk. Such an approach will be adopted at all levels of the HSCI Partnership to include management decisions and front line services with consideration of service users' and carers' views.

5.10 Equality and Diversity

Taking equalities into account is important as the demographics and needs of individuals and communities can be different and can change. It is necessary to consider equalities and diversity so that the Strategic Plan can have a positive impact on people that take account of their personal protected characteristics.

The HSCI Partnership will publish a set of equality outcomes and prepare a mainstreaming report.

5.11 Market Facilitation Plan

The Strategic Plan will be underpinned by a Market Facilitation Plan. The plan will give the Partnership a good understanding of the current levels of need and demand for health and social care services. This will then help us to identify what the future demand for care and support might look like and help support and shape the market. This will ensure there is a diverse, appropriate and affordable provision available to deliver effective outcomes and to meet needs.

The plan will represent the dialogue with service providers, service users, carers and other stakeholders about the future shape of our local social care and support market. By implementing the plan, we can ensure that we are responsive to the changing needs and aspirations of Falkirk's residents.

5.12 Performance Management and Reporting

Performance management is necessary to ensure the efficiency, effectiveness and quality of services and that these are regularly evaluated and monitored. This will include evaluating collaborative working within and across all sectors.

The Integration Joint Board will be held accountable for all services within their responsibility and need to publish an annual performance report. This will set out how the partnership is improving the National Health and Wellbeing Outcomes.

The Scottish Government has set out a range of core integration indicators to guide us (see Appendix 1). These are based on survey feedback, to emphasise the importance of a personal outcomes approach and the key role of user feedback in improving quality. While national user feedback will only be available every 2 years, we will supplement performance reports with local information that is collected more often.

Additionally a local suite of performance indicators will monitor progress against outcomes and priorities. Regular performance reports will be submitted to the Integration Joint Board. These will be included in the annual performance report.

Appendix 2

Falkirk Health and Social Care Integration Partnership

Strategic Plan Consultation and Engagement Report

Summary Findings

In summary, engagement and consultation has highlighted:

People generally see the integration of health and social care as an opportunity to improve care and support provided, however some feel the cultural differences between agencies will present a challenge that must be addressed.

People feel that joined process and procedure will allow effective integration, but that the focus should be on service improvement, effective use of resources and avoiding bureaucracy.

Improved communication with people who receive services and between agencies was consistently highlighted as important, as were accessible services with well trained and engaged staff.

Introduction

The Health and Social Care Integration (HSCI) Partnership set out to involve key stakeholders during the production of the Strategic Plan. Service users, carers, health and social care staff, , the public and key partners have had various opportunities to tell us what they think and participate in the production of the Strategic Plan. This was done through a series of information and consultation methods.

The engagement plan set out:

- 7 Staff engagement sessions: April to May 2015
- Transitional Board priority setting workshop: 18 June 2015
- Stakeholder engagement event for staff across all sectors: 30 June 2015
- Strategic Planning Group meetings: August and November 2015 & January 2016
- Presentation and Feedback sessions targeted: November to December 2015
- Online and Citizen's Panel survey

Information was disseminated to the public through staff newsletters, local media, social media, the Council and NHS Forth Valley websites and posters in in key spaces (including GP surgeries). A mix of consultative methods were used: a module of HSCI questions were included in the Council's Citizens Panel in November 2015, an online survey was open through November and December 2015 (routed from the Council and NHS Forth Valley's websites), and targeted presentation/feedback sessions took place throughout November and December 2015.

Staff engagement sessions were used to inform staff and changes and allow them to provide feedback on how their approach to work could alter. These staff included nurses, Occupational Therapists, Social Workers and Care Workers and also staff from Third and Independent Sector providers. Staff in these sessions discussed the impact of the HSCI changes on the day-to-day delivery of health and social care services. What was discussed then informed the Strategic Planning Group as they further refined the Strategic Plan's priorities.

The membership of the Strategic Planning Group (SPG) is prescribed in the Public Bodies (Joint Working) (Membership of the Strategic Planning Group) (Scotland) Regulations 2014, however the Integration Joint Board agreed to extend the minimum prescribed membership to include Board, GP and staff representation. The prescribed membership includes representatives from service users, carers the Independent and Third Sector and Housing.

The proposed priorities were then distributed for wider consultation via the Citizens Panel and online surveys in November 2015 and targeted presentation and feedback sessions. The results of the surveys and sessions with the public have been fed into the redrafting of the Strategic Plan.

This report now presents consultation findings followed by a brief discussion and conclusion.

Citizens Panel 15 Findings

The Citizens Panel is made up of around 1,500 residents from across the Council area, with questionnaires distributed electronically or by post three times a year. The questionnaires have covered a variety of topics, with questions on quality of life, housing, , community safety and public health. This was the 15th Citizens Panel survey and had four particular sections: Local Development Plan, Local Housing Strategy, Health and Social Care Integration and About You.

There were 493 responses to the survey, with 174 postal returns and 319 online completions. For postal surveys we cannot utilise mandatory fields and therefore the number of responses is variable across questions.

39% of respondents were male, 42% were female and 19% did not specify their gender. The age range of this Citizens Panel was weighted to people over 45, with 38% aged 65 years or over and 72% aged 45 years or older. 12% were aged 25 to 44 years old. 15% did not specify their age. Figure 1.1 shows a complete breakdown of the age categories.

15% of respondents self-identified as disabled, with 69% stating they were not disabled. 16% did not answer the question.

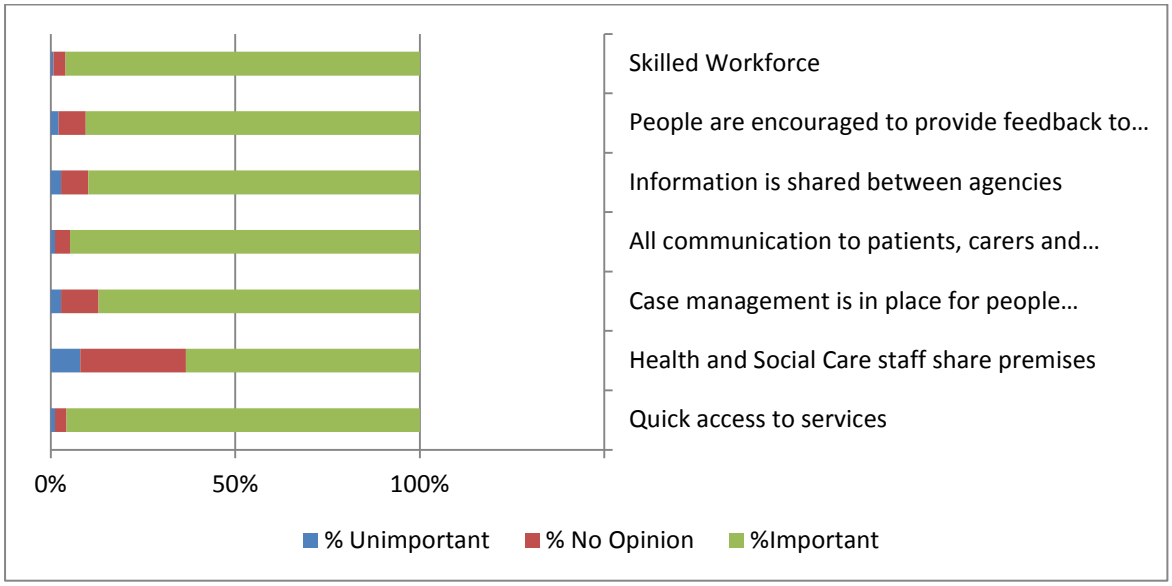
There were two questions within the HSCI section of the Citizens Panel questionnaire:

- *Q 34 - Here are a series of statements about Health and Social Care Integration. Please tell us how important these are to you.*
- *Q 35 - Based upon your experience, is there anything about Health and Social Care Services that you would like incorporated into the Strategic Plan?*

Q34: Here are a series of statements about Health and Social Care Integration. Please tell us how important these are to you.

423 people answered this question. Figure 1 below shows that most people think all themes are relatively important (i.e. noted important or very important on the Likert Scale), with the exception of co-location. Quick access to services and a skilled workforce could be identified as respondents' most important themes.

Figure 1: Importance of HSCI Themes



There were 33 comments in the 'other' field. Transport, confidentiality, operational capacity and communication were the most commonly recurring themes. (These themes were each identified by 4 people.) Table 1 provides illustrative quotes alongside key themes.

Table 1: Coded Responses to HSCI Themes

Theme	Responses	What People Said
Transport	**4**	*'Problems with transport to get to hospital for appointments.'* *'No shuttle transport from my area which goes near local health centre.'* *'dedicated transport enabling accessibility by elderly and infirm within the area of health care provision.'* *'Why do health centres have NO PARKING facilities for cycles?'*
Confidentiality	**4**	*'Assurance that confidentiality is maintained.'* *'more specific - and not all information should be shared around everyone unless it is on people who are in danger.'* *'Private and Confidential* [sic] *information should be as always.'* *'PRIVATE AND CONFIDENTCIAL* [sic]*!'* *'Information is only shared with other agencies where relevant.'*
Operational capacity	**4**	*'home carers* [sic] *are underpaid'* '*not enough care service today , too many hurdles , social services inadequate , only managers no Indians !! nobody willing to listen or act*.' *'Less PC….. more real people.'* *'Processes need to reflect support required for the ageing population.'*

Communication	**4**	*'Information must be relevant to those concerned.'* *'All communication should be in plain English with no jargon.'* *'Keep it simple.'* *'At the moment there is very little communication be the services.'*

Q35: Based upon your experience, is there anything about Health and Social Care Services that you would like incorporated into the Strategic Plan?

There were 117 responses to this question. The most commonly recurring themes were information sharing (20%); care-plan reviews (14%) and GPs (13%). Several aspects of GP care were raised, such as the number of GPs, the waiting times or length of GP appointments. Care-plan comments included the need for better dialogue between service providers and service users (co-production) and quicker assessment.

Box 1: People's Experiences of Health and Social Care Services

Information Sharing
'There needs to be more time spent with the elderly and more communication with health centres & families [sic]*.'*
'At the moment it seems that information is taking a long time to reach other departments, in this technology age that should not be a problem.'
'The different services need to work together to provide the best care. it is too disjointed & one department don't know what the other is doing.'

Care-plan Reviews
'Peoples [sic] *careplan should be reviewed ….., communication must be better between services.'*
'social care service that listens and then acts.'
'Timelines and all key contacts regularly reviewed.'
'Better understanding for people who require care.'

GPs
'More long-term doctor's at our clinic's easier appointment system week in advance not daily phone calls for appointments then being told to phone back next day etc, etc by receptionist.'
'Why are surgeries only open during office hours? Why not at weekends? I should have a blood checks at my local surgery. To do this I would need to take holidays. '
'Longer opening times at GP practices, including weekends.'
'Health centre is a joke at Bonnybridge + Banknock. Unable to see doctor for 4 weeks in between appointments. Bonnybridge drop in is ok if you are willing to wait between 2-3 hrs. With babies + children this is impossible.'

Online Survey

There were 73 responses in total to the HSCI online survey. The number of responses for each question was highly variable.

The online survey was promoted via:

- Front page banners on NHS Forth Valley and Falkirk Council Websites linking to the survey
- Partner agencies such as Third Sector Interface and Carers Centre promoting the consultation via their websites and newsletters
- Posters in community centres and GP surgeries, across the Falkirk area
- Information included within all Falkirk Council and NHS Forth Valley staff Pay slips
- Email via distribution lists?

There were targeted presentations to 23 groups across the Falkirk area (also giving opportunity for feedback).48 people told us whether they were staff, service users, carers and/or Third Sector workers. People could select more than one category, reflecting that someone can provide and use services. 58% (28 people) identifying themselves as service users., 42% (20 people) identified themselves as health and social care professionals, 40% (19 people) as carers and 31% (15 people) as Third Sector Organisations. 10 respondents identified themselves as representing an organisation, with 41 people answering as individuals and 22 non-responses.

There were 38 responses to the gender question, with 76% identifying themselves as female and 24% as male. All respondents had the same gender identity at birth. 83% (29) of 35 respondents identified themselves as heterosexual, with one person self-identifying as 'other' and 5 people selecting 'prefer not to answer'. 29 people stated their age on their last birthday, with 34% (10 people) aged 25 to 44, 34% aged 45 to 64 and 31% (9) aged 65 years or older.

All 38 respondents who gave their ethnicity identified themselves as white. Church of Scotland was the most prevalent religious affiliation, with 44% of 36 respondents followed by 31% identifying themselves as atheist.

11 people identified themselves as having a disability, 28% of the 39 people who answered that question. However, contradicting this data, 23 people specified a particular disability. 48% stated a physical disability, 48% a long term health condition and 35% a mental health condition.

There were seven questions in the HSCI online survey:

Q1: Based on your experience, is there anything that you would like to tell us about Health and Social Care Services that will help develop the plan?

There were 42 responses to this question. Table 2 provides a breakdown of the main issues people responded with and a selection of quotes for each. 42% of respondents emphasised a need for effective partnership working, whilst 29% underlined the importance of information sharing between key stakeholders. Improving patient care, smoothing access to services (such as a single point of contact), addressing the root cause of conditions and plain English communications were also put forward by 5 or 6 people each.

Table 2: Suggestions for Improving the Plan

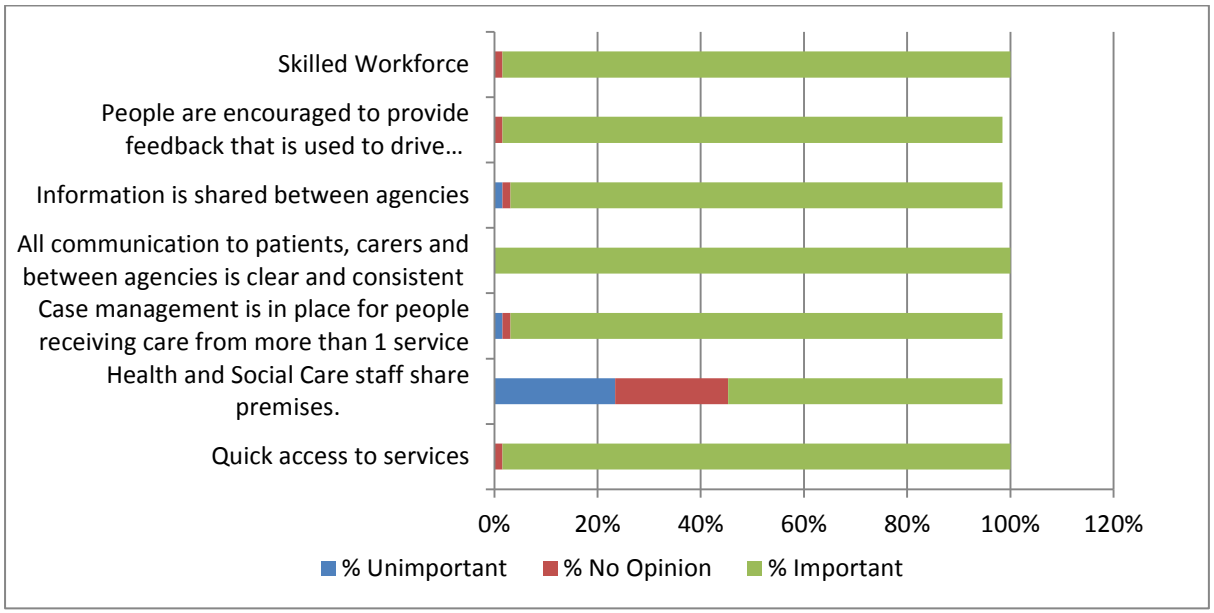
Theme	Responses	What People Said
Partnership Working	**17**	*'Reference to more explicit commitment to community planning (at strategic , tactical and operational levels) would strengthen the Plan and demonstrate a willingness to work in partnership with CPP partners to achieve improved outcomes.'* *'The partnership* [sic]*working across both services must continue and respect of each others roles acknowledged. Single shared assessment has never been evolved fully.'*[']*There is a need for a seamless transition between health and social services provision. More consideration is required for the transition from childrens* [sic] *services (health) to adult services (social work) where disabled are concerned.'*
Shared Information	**12**	*'IT communication should be improved to allow sharing of information easier.'* *'More communication between staff might make a difference.'* *'I think to have effective integrated teams there needs to be huge*

		consideration taken about having teams located together and everyone in those teams having access to each others information systems.'
Single Point of Contact/Ease of Access to Services	**6**	*'The near impossibility to contact a social worker to discuss possible future needs - this could result in the caring services being subject to unnecessary stress and expense.'* *'There are no easy answers to dealing with MS, but a single point of contact for me would really have helped me during the year since diagnosis.'*
Specific Condition	**6**	*'Right now management of long term conditions is lacking and within health there is not consistent treatment with locums and lack of services from GPs. The use of CBT for all mental health conditions and substance misuse is a short term plaster on the wound approach rather than a sustainable look at the root cause approach.'*
Improving Patient Care	**6**	*'Integration seems to be about bringing together two "organisational" bodies - what is needed is integral health and social care, integral medicine - all we are doing is producing more of the same whereas what is need is a change not only in how we do medicine and care but the kind of care and medicine we do. This is completely overlooked.'*

Q2: Here are a series of statements about Health and Social Care Integration. Please tell us how important these are to you.

64 people answered this question. Figure 2 below shows that most people think all themes are relatively important (i.e. noted important or very important on the Likert Scale), with the exception of co-location. This matches the results from CP15. Communications could be identified as the most important theme. There were 11 comments entered in the 'other' field. Four of these emphasised improving patient care, two suggested information sharing, whilst prevention, co-location and community-based support were mentioned once each.

Figure 2: Importance of HSCI Themes



Q3: Do you agree that by focusing on the priorities within the draft Plan, that health and social care will improve?

There were 73 responses to this question. 71% said yes and 29% said no. Three of these suggested insufficient capacity within health and social care to meet the objectives of the Strategic Plan, particularly in light of service reductions. Seven people specified the difference in organisational cultures as a barrier to improving health and social care services. Box 2 contains some of the things people said.

Box 2: Organisational Culture

'services may have shared budget and management[sic] *but still work within two different systems , practical day to day working needs to be a priority'*

'Social work and health are like oil and water. They speak different languages'

' I don't believe joint working is going to have good outcomes. I believe it will be health focused and not social work minded.'

'The plan has no real substance to it full of strategies and no doubt endless meetings to discuss how to do things meaning more bureaucracy and no real quality services at the front line'

'They are limited in scope and not aspirational enough'

'Has the field work staff been involved in the initial proposals and planning? Staff feel this has been proposed by politicians.'

Q5: Are there any other priorities that you think should be included?

65 people answered this question. 52% stated there were, whilst 48% said there were not. 28 people suggested additions to the existing priorities, with two most prominent suggestions being the engagement of service users and/or carers (36%/10 people) and improving some aspect of the health and social care user experience (29% /8 people). Partnership working, prevention, information sharing were each suggested by four people. More explicit focus on dementia, palliative care and drugs and alcohol were each suggested by one person. Table 3 contains more details on suggested additions to the Strategic Plan.

Table 3: Suggested Additions to the Plan

Theme	Responses	What People Said
Engaging service users/carers	**10**	*'Where to get information on how people can get more involved.'* *'More freedom to allow carers to dispense basic medication with agreement with family.'* *'Consultation with parents and carers did not happen before the decision to close the Rowans was taken.'* *'An embracing of a new medical / care paradigm, one which REALLY puts the patient at the centre, which treats causes not just signs and symptoms, which embraces the best of conventional and functional, integrative, complimentary approaches, and which truly LISTENS and communicates better. Patients are not all ill-informed nor ignorant.'* 'Use of project management approaches and customer feedback to help communicate changes to both staff and public.' 'Use of technology to support people to articulate their needs,

		provide feedback and influence services and plans and improve care, particularly at home…'
Improving Patient Care	**8**	*'To*[sic] *many people are being sent home from hospital to early meaning they end up back at hospital. Not everyone is seen by the appropriate professionals i.e physio, O.T. This could be avoided with better planning and a checklist should be made before someone can go home. Especially people who live on their own.'* 'Continue process to check post in-patient medicine reconciliation which has received attention in last few years. […] *Reduce medicine costs by not disposing of all unused medicines. Allow pharmacists* [sic] *to make the decision on which medicine can be sensibly re-used. Address wastage across the NHS. Doctors should tell the patients how much their medication costs so they might appreciate what they are getting free and* [sic] *finish the course.'* *'Achieving cultural* [sic] *shift to use of TEC in care planning as a first and not as a last resort.'*

Q7: Do you have any other comments you wish to make?

There were 24 responses to this question. The most common theme here was the practical impact that the organisational restructure could have. Box 3 contains some of the things people said

Box 3: Organisational Restructure

'A more joined up approach will benefit all stakeholders.'

'The plan should logically model the outcomes of the H and SC Board, the CPP and the ADP as they have similar priorities and outcomes.'

'Whilst core performance indicators are welcome, it would be beneficial if targets or quantitative measures of improved outcomes were included in the Plan.'

'More joined up services between GPs, DN and SW staff. Meet regularly, work together.'

'There needs to be a massive restructure of health and social care with less managers having ridiculously high salaries and massive pensions with more being spent on those actually delivering the services. More knowledge of what is actually behind poor health and less money wasted on meeting after meeting to discuss strategies and then implementation of strategies then changing strategies to justify management posts'

'Do not join up it will see a reduction in services and not person centred [sic] *outcomes which will benefit me or others.'*

5 people provided general comments on the engagement of service users and carers. There were two specific suggested amendments to the report:

> *'In the summary statement under local initiatives PDS should be under self management and instead the Alzheimer Scotland Community Connections programme should be under the community based support.'*

'The latter pages of the report where the 5 Outcomes are spelled out as against the nine areas in the 2020 vision makes for very confused reading for me as a professional and would be a severe challenge to most. The layout is the issue and improvements in this would be helpful in making sense of this as a summary.'

Presentation/Feedback Sessions

There were 23 different sessions with a range of participants. The following table provides a breakdown of who we spoke with.

Table 4: Presentation/Feedback Sessions

Participants	Group/Forum
Communities Carers Service Users Staff – health and social care	Community Council Forum Carers Forum ALFY Public Education Events Patient Participation Forum Friends of Dundas
Staff– health and social care	Occupational Therapists Forum GP Sub Committee NHS Forth Valley Corporate Management Team Community Care Service Managers Meeting Playing to your Strengths Event
Partners Communities Carers Service Users Staff – health and social care Third sector Independent Sector Housing sector	NHS Forth Valley Board Falkirk Council Falkirk Community Planning Partnership Integrated Care Fund Project Leads Alcohol and Drugs Partnership Community Care and Health Forum Independent Sector Providers Make it Happen Forum (for over-50s) Fife and Forth Valley Community Justice Authority Board Local Housing Strategy group - think this was the name of the group

Each session was made up of a presentation by a member of the Strategic Plan Co-ordinating Group followed by an opportunity for discussion and feedback. Similar themes emerged in the sessions as those raised in responses to the Citizens Panel and online survey. The most common theme was that people wanted integration to lead to improvement of health and social care services. All other themes discussed tie in with this, unsurprisingly. Information sharing and communications were discussed regularly. People also talked about the accessibility of services, how communities had been engaged and would be engaged in future, and they also asked how services would be resourced. Accountability was a common theme of the feedback exercises, with people asking who would be responsible for different parts of health and social care services at various points of time.

Table 5 below presents the main themes discussed and some of the things that people said.

Table 5: Key Themes from Information/Feedback Sessions

Theme	Occurrences	What People Said
Improved Services	**28**	*'There have been positive developments – Independent Sector Development Officer post has enabled better information sharing; learning opportunities in place – at local and national level'* *'Plan must recognise transition between child and adult services. Important to make strong links with Children Services in general'* *'How will the Board ensure that information is shared appropriately and securely?'* *'What is the role of the Board in regard to planning and service delivery?'* *'What difference will plan make?'*
Accountability	**20**	*'… clear implementation plan with delivery actions including the need to agree that these are the Partnership priorities and commit officer to proceed with these'* *'need to build an accountability to the delivery of the plan, challenge when this is not being done'*
Information Sharing	**17**	*'Need for improved information sharing was agreed as a priority area'* *'How will the Board ensure that information is shared appropriately and securely?'*
Accessing Services	**14**	*'Who can be key contact for people?'* *'It would be helpful if there was one person, one key contact who could contact everyone to inform them'*
Level of Resources	**13**	*'The ICF process needs reviewed for future allocations'* *'The independent sector is facing a lot of challenges – recruitment and retention; low pay; ability to offer contracts to staff* […] [these are] *impacting on ability to deliver these hours of care'*
Community Engagement	**13**	*'Community Council know their areas – what is needed and potential solutions – and should be more engaged in discussion about services'*
Communications	**13**	*'need to have a clear vision that is known by all and clarity how this will be communicated'* *'Community Councils have their own Facebook pages and can share information to the wider community'*

Going Forward

Staff engagement has been relatively strong, but engagement with the public has not been as strong as we would have liked. Only 73 people took part in the online survey and nearly half of those people work in health and social care. However, this is just the first stage in an ongoing engagement with service users, carers, staff, partners and local communities.

The key issues people raised throughout the HSCI engagement were effective information sharing; clear communications; accessible, accountable and improved services and meaningful community engagement. We have made sure that these issues are represented within the Strategic Plan. We have also, as and when required, provided information to the relevant people on suggested improvements to services. This is part of our concerted efforts to listen to the needs of people and make our services more responsive to people's needs.