Falkirk Council

NHS Forth Valley

Falkirk Integrated Strategic Plan 2016-2019

Version Control		
Date	Change	Doc Name
23/10/15	Added – Housing & Deprivation info section 2	Falkirk_Integrated_Strategic_Plan_231015.doc
27/10/15	Added – 5.3 'Developing an Enabling Structure' and amended - priorities in appendix and 4.4.	Falkirk_Integrated_Strategic_Plan_271015.doc
28/10/15	Amended – 1.1 and local initiatives	Falkirk_Integrated_Strategic_Plan_281015.doc
29/10/2015	Amended – 2.7 Delayed Discharges; 2.10 summary; proofread for typos Foreword, priorities	Falkirk_Integrated_Strategic_Plan_291015.doc

FOREWORD

Insert Photo

On behalf of the Falkirk Health and Social Care Partnership, we are pleased to introduce our draft Strategic Plan for your views. This will be the first Strategic Plan for health and social care integration for the Falkirk area. This is required with the introduction of new legislation that is intended 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.

To achieve our plan, we understand there is a need to build on our existing relationships and develop new relationships with residents and communities, our services and staff, and many other organisations. This will ensure a joint contribution to encouraging, supporting and maintaining the health and wellbeing of people who live in our community.

The integration of Health and Social Care will see the establishment of a Partnership with it's own Integration Joint Board, developed by Falkirk Council and NHS Forth Valley, giving the opportunity to work in a truly integrated way. The main purpose of the Partnership is to ensure that people get the joined up and seamless support and care they require to meet their individual needs. **This will enable people to live full, independent and positive lives within supportive communities**; forming Falkirk's vision.

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.

We do recognise that there are challenges for the new partnership, including the current and forecast financial climate and increased demand that will exceed the resources available if we do not work together in a more integrated way. There is an opportunity to look at how as a Partnership, we can use our combined resources in a more effective, efficient and person-centred way.

There are inequalities within our communities, which we aim to address by working with our partners to prevent and reduce poverty, promote equality of access, and tackle patterns of ill health in communities at a local level. We will ensure that people have the opportunity to achieve the outcomes that matter to them in an equal and fair way.

The partnership will have a focus on prevention and early involvement to encourage and support self-management and people being in control of their own health and care, as it has proven to add to a better quality of life and can lead to better long term outcomes. We will do this in a way that supports people to be independent.

This three year strategic plan is informed by a variety of events and local and national information available to us. However, in order to make this Partnership the best possible for our residents, your view is essential. We would therefore like to

invite you to provide us with your perspectives and views on what good care would look like for you and those around you, in order to shape our plans for the future.

On behalf of Falkirk Health & Social Care Partnership:

Allyson Black	**Tracey McKigen**
Chair, Falkirk Integration Joint Board	**Interim Chief Officer**

1 INTRODUCTION

1.1 Setting the Scene

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. Such a vision will only become a reality, locally, by statutory agencies working together. In order to make this new way of working truly successful, it is key that the views of people within local communities, including service users, their carers and families are taken into account in shaping future services.

The *Public Bodies (Joint Working) (Scotland) Act 2014* formalises the requirement to work towards the *2020 Vision* and legally requires NHS Boards and Local Authorities to establish Health and Social Care Partnerships. These Partnerships are required to work in an integrated way and are responsible for the delivery of national agreed outcome targets, termed *National Health and Wellbeing Outcomes*.

Whatever the setting, the person should be at the centre of all decisions and their care and support must be provided to the highest quality and safety standards. When admission to hospital is required, there will be a focus on ensuring that people are supported to return back into their home or community environment as soon as appropriate. In doing so, there is a need to ensure there is minimal risk of re-admission to hospital**,** whilst focusing on prevention, anticipation and supported self-management.

At a local level, NHS Forth Valley and Falkirk Council are building on existing common working practices to put in place robust single working arrangements with the aim of providing 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 personal outcomes;
- Locally there is an opportunity to make better use of public resources while creating increased public value in avoiding duplication of effort.

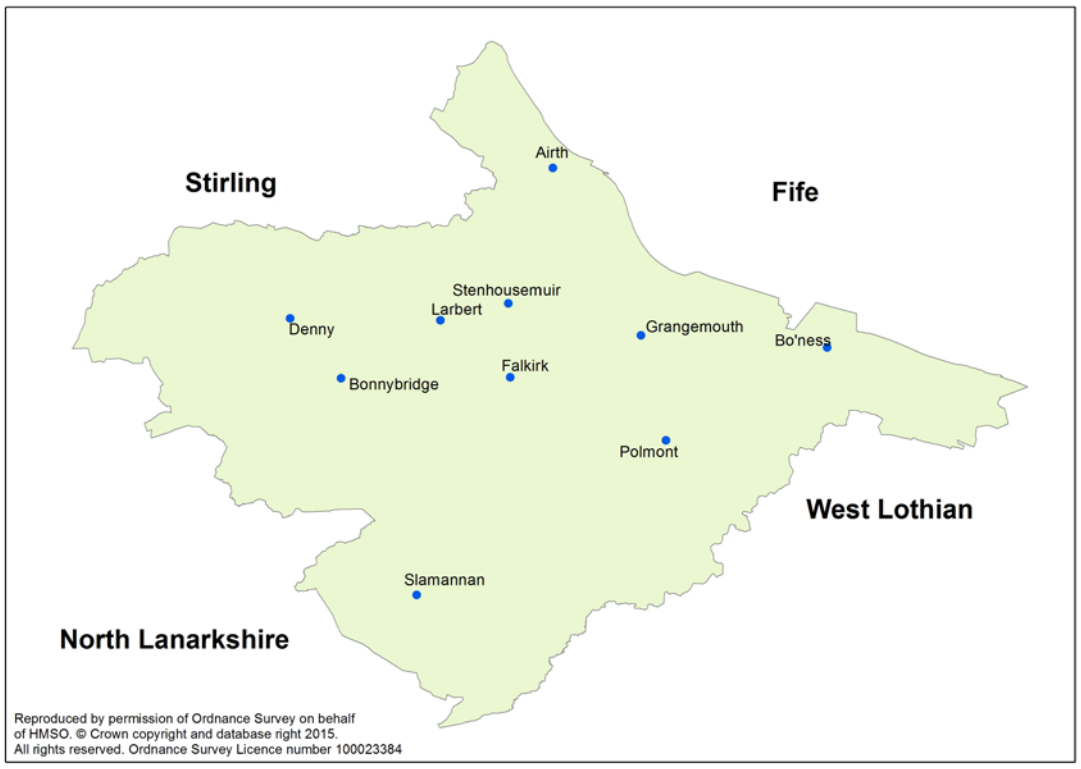
NHS Forth Valley and Falkirk Council have agreed to deliver integrated health and social care services through delegation to an Integration Joint Board. The Board is established as a *body corporate*, with the appointment of a Chief Officer as the jointly accountable officer. With effect from 1st April 2016, the Integration Joint Board will be operational and will have responsibility for the

planning and delivery of health and social care for adults within the boundaries of the Falkirk Council area. In order to facilitate this transition, the Integration Joint Board was established on 3rd October 2015.

Consistent with legislation, the partnership has to identify locality areas for service planning purposes. It has been agreed to establish three localities within the Falkirk Council area, namely:

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

Falkirk Council Area



The establishment of these three localities will provide further opportunity for local communities and professionals (including GPs, acute clinicians, community care workers, nurses, Allied Health Professionals, pharmacists, Care at Home Staff, Residential Care Staff and others) to play an active role in the development of future local services.

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. Furthermore, a number of key priorities have been identified, which will help people living in Falkirk to live full and positive lives.

2 WHY CHANGE?

2.1 The Key Challenges

Change is constant. At the moment, people within the Falkirk Council area are living longer and healthier lives. Many people over 60 contribute greatly to society through volunteering within their community and caring for relatives. Simultaneously, this brings new challenges. The way that health and social care is being provided must change to meet current and future demands, as well as rising public expectations. The current delivery of health and social care is unsustainable, due to an ageing population; growing numbers of older people living with multiple conditions and complex needs; and the continuing shift in the pattern of disease towards long term conditions.

It is becoming increasingly difficult to afford and sustain health care and social care systems which have traditionally focussed on a crisis reactive approach. Consequently, providing institutional care for people rather than supporting them to live more independent lives in their communities. This reactive approach often leads to unnecessary, potentially damaging, expensive and prolonged hospital admissions and to a dependency on social care, which is unsustainable in the longer term.

Moreover, high levels of public resources are devoted annually to alleviating health and social problems, related to individuals and families who are trapped in cycles of ill health *(Christie, 2011)*. Consideration should also be given to other important factors, such as unemployment and poverty. This suggests the need to adopt a whole-systems approach to maximise health and social care outcomes. The Partnership will work alongside Community Planners in order to address these wider issues.

In summary, the traditional ways in which health and social care and support services are structured and delivered in Falkirk are becoming increasingly untenable and therefore fundamental change is required.

The information presented within this section has been drawn from the draft Joint Strategic Needs Analysis (JSNA), outlining some of the key challenges driving change. The JSNA is still under development and therefore, as information becomes available, further consideration will be given to emerging priorities, which will then be reflected in the final Strategic Plan.

2.2 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%, and had the ninth fastest growth rate of all Scotland's councils.

Based on the previous 2012 mid-year estimate of population from *National Records of Scotland (NRS)*, the population is projected to increase further to 162,800 by 2020 and 173,100 by 2037 (see Figure 1 and 2). The growing population presents a key challenge to the Falkirk Partnership by placing increasing demands on services.

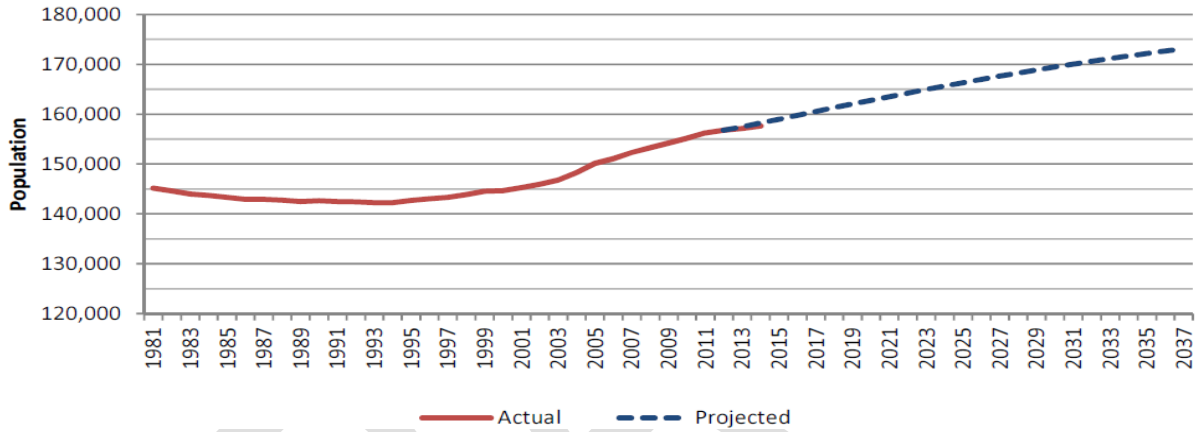


Figure 1. Population 1981-2037 *Source: National Records of Scotland midyear estimates of population 1981-2014 (Crown Copyright) 2012 based population projections 2012-2037 (Crown Copyright).*

Figure 2 illustrates an increasing forecasted population, with the biggest increase represented by the 65+ age group. A decline is forecasted for the 16-49 age group.

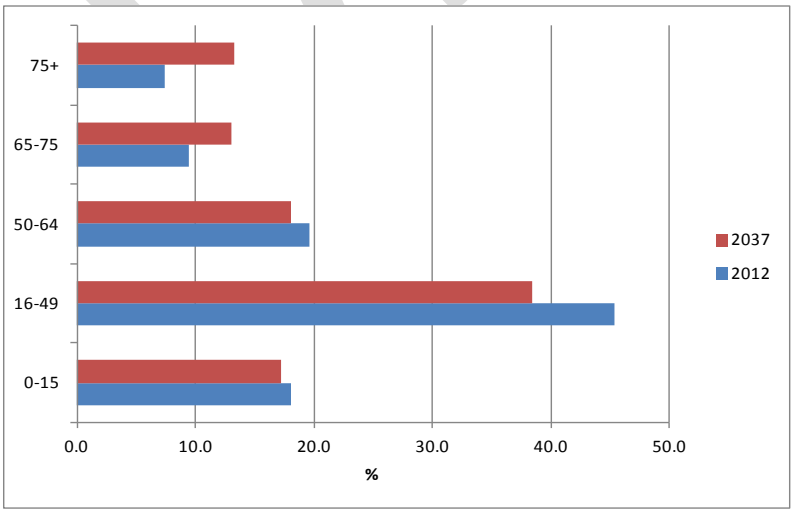


Figure 2. Projected Population Age distribution in Falkirk. *Source: NRS population projections.*

In reviewing various localities, Table 1 illustrates work carried out for the *Falkirk Housing Strategy* and the *Local Development Plan*. On a 2008 base, it is demonstrated that up to 2018, all areas except Grangemouth would have an increase in population. By 2033, both Falkirk and Grangemouth are expected to begin to show a decrease in population.

Sub area	2008	2018	2033	Change 2008-2018 No	Change 2008-2018 %	Change 2008-2033 No	Change 2008-2033 %
Bo'ness	15,297	15,658	17,313	+ 361	+ 2.4%	+ 2,016	+ 13.2%
Denny and Bonnybridge	26,394	30,094	33,291	+ 3,700	+ 14.0%	+ 6,897	+ 26.1%
Falkirk	37,872	38,139	35,716	+ 267	+ 0.7%	- 2,156	- 5.7%
Grangemouth	16,827	16,157	14,290	- 670	- 4.0%	- 2,537	- 15.1%
Larbert, Stenhousemuir and Rural North	26,230	27,470	31,435	+ 1,240	+ 4.7%	+ 5,205	+ 19.8%
Polmont and Rural South	28,954	32,721	39,166	+ 3,767	+ 13.0%	+ 10,212	+ 35.3%
Falkirk Council total	151,570	160,239	171,211	+ 8,669	+ 5.7%	+ 19,641	+ 13.0%

Table 1. Sub area projections of total population 2018 and 2033 (on a 2008 base) *Source: Falkirk Council, Local Housing Strategy 2011-2016, Demographic Report Table 27*

In order to ensure that people have access to services, irrespective of where they live, consideration must be given to the challenges faced by people living in rural areas. The majority (90%) of Falkirk's Partnership area population, lives in urban areas, and a small percentage live in Accessible Small Towns (2%) and Accessible Rural Areas (8%) (Figure 3).

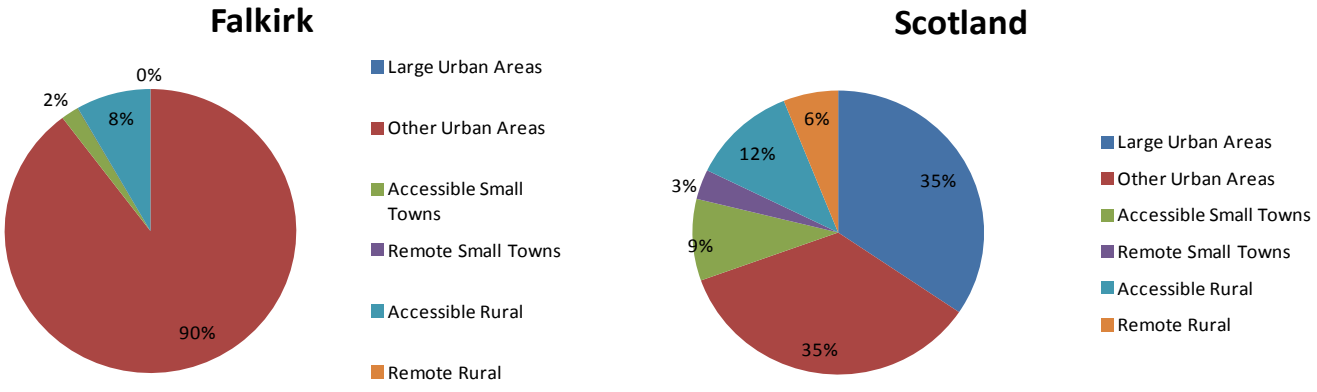


Figure 3. Population Density (persons per square kilometre) 2011. *Source: Census 2011*

2.3 Employment

Personal financial issues and concerns can cause health and social problems. Job insecurity, redundancy, debt and financial problems can all cause emotional distress, affect a person's mental health and contribute to other health issues.

Table 2 below shows the percentage of the population aged 16-74 by their economic activity in Falkirk, and Scotland as a whole. The percentage of people who are economically active is 65% of the population in Falkirk, a couple of percentage points higher than the national average. As a result the proportion of those economically inactive is lower than the Scottish figure, although the percentage of people who are disabled or long-term sick is the same.

Area	Economically active	Unemployed (actively seeking work)	Economically inactive (includes retirees & students)	Long-term sick or disabled
Falkirk	65.0%	5.2%	35.0%	4.8%
Scotland	62.8%	5.1%	37.2%	4.8%

Table 2. Percentage of total population by economic activity. *Source: 2011 Census*

Figures from the Department for Work and Pensions show that there were 13,104 claims for housing benefit in Falkirk in May 2015.

2.4 Housing

Housing may be considered a determinant of health. Inadequate housing can cause or contribute to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer (King's Fund, 2014).

The National Records of Scotland household projections predict that household numbers will increase between 2012 and 2037. Falkirk's increase will be lower (16%) than Scotland's (17%).

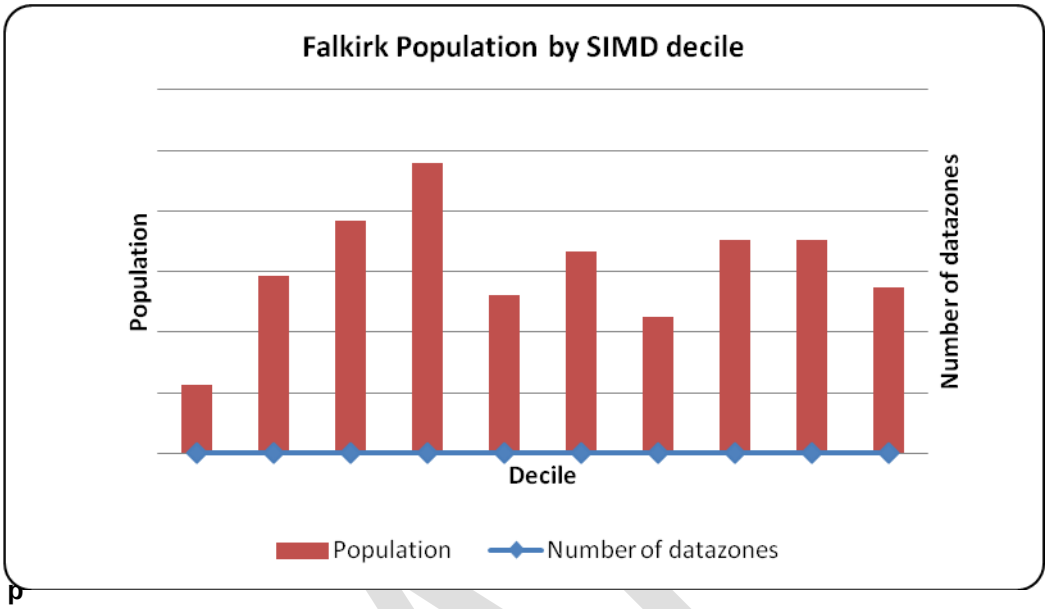
The percentage of those households headed by someone aged 75 and over is estimated to increase from 2012-2037 by 89% in Falkirk, greater than that in Scotland which is estimated to increase by 83%.

In 2013 home ownership accounted for 65% of households in Falkirk, comparable to 61% in Scotland. (Scottish Household Survey 2013). Social renting was the second largest group accounting for 27%, and private renting 8%.

2.5 Deprivation

Deprivation is a risk factor for the vast majority of conditions. Health and social care services 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 4 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.



p
opulation by SIMD decile. *Source: SIMD 2012*

2.6 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 5 shows the number of emergency hospital admissions for patients aged 65+ from 2004/5 to 2013/14 which has increased. Figure 5 demonstrates that the rate and number of admissions remains below the Scottish average.

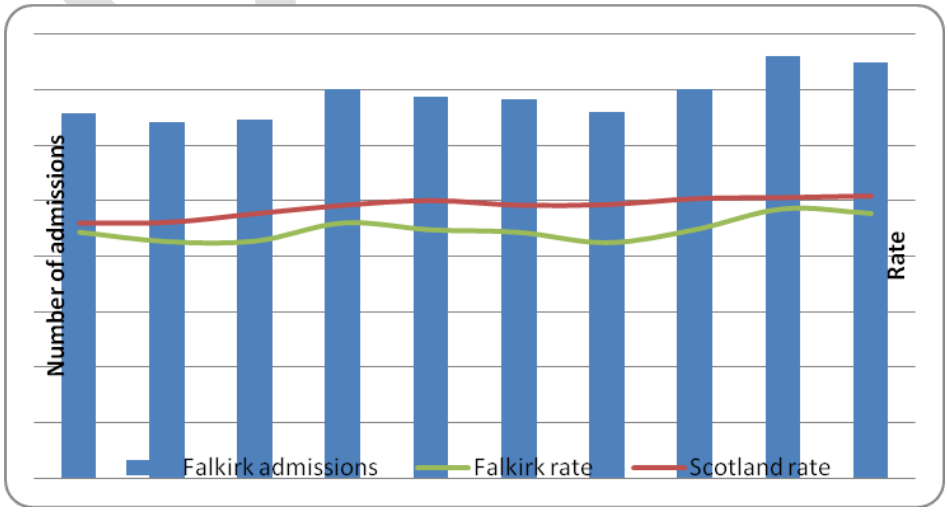


Figure 5. Falkirk emergency admissions to hospital - 2004/05 to 2013/14. *Source: ISD Scotland*

As the numbers of older people increase, the number of hospital admissions is likely to increase. For example, Figure 6 demonstrates that 65+ year olds represent over a third of emergency admissions. Therefore, there is a need to reduce the rate of avoidable admissions.

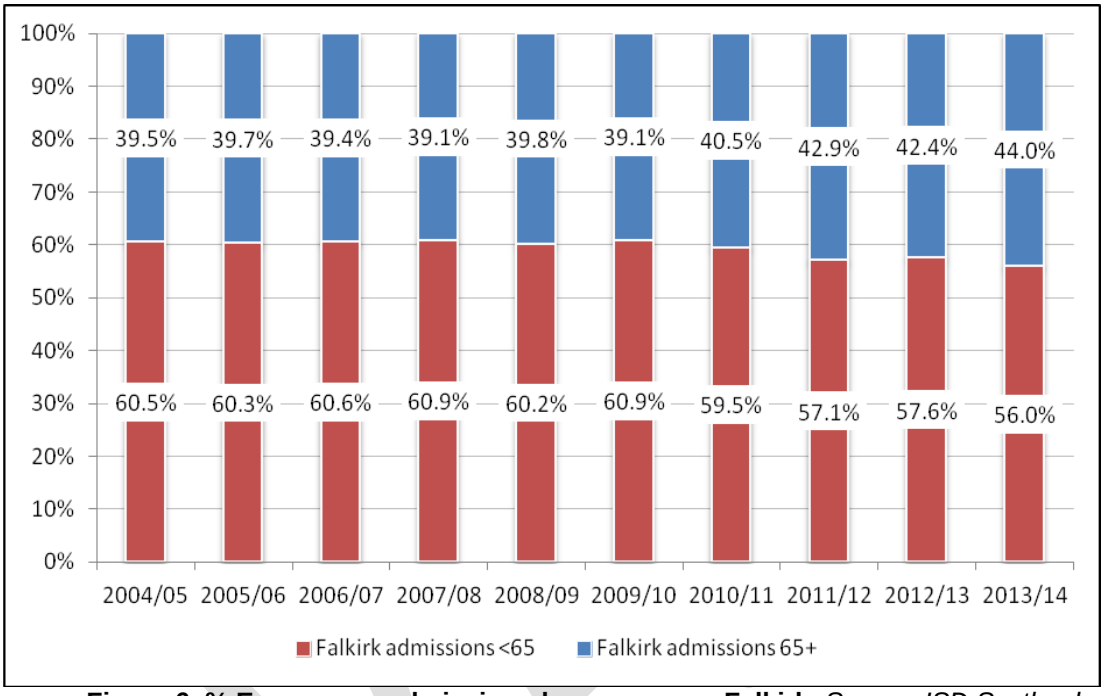


Figure 6. % Emergency admissions by age group, Falkirk. *Source: ISD Scotland*

2.7 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 7 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.

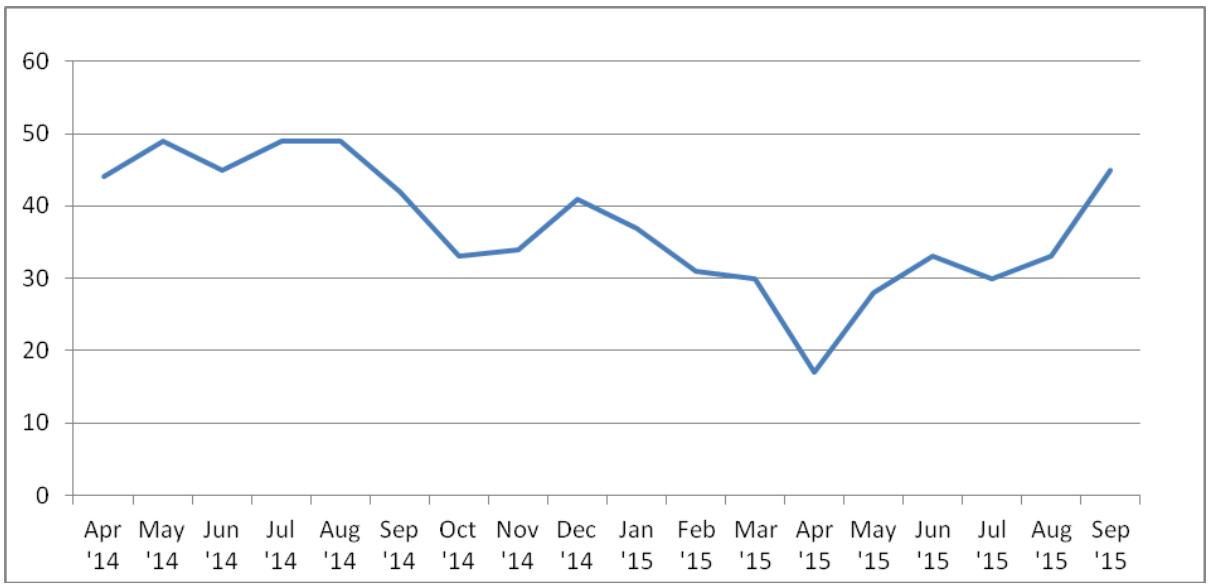


Figure 7. Delayed Discharges in Falkirk LA, April 2014 – September 2015. Source: ISD Scotland

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.

2.8 Multiple and Long-term Conditions

Consistent with many partnerships across Scotland, Falkirk has to manage an increase in demand, whilst facing pressures on scarce resources. For example, Falkirk has an ageing population with many more people living with multiple and long-term conditions. This has contributed to escalating the number of people in middle and older age groups presenting with co-morbidities. Furthermore, from national research it emerged that people generally have less family and informal social support resulting in increasing reliance on health and social care services.

Figure 8 demonstrates the estimates of the proportion of the population in Falkirk, with various numbers of long term conditions, which is forecasted to increase between 2015 and 2037 (Figure 8 and 9).

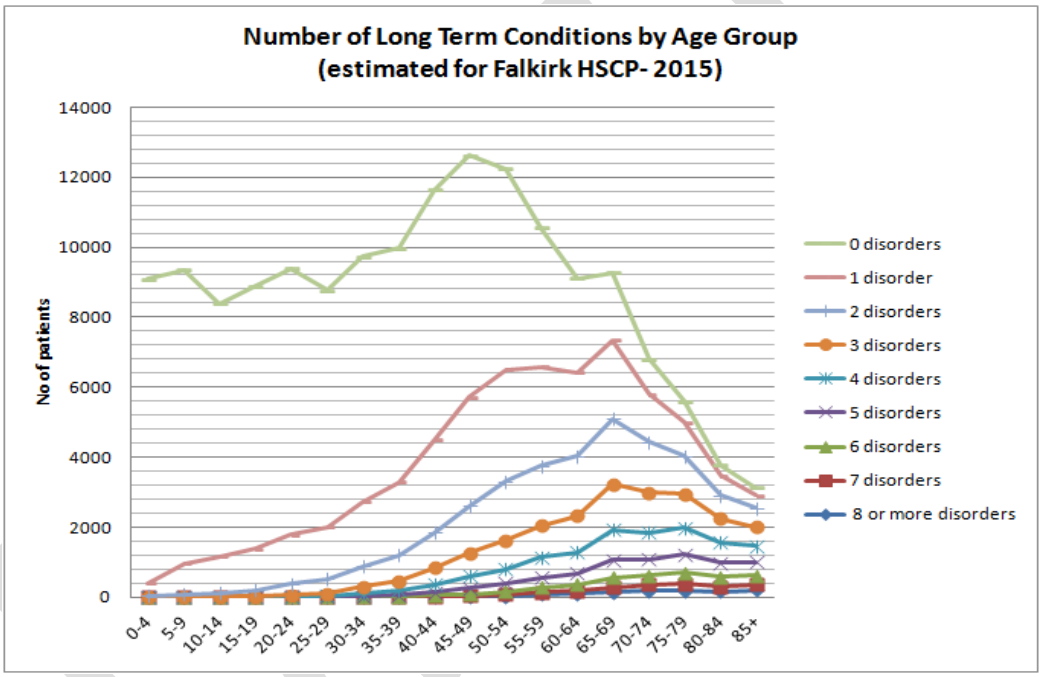


Figure 8. Estimated number of people within Falkirk with various numbers of long-term conditions – 2015. Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk

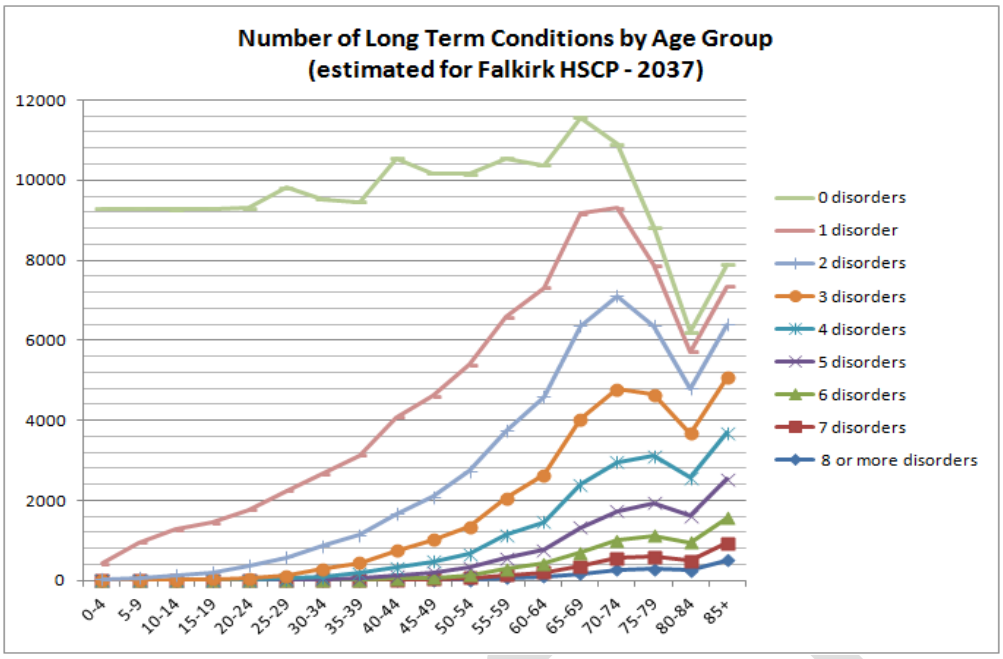


Figure 9. Estimated number of people within Falkrik with various numbers of long-term conditions – 2037. Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk.

2.9 Carers

It is estimated that in the UK nearly two million carers provide care for over 20 hours a week. Individuals and families experiencing the impact of disability, illness and ageing are dependent on a care and support system that responds to their real needs *(Glasby et al., 2010)*.

Research also indicates that although an average of 12% of the population provides a high proportion of unpaid care, as carers get older, they take on more caring responsibility. This was acknowledged in the *Scottish Government Caring Together: The Carers Strategy for Scotland 2010 – 2015* which predicts that the wider society will become even more dependent on older carers' contribution to health and social care delivery.

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. This comprised of approximately 15,056 in Falkirk, 9.7% of the local population. The Falkirk Partnership 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 enabled 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.
- Will recognise the needs of young carers as carers of adults are supported.

2.10 Summary

The previous section outlines some of the key challenges faced within the Falkirk Council area. These include an ageing population with an increase in multiple and long-term conditions, which have an impact on emergency hospital admissions as well as delays in discharge. Another challenge is the increase of dependency of the wider society on carers. Simultaneously, housing, employment and deprivation pose challenges for the health and wellbeing of Falkirk's population.

It is important that the Integration Joint Board is able to monitor progress being made towards local outcomes, through focussing on the priority areas identified. As further needs analysis information is produced and analysed, priorities and agreed outcomes will also be reviewed and further developed, where appropriate.

3 WHAT IS THE...?

3.1 Falkirk Strategic Plan

The Falkirk strategic plan is a high level strategic framework setting the context for how Falkirk Health and Social Care Partnership will begin to make the transformational changes and improvements to develop health and social services for adults over the next three years.

This plan takes account of the neighbouring partnership priorities of Clackmannanshire and Stirling. 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. Further consideration has also been given that Falkirk residents may access specialist services outwith Forth Valley.

There are a number of existing plans that relate to health and social care, which have been developed and implemented by partners over the last five years. In the development of the Strategic Plan it is important to recognise existing plans. Whilst this is not an exhaustive list these include:

- Falkirk Single Outcome Agreement 2013 - 23
- Falkirk Area Strategic Community Plan 2010 - 15
- NHS Forth Valley Strategic Plan 2015 - 2020
- Adult Services Plan 2015 - 2016
- NHS Forth Valley Clinical Services Review 2015
- NHS Forth Valley Local Delivery Plan 2015 - 16
- NHS Forth Valley Winter Plan 2014 - 15
- NHS Forth Valley Workforce Plan 2013 - 14
- Falkirk Council Corporate Plan 2012 - 17
- Poverty Strategy: Towards a Fairer Falkirk 2011- 21
- NHS Forth Valley Integrated Healthcare Strategy 2011 – 14
- Joint Commissioning Plan for Older People 2014 – 17
- Forth Valley Integrated Carers Strategy 2012 - 15
- Drug and Alcohol Strategy (*2015*)
- FV Falls Fracture Prevention & Bone Health Strategy 2008 -13
- National Mental Health Strategy 2012 - 15
- National Keys to Life Strategy (Learning Disabilities) 2013
- National Dementia Strategy 2012
- Integrated Children Services Plan 2010 - 15
- Physical Activity Strategy 2007 - 17

3.2 Policy Context

Integration of Health and Social Care is one of the Scottish Government's major legislative programmes of reform of public bodies' roles and responsibilities. At its centre, Health and Social Care Integration seeks to ensure that those who use services get the right care and support whatever their needs, at any point in their care journey.

The mutual dependency and overlap of responsibilities that exists between adult health and social care services is well documented. However, there often still remains a lack of clarity for people using services and their carers around the co-ordination of services resulting in a disjointed and fragmented approach**.** Figure 7 provides a simple illustration of this common disjointed and fragmented approach.

Figure 7. Disjointed and Fragmented Care provision (Thistlewaite, 2011).

However, by bringing together health and social care services across Falkirk and having staff working under the umbrella of a single organisation, there is an opportunity to improve the outcomes for people receiving services. Indeed, such an approach would improve outcomes for people and their carers, enhance communication, improve efficiency and reduce duplication. Figure 8 provides an illustration of how the Falkirk Partnership seeks to deliver joint up and coordinated care.

Figure 8. Joint up and Coordinated Care provision (Thistlewaite, 2011).

3.3 Scope of Services

Locally within the Falkirk Council area there is an existing range of excellent social care, primary and secondary healthcare and public health improvement services that will provide the fundamental infrastructure required. By further enhancing how staff across these services can work together in a much more integrated way and avoiding unnecessary duplication, the outcomes of those using health and social care services will be improved.

The *Public Bodies (Joint Working) (Scotland) Act 2014* has required that NHS Forth Valley and Falkirk Council integrate the planning and delivery of adult health and social care services under the agreed scope of a number of key services.

It has therefore been agreed within the *Health and Social Care Integration Scheme for Falkirk (2015)* that the following services currently provided by the NHS Forth and Falkirk Council are to be integrated, namely:

<table>
<tr><th>Community Health Based Services</th><th>Local Authority Based Services</th></tr>
<tr><td>• District Nursing;
• Services related to substance addiction;
• Services provided by AHPs in outpatient clinics or out of hospital;
• Public dental service/Primary medical services/General dental, Ophthalmic and Pharmaceutical services;
• Community Mental Health and Learning Disability services.</td><td rowspan="3">• 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;
• Day services;
• Local area co-ordination;
• Respite provision;
• Occupational therapy services;
• Re-ablement services, equipment and Technology Enabled Care.</td></tr>
<tr><th>Hospital Based Services*</th></tr>
<tr><td>• Emergency Department;
• Inpatient hospital services (General Medicine/Geriatric Medicine/Rehab Medicine/Respiratory);
• Hospital based Mental Health services;
• Psychiatry of Learning Disability.</td></tr>
</table>

* for Strategic Planning purposes

3.4 Participation and Engagement

The Falkirk Partnership will ensure that people continue to be at the centre of developing current and future services and fully contribute to discussions around new ways of working. The Partnership would like to promote an open and honest dialogue with people and acknowledge the valuable contribution that communities make.

As previously indicated, redesigning services must be informed by the views of people within local communities. *The Falkirk Participation and Engagement Plan* describes in detail how it is intended to involve all stakeholders in the redesign of local health and social care services. It draws on a variety of national and local plans and reviews, which have taken into account the views of a variety of stakeholders.

Various public and staff engagement activities have taken place to help identify Falkirk's strategic priorities. The following provides a list of the type of key ongoing engagement activity undertaken locally:

Engagement Activities
• Cross sector Staff Engagement Sessions; • Transitional Board Strategic Planning Workshop; • Falkirk Stakeholder Strategic Planning Event; • Staff Newsletter; • Discussion with Falkirk's Community Care and Health Forum; • Discussion with Falkirk Community Planning Partnership; • Discussion with Falkirk Council and NHS Forth Valley Health Board

4 A PLAN FOR FALKIRK

4.1 Vision

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

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

4.2 Falkirk's Outcomes

Consistent with the nine national *Health and Well-being Outcomes,* the following five high level local outcomes have been agreed to describe what changes the Falkirk Partnership wishes to see over the next three years:

Theme	Desired Local Outcome
Self-Management	Individuals, their carers and families are enabled to manage their own health, care and wellbeing.
Autonomy and Decision Making	Where formal supports are required, people are enabled to exercise as much control and choice as possible over what is provided.
Safe	Health and social care support systems are in place, to help keep people safe and live well for longer.
Experience	People have a fair and positive experience of health and social care.
Community Based Supports	Informal supports are in place, which are accessible and enable people, where possible, to live well for longer at home or in homely settings within their community.

4.3 People's Views

Stakeholder engagement events have allowed participants to consider the five local outcomes with a view to identify what future services should look like, **to *enable people in Falkirk to live full and positive lives within supportive communities*.** People said future services should be:

- **Person-centred** – Good services are outcomes focused, centred round the needs of individuals. Individuals are able to make informed decision regarding their own care pathway and supported to self-manage, where possible. 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.

- **Enhancing Information sharing** – Information sharing is critical to good integrated care – and is extend across all sectors. Information sharing includes single shared assessments and care plans, which are co-produced by services 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 access and use the system.

- **Focusing on Early Intervention** – Individuals are supported by responsive, proactive services, before reaching crisis. Education and information is accessible and readily available to individuals, their carers and families, which allows them to make informed choices and manage their own health and wellbeing.

- **Improving Access** – Individuals are able to access services quickly via a single point of contact. Transition between services is supported with a back office infrastructure that facilitates smooth transition via effective communication and information sharing. In addition, services are responsive and available consistently throughout the year, on a 24/7 basis, if appropriate.

- **Developing the Workforce** – A shared vision is held across all partners. The workforce across all sectors is highly skilled. Collaborative 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 service user.

4.4 Falkirk's Priorities

Taking into consideration both the first draft Joint Strategic Needs Assessment and the output from the Stakeholder Engagement Events, the following priorities were identified:

Falkirk Partnership Outcomes				
Self Management	**Autonomy and Decision Making**	**Safe**	**Experience**	**Community based support**
Individuals, their carers and families are enabled to manage their own health, care and wellbeing.	Where formal supports are required, people are enabled to exercise as much control and choice as possible over what is provided.	Health and social care support systems help to keep people safe and live well for longer.	People have fair and positive experience of health and social care.	Informal supports are in place, accessible and enable people, where possible, to live well for longer at home or in homely settings within their community.
Universal Priorities				
Cultural change across agencies and the public Information sharing Workforce, including unpaid carers Maximise better use of existing resources Early intervention & Prevention Availability of Services and Resources Effective Risk Management at all levels Information is accessible and presented in a consistent manner				
Falkirk's Priorities				
Education is accessible and delivered consistency with messages being reinforced Support is available for un-paid Carers	Person-Centred care is reinforced, acknowledging family/carer views Care and support is underpinned by informed choices and decision making throughout life	Technology is used in an effective and appropriate way to support care Risk is acknowledged and managed effectively	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 Partnership Co-location, where appropriate	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 Support is available for un-paid Carers

In summary, the Falkirk Health and Social Partnership seeks to establish an integrated health and social care approach with an emphasis on self-management, early intervention and prevention, balanced with the ability to react responsively to acute health and social care needs.

5 HOW WILL THIS PLAN BE DELIVERED?

5.1 Building on Existing Policies and Plans

There are a number of priorities and actions that have been identified from existing national and local policies and plans (see section 4.1) that partners have individually and/or collectively agreed to work towards. It is acknowledged that these plans are at different stages of completion. Nevertheless within the context of this Strategic Plan, those plans are critical as helpful starting points in which to identify future partnership activity to be implemented.

In addition, within Falkirk there are several examples of integrated working arrangements already in place, such as Community Mental Health and Learning Disability Teams. These provide valuable insight into integrated practice.

Public views and evidence based approaches have informed the development of these local plans, which were subject to wide consultation and research. Partners have started to take into account the new and emerging legislative strategic planning requirements and how future local plans must align with the integration agenda and a whole system approach.

5.2 Falkirk's Commitments

It is important that the Falkirk Partnership continually focuses on the identified priorities in order to achieve its outcomes. Collectively these priorities will support the transformational change leading to robust integrated services.

A number of commitments have also been identified within the Integration Scheme, which underpins how these priorities will be approached, these are;

- Putting individuals, 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.
- Recognising the importance of encouraging independence by focusing on reablement, rehabilitation and recovery.
- Providing timely access to services, based on assessed need and best use of available resources.
- Providing joined up services to improve quality of lives.
- Reducing avoidable admissions to hospital by ensuring that priority is given to strengthening community based supports.
- Sharing information appropriately to ensure a safe transition between all services.
- Encouraging continuous improvement by supporting and developing our workforce.
- Identifying and addressing inequalities.
- Building on the strengths of our communities.
- Planning and delivering Health and Social Care in partnership with

Community Planning Partners.
- Working in partnership with organisations across all sectors e.g. Third Sector and Independent Sector.
- Communicating in a way which is clear, accessible and understandable and ensures a two way conversation.

5.3 Developing an Enabling Structure

In realising the strategic vision and delivering the agreed outcomes, Falkirk Partnership is committed to ensuring that there is effective leadership, systematic risk management arrangements, robust accountability and an agreed performance management system. This will allow evidence based decisions to be taken.

Effective leadership – is crucial in providing direction and delegation, enabling staff at all levels across the 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.

Systematic risk management – will provide staff with the necessary structure, to empower them to manage and tolerate certain levels of risk. Such an approach will be adopted at all levels of the partnership to include management decisions and front line services with consideration of service users' and carers' views.

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.

Performance management – is vital to ensure that efficiency, effectiveness and quality of services are evaluated and monitored regularly. The Integration Joint Board will be held accountable for all services within the scope of the Integrated Service provision. This will include evaluating collaborative working within and across all sectors.

6 SUMMARY STATEMENT

The Scottish Government has set out its future vision for Health and Social care namely the *2020 Vision.* This vision is supported by the National Health and Well-being Outcomes. These outcomes are set within the legal framework of the *Public Bodies (Joint Working) (Scotland) Act.*

Falkirk's Partnership has identified its local vision and five specific outcomes. In order to achieve these outcomes a number of priorities have been identified which align to each outcome. It is acknowledged that a number of these priorities are relevant to all the outcomes.

Many of initiatives are currently running within the Falkirk area, which are already contributing to local outcomes. Actions have been and will continue to be developed consistent with the priority areas.

The following overview demonstrates the alignment between the national and local outcomes and priorities. Additionally, existing local initiatives and programmes have been included.

Scottish Government's 2020 Vision for Health and Social care

By 2020 everyone is able to live longer healthier lives at home, or in a homely setting

National Health and Well-being Outcomes

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

Integrated Vision for Falkirk

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

Local Outcomes

Self-Management – Individuals, their carers and families are enabled to manage their own health, care and wellbeing.	*Autonomy and Decision Making* – Where formal supports are required, people are enabled to exercise as much control and choice as possible over what is provided.	*Safe* – Health and social care support systems help to keep people safe and live well for longer.	*Experience* – People have fair and positive experience of health and social care.	*Community based Supports* – Informal supports are in place, accessible and enable people, where possible, to live well for longer at home or in homely settings within their community.

Falkirk Partnership Priorities

Universal Priorities

Cultural change across agencies and the public
Information sharing
Workforce, including unpaid carers
Maximise better use of existing resources
Early intervention & Prevention
Availability of Services and Resources
Risk Management
Information is accessible and presented in a consistent manner

Self-Management	Autonomy and Decision Making	Safe	Experience	Community based Supports
Education is accessible and delivered consistency with messages being reinforced	Person-Centred care is reinforced, acknowledging family/carer views Care and support is underpinned by	Technology is used in an effective and appropriate way to support care Risk is acknowledged and managed	Greater focus is given to an individual case management approach, enhanced by the	Information about community based support is accessible and presented in a consistent manner

Support is available for un-paid Carers

informed choices and decision making throughout life

effectively

provision of advocacy support

Feedback drives continuous improvement

Service users are engaged and involved across the Partnership

Co-location is pursued where appropriate

Build sustainable capacity within all sectors

Adopt a consistent framework when commissioning services

Build on existing assets within local communities

Support is available for unpaid Carers

Local Initiatives aligned with Local Outcomes & Priorities				
Self-Management	**Autonomy and Decision Making**	**Safe**	**Experience**	**Community based Supports**
Health and Wellbeing activities programme (carers) Support break for carers Community rehab at home Intermediate rehabilitation service Enhanced support for FCH developing the rehab support worker Developing personalised assessment and support planning for carers	FDAMH social prescribing service Intermediate care capacity Short term assessment out of hospital	Telecare innovations – MECs (**Mobile Emergency Care Service)** night services and Fall management Augmented capacity in the Falkirk Community Hospital Social Work Team OT, equipment and adaptation redesign Support for carers at hospital discharge Rapid Access Frailty Clinic at FVRH Home Essential Leaving Pack (HELP) Medication management project	Forth Valley case management service for people with Alcohol Related Brain Damage Expansion of the Delayed Discharge Hub and associated staffing	Top Toes Living it up (DALLAS) Braveheart Optimise Health and Wellbeing Service Marie Curie patient visit services Alzheimer's Scotland PDS link workers Training for carers in their own community Active minds: a physical activity and wellbeing programme for Falkirk Closer to home project

7 Appendix 1 - Core Indicators

Core Indicators That Will Guide Us

Outcome indicators 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, it is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often.

1. Percentage of adults able to look after their health very well or quite well.
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5. Percentage of adults receiving any care or support who rate it as excellent or good
6. Percentage of people with positive experience of care at their GP practice.
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
8. Percentage of carers who feel supported to continue in their caring role.
9. Percentage of adults supported at home who agree they felt safe.
10. Percentage of staff who say they would recommend their workplace as a good place to work.*

Indicators derived from organisational/system data primarily collected for other reasons. These indicators will be available annually or more often.

11. Premature mortality rate.
12. Rate of emergency admissions for adults.*
13. Rate of emergency bed days for adults.*
14. Readmissions to hospital within 28 days of discharge.*
15. Proportion of last 6 months of life spent at home or in community setting.
16. Falls rate per 1,000 population in over 65s.*
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
18. Percentage of adults with intensive needs receiving care at home.
19. Number of days people spend in hospital when they are ready to be discharged.
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
22. Percentage of people who are discharged from hospital within 72 hours of being ready.*
23. Expenditure on end of life care.*

***** Indicator under development

http://www.gov.scot/Resource/0047/00473516.pdf

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