This paper relates to Agenda Item 6

Report to: **Integration Joint Board**

Title/Subject: **Strategic Plan**

Date: **24 March 2016**

Submitted By: **Chief Officer**

Action: **For Decision**

1. INTRODUCTION

1.1. The purpose of the report is to provide an update to the Integration Joint Board on the Strategic Planning arrangements and to consider the draft Strategic Plan and associated documents for approval.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1. agree the draft Strategic Plan attached at Appendix 1, subject to financial statement being finalised

2.2. agree the draft Strategic Plan summary plan attached at Appendix 2

2.3. agree that the draft Joint Strategic Needs Assessment attached at Appendix 3 is published

2.4. agree that the draft Consultation and Engagement report on the development of the Strategic Plan attached at Appendix 4 is published

2.5. note the Equalities and Poverty Impact Assessment attached at Appendix 5

2.6. agree that the proposed direction attached at Appendix 6 is issued to Falkirk Council

2.7. note the contribution by members of the Strategic Planning Group in the development of the plan.

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.

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.

3.3. The Board is required to establish a Strategic Planning Group as part of the process to prepare the Strategic Plan for their area. The draft Strategic Plan has been prepared in line with the legislative requirements defined in the Public Bodies (Joint Working) (Scotland) Act 2014.

4. STRATEGIC PLAN

4.1. Following the consultation period, the Strategic Planning Group met on 15 January 2016 to consider the consultation feedback and to propose amendments to the draft Strategic Plan. This was presented to the Board members on the 5 February 2016, and the comments received have been taken into account.

4.2. In line with legislative requirements, the Strategic Planning Group (SPG) has supported the development of the draft Strategic Plan. The SPG has met again on 10 March 2016 to consider the final draft plan to be presented to the IJB for approval.

4.3. The Strategic Planning Co-ordinating Group has continued to meet on a weekly basis, to ensure the comments from the SPG and consultation process have been reflected in the production of the final Strategic Plan. The group also considered work ongoing to develop the community planning partnerships strategic outcome and local delivery plan to ensure there is consistency and read across between both plans.

4.4. The final draft Strategic Plan is attached at Appendix 1 for approval.

4.5. The Strategic Planning Group has also considered the development of a summary Strategic Plan. The intention is that this can be more widely distributed across the partnership area as a more accessible document. This has been prepared and is attached at Appendix 2 for approval.

5. STRATEGIC PLAN DELIVERY PLAN

5.1. To ensure the implementation of the Strategic Plan, arrangements to develop a delivery plan are being taken forward. This will ensure the IJB, through its Strategic Plan, will deliver on the priorities across the partnership area. It is important that there is clarity on the required actions, timescales, resources and leads and that there are appropriate levels of engagement with key stakeholders.

5.2. A participative process with key stakeholders will be put in place to develop the delivery plan. This will be commissioned through a short term project, and it is anticipated this would involve facilitated workshops to engage stakeholders using a logic modelling methodology. This methodology has proven to be successful in other areas and importantly provides clarity on the required actions to achieve the strategic outcomes and overall vision for the Partnership.

5.3. This will produce a delivery plan for each outcome and locality area including agreed outputs, milestones and impact measures. It is proposed that this work would be

started in early April and concluded by the end of May 2016. It is essential that the partners prioritise this work and facilitate the release of key officers to engage and participate in the process. The Board will receive an update on the process, and where available, the draft delivery plans for consideration at the next meeting on 3 June 2016.

6. JOINT STRATEGIC NEEDS ASSESSMENT

6.1. The Public Bodies (Joint Working) (Scotland) Act 2014 requires partnerships to undertake a Joint Strategic Need Assessment (JSNA) in order to understand and demonstrate the needs which exist in the partnership and to inform the Strategic Plan.

6.2. The partnership previously accepted the offer of additional analytical support from NHS National Services Scotland and the Information Services Division through the Local Intelligence Support Team (LIST).

6.3. This team has supported the development of the JSNA which is attached at Appendix 3 for approval to publish.

6.4. The Chief Officer has received confirmation that the 2 LIST analysts (0.75 WTE) will be extended until March 2017 to provide analytical support. They will continue to work closely with local performance management and Public Health colleagues, particularly to develop locality profiles that will support the locality planning arrangements that will be taken forward.

7. CONSULTATION AND ENGAGEMENT REPORT

7.1. The Board received a report on the 5 February 2016 with the draft Consultation and Engagement report setting out the arrangements that took place during the consultation on the draft Plan.

7.2. This is attached at Appendix 4 for approval to publish.

8. FINANCIAL STATEMENT

8.2 At the time of preparing the report, this information was not available, pending the necessary decisions to be taken by the NHS Forth Valley Board. It is understood that this information will be available at the next meeting. This will be presented in the Chief Finance Officer report on the IJB budget.

9. DIRECTIONS

9.1 Directions are the means by which the IJB gives effect to its Strategic Plan and the Strategic Delivery Plan which will follow from it. The 2014 Act requires the IJB to give a direction to one of the constituent authorities in relation to each of the delegated functions. Prior to the development of the Strategic Delivery Plan the directions to be given will be general in nature and require services to be delivered as at present, subject to any relevant decisions of the constituent authorities prior to the direction.

9.2 The proposed direction to the Council is attached at Appendix 6 and refers to all the functions delegated from the Council. The direction to the Health Board will be in a similar form but is not attached as the budget information is not available from the health board at the time of the agenda being published. It is likely to be submitted with a supplementary report from the Chief Finance Officer following the special meeting of the Health Board on 18 March.

10. EQUALITIES AND POVERTY IMPACT ASSESSMENT

10.1. An equalities and impact assessment has been required for the development of the Strategic Plan. The Strategic Planning Coordinating Group has used the existing Falkirk Council Equalities and Poverty Impact Assessment to complete this work. This is attached at Appendix 5 for information.

11. CONCLUSION

11.1. The Board has received reports outlining the development of the Strategic Plan to ensure this is delivered in line with legislative requirements.

Resource Implications

The resource implications will be presented to the Board in the Chief Finance Officer report on the IJB budget.

Impact on Integration Joint Board Outcomes and Priorities

The draft Strategic Plan has been developed in line with the outcomes described in the Falkirk Integration Scheme and sets out the priorities for the IJB over the next 3 years. This will be reviewed on an annual basis.

Legal & Risk Implications

The Board will need to have an approved Strategic Plan in place in line with the Public Bodies (Joint Working) (Scotland) Act 2014. 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.

Consultation

The consultation arrangements are described in the Consultation and Engagement report as noted in section 7.

Equality and Human Rights Impact Assessment

This is described at section 10.

Exempt report

No.

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Approved for submission by: Patricia Cassidy, Chief Officer

Author: Suzanne Thomson, Programme Manager – Integration (Falkirk)
Date: 14 March 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
Integration Joint Board report: 5 February 2016 – Strategic Planning

Appendix 1

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 people 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*.

In addition, as a statutory member of Falkirk's Community Planning Partnership, the HSCI Partnership has a key role. Specifically this will be in contributing to the delivery of the strategic priorities and outcomes contained in the Strategic Outcomes and Local Delivery Plan. The HSCI Partnership will take into account our role in supporting adults and considering the impact on young people and families, making the necessary connections across strategic planning and service delivery.

The HSCI Partnership will prioritise services in response to the key issues set out in Section 3 and the detailed Joint Strategic Needs Assessment (JSNA).

The key issues for the Falkirk area are:

- there is an ageing population
- there are growing numbers of people living with long term conditions, multiple conditions and complex needs
- early intervention and prevention can make a difference

- carers support
- workforce
- deprivation, housing and employment.

NHS Forth Valley and Falkirk Council are building on existing working practices that will put in place integrated working arrangements. In doing so we will continue to ensure we make connections with other partnerships. These will aim to provide better, more seamless 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**

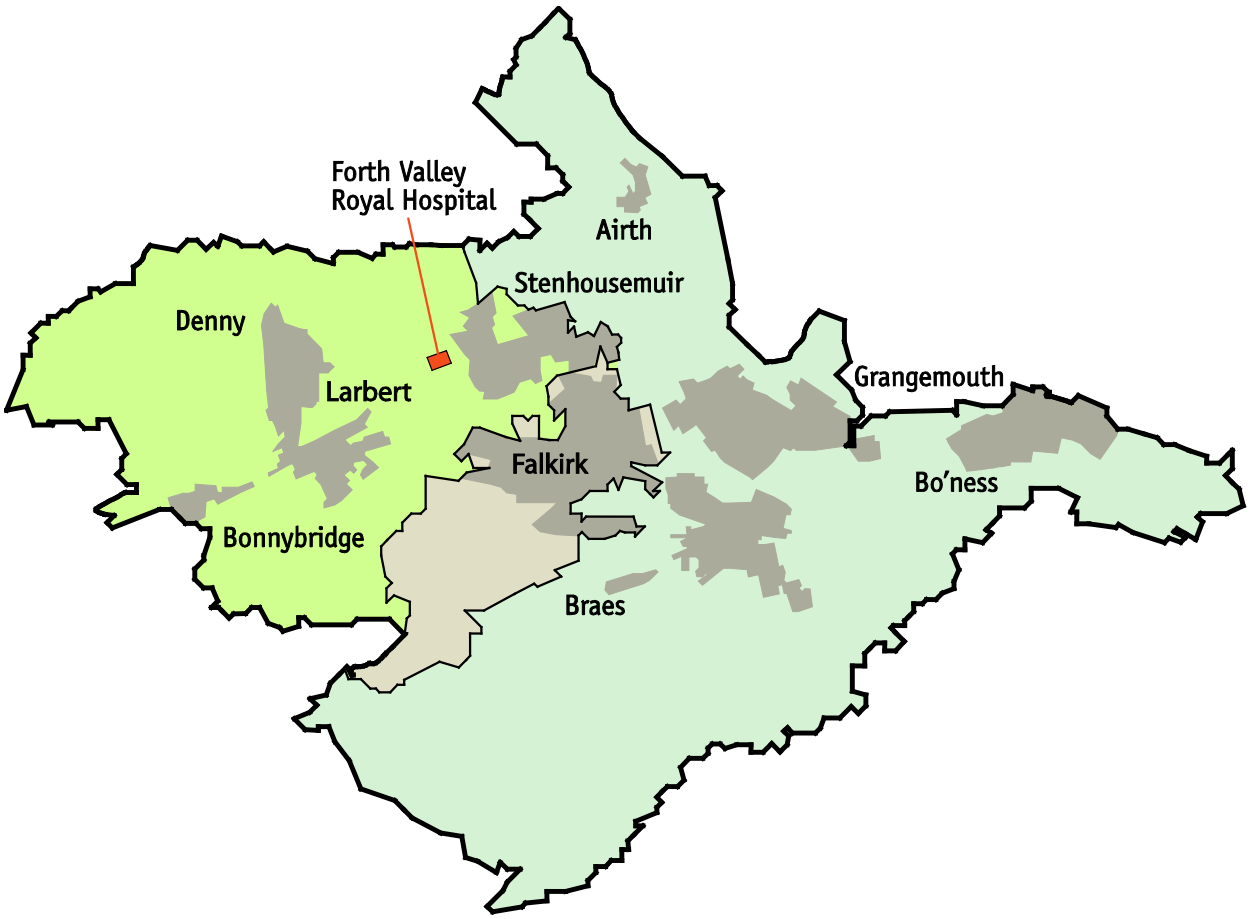
  This is the largest of the three Heath and Social Care Localities, both in terms of area (176 sq km) and population (over 65,000). It lies along the coastline of the

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.

Figure 1: Falkirk Health & Social Care Locality Areas



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* and are:

- **Self-Management**: Individuals, carers and families are enabled to manage their own health, care and wellbeing
- **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
- **Safe**: Health and social care support systems are in place, to help keep people safe and live well for longer
- **Service User Experience:** People have a fair and positive experience of health and social care
- **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

The local outcomes address the key challenges highlighted in the Joint Strategic Needs Assessment (JSNA) (as outlined in section 3). 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 term 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. These are set out in sections 2.4 – 2.8. 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
Acute 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	Equitable support for carers
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 - 2017

2.1 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 Integrated 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 We will provide information that enables people to manage their condition and is accessible and delivered consistently

2.2 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

2.3 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 ensure there are robust systems in place to review the effectiveness of arrangements in place to support the delivery of safe, effective and person centred services. This will be through for example the Clinical and Care Governance Framework and the Adult Support and Protection Committee. 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 and Care Governance framework We will continue to invest in Technology Enabled Care as an effective and appropriate way to support care.

2.4 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 We will pursue co-location of staff and services where appropriate to support integration

2.5 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 We will provide information about community based support that is accessible and presented in a consistent manner

	National Health and Wellbeing Outcomes	Local Outcomes	Evidence	What People Said	Priorities	Local Outcomes: What They mean and what we're going to do (Section XX)
		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'	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	

			We will provide information that enables people to manage their condition is accessible and delivered consistently
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.'	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
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	'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,	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

			• 10,868 adults with physical disability, 53% aged 50-74.	provide feedback and influence services and plans and improve care'	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	
		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'	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	

		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!'	Engagement Strategy 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 We will provide information about community based support is accessible and presented in a consistent manner	

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

Table 3:

3. WHY CHANGE?

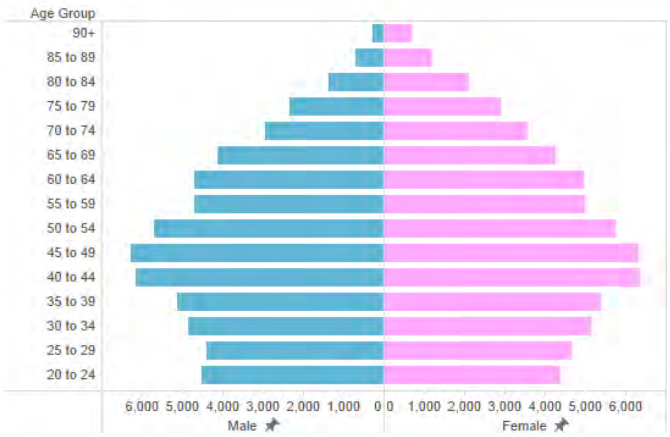
The demand and expectations of our communities is changing and thus the need for services and supports is also changing. People in our communities have increasing complexity of need. There is greater public expectation coupled with reducing resources means the need to change significantly what we deliver as well as the way services are delivered.

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 ie the outcomes we want and have described in this plan. This means that care is provided to people rather than supporting them to be as independent as they can be within their own homes and in their communities. A traditional approach can lead to unnecessary, expensive and prolonged hospital admissions with a subsequent and increased dependency on care services. We can also provide minimal amounts of service that in fact have no demonstrable benefits for people but which do use quite a lot of resource. This approach is unsustainable and fundamental change is required.

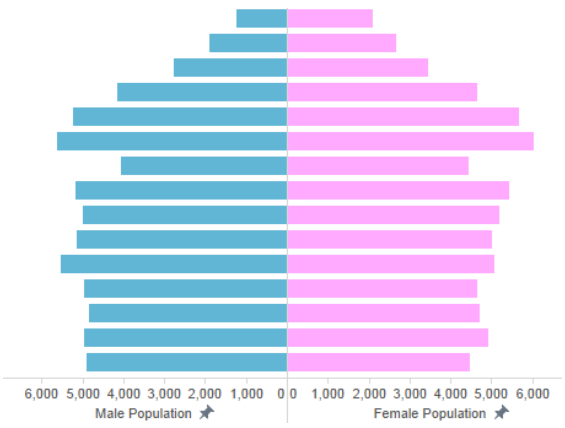
3.1 Local Population

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.

Number of Long Term Conditions by Age Group
(estimated for Falkirk HSCP-2015)

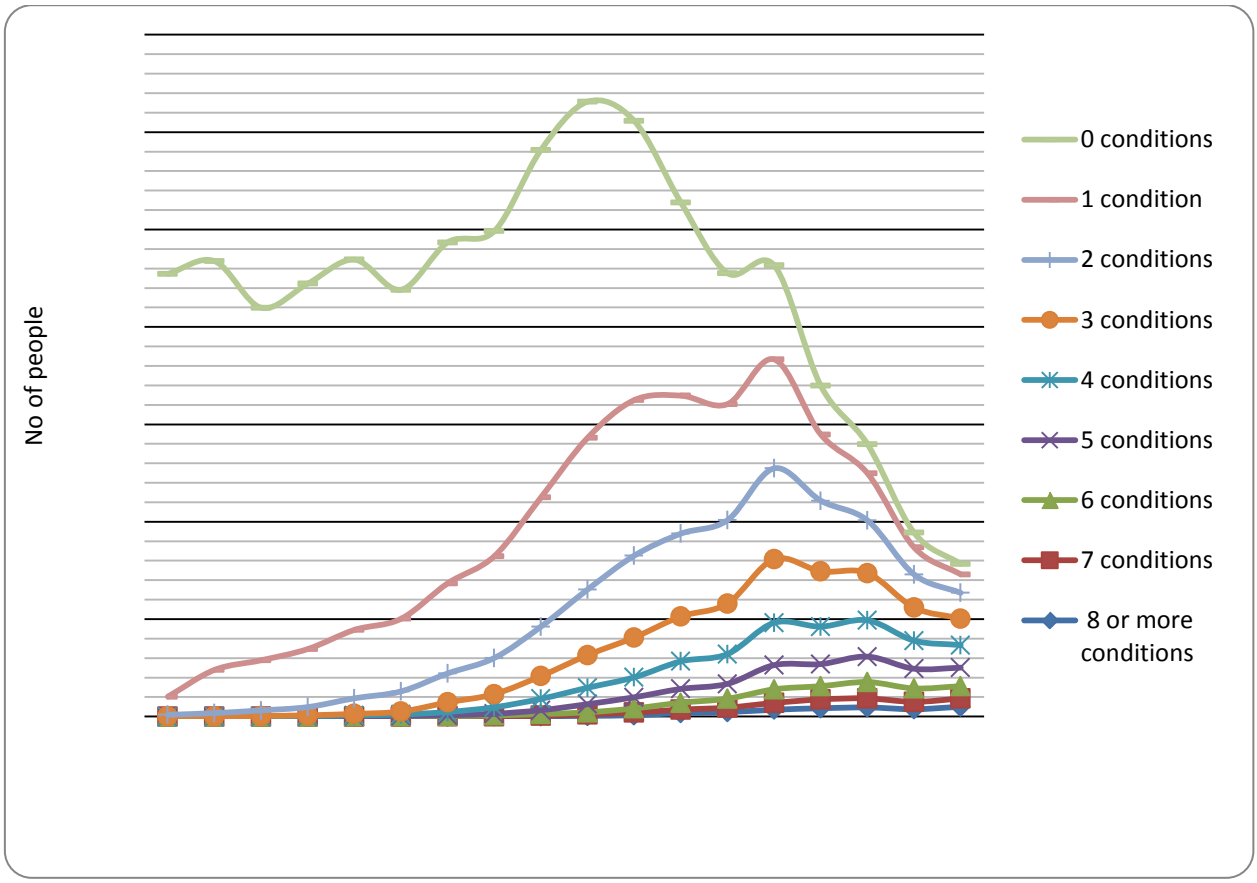


Figure 5:Estimated number of people within Falkirk with various numbers of long-term conditions - 2015. Source: The Challenge of Multi-morbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk

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.

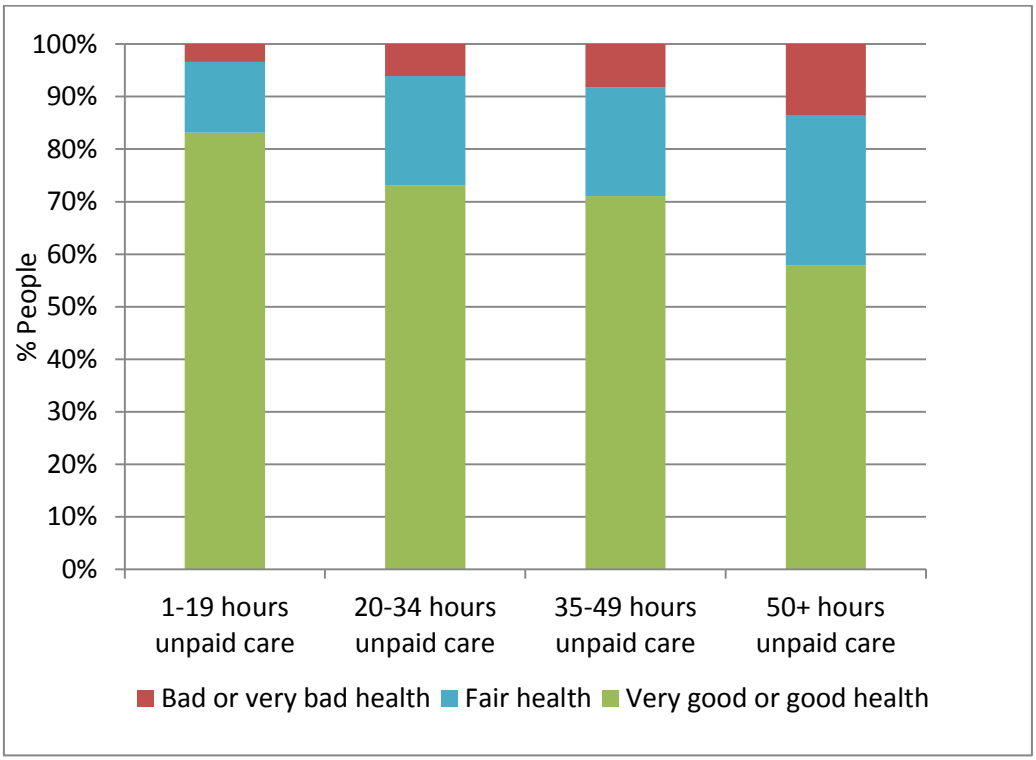


Figure 6: General health by level of unpaid care provision - Falkirk, Scotland's Census 2011

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.

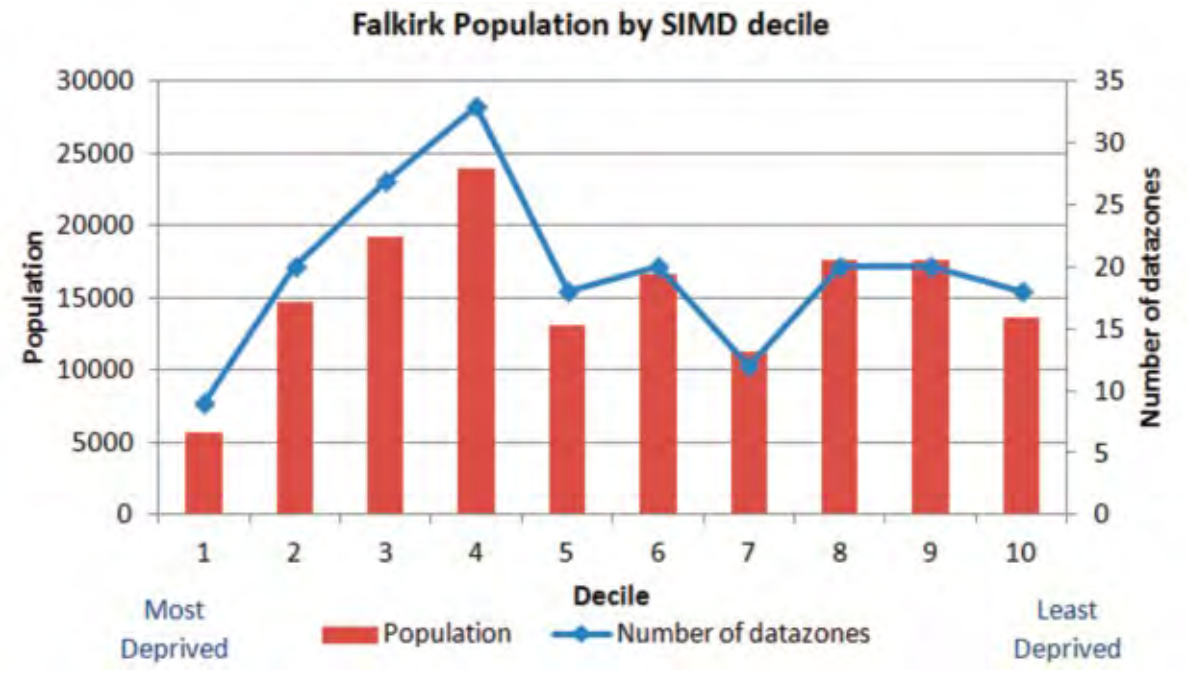


Figure 7:
Falkirk area population by SIMD decile. *Source: SIMD 2012*

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.

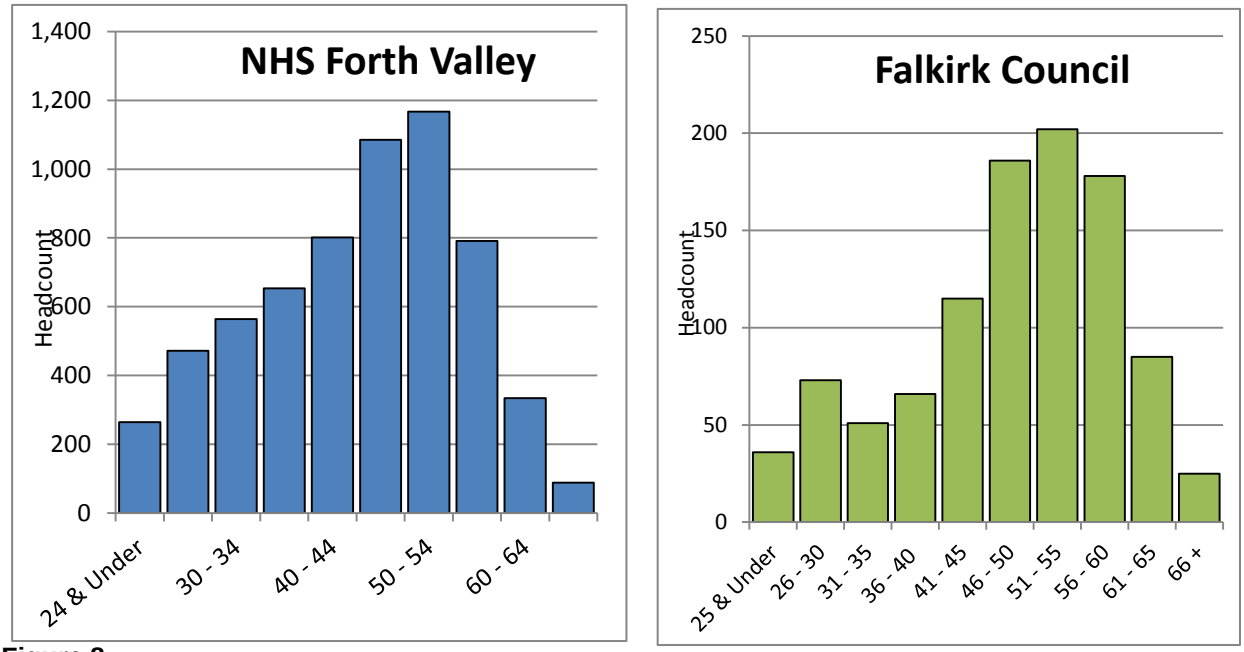


Figure 8:
Workforce age profiles for NHS Forth Valley and Falkirk Council – September 2015 Source: Scottish Workforce Information Standard System (SWISS) & Falkirk Council
Note – NHS Forth Valley figures represent the entire workforce, not just those in scope for integration, it is assumed that the relevant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

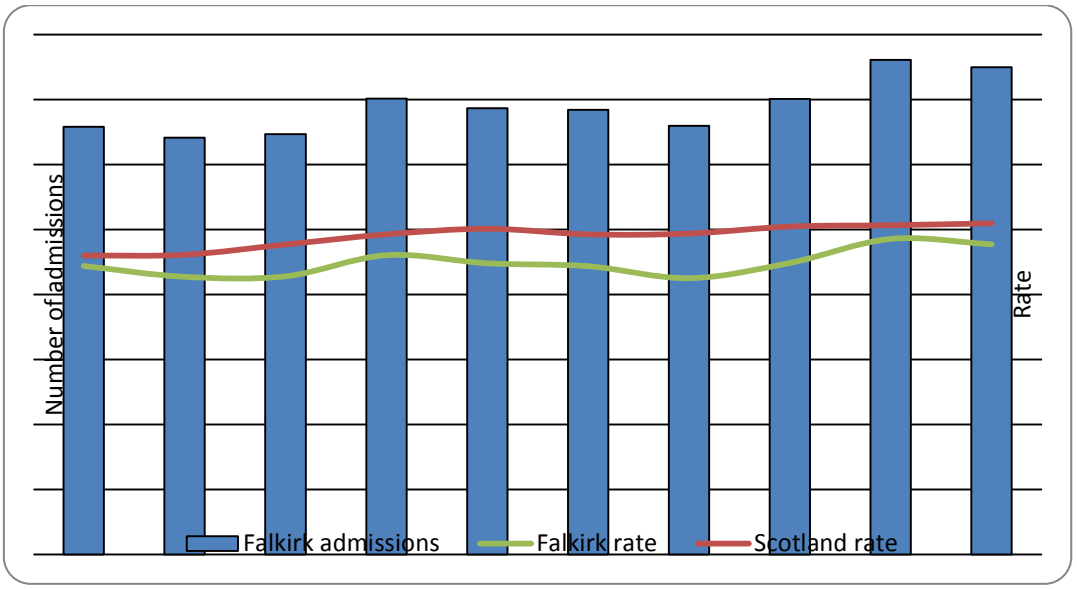


Figure 9:
Falkirk emergency admissions to hospital - 2004/05 to 2013/14. *Source: ISD Scotland*

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.

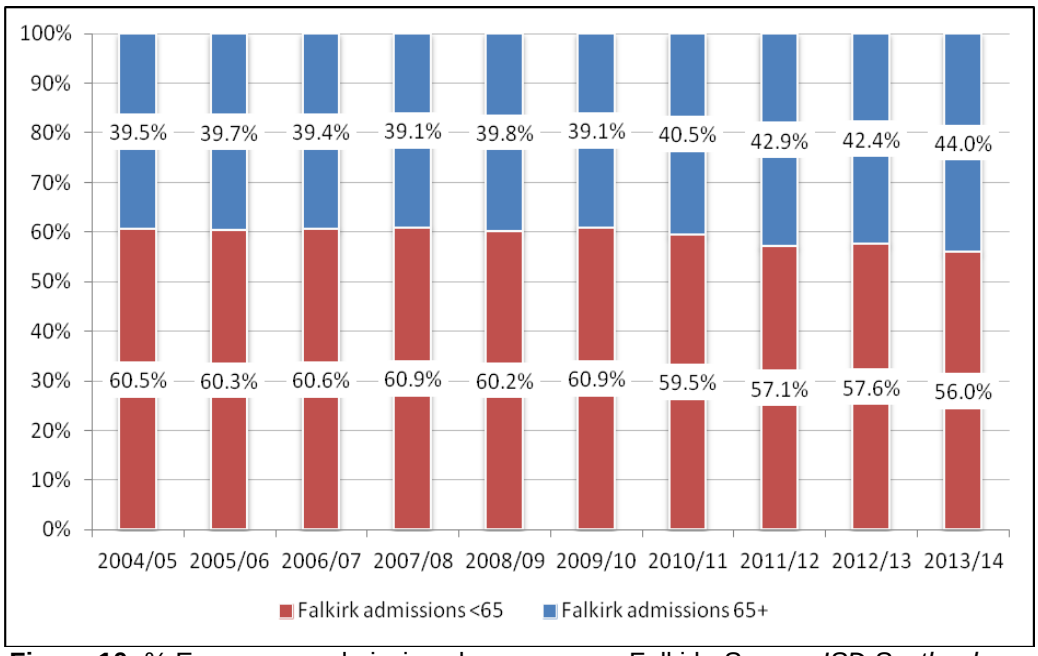


Figure 10: % Emergency admissions by age group, Falkirk. *Source*: *ISD Scotland*

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.

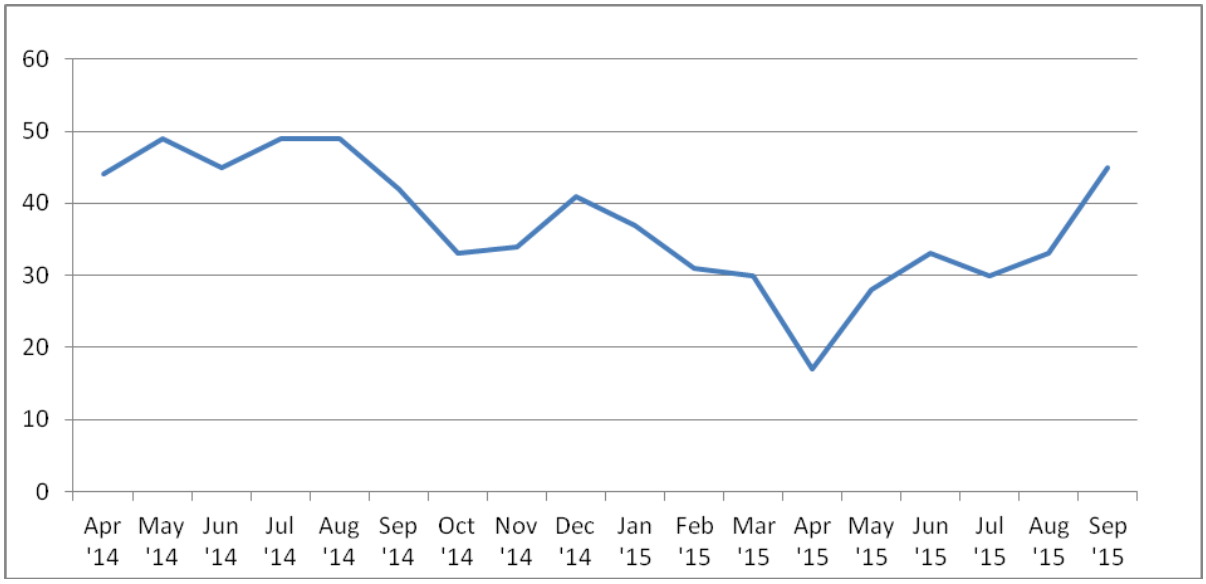


Figure 11: Delayed Discharges in Falkirk LA, April 2014 – September 2015. Source: ISD Scotland

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

Falkirk HSCI Partnership is a statutory member of Falkirk Community Planning Partnership and therefore has a shared responsibility for the delivery of the priorities and outcomes set out in the Strategic Outcomes Local Delivery (SOLD) Plan. The SOLD priorities and outcomes have been identified by looking at evidence, speaking to our communities and identifying issues within our communities.

Priorities

- Improving mental health and wellbeing
- Maximising job creation and employability
- Minimising the impact of substance misuse on communities, families and individuals
- Tackling the impact of poverty on children

Outcomes

- Our Area Will Be a Fairer and More Equal Place to Live
- We Will Grow Our Local Economy to Secure Successful Businesses, Investment & Employment
- Children Will Become Adults Who Are Successful and Confident
- Our Population Will Be Healthier

- People live full, independent and positive lives within supportive communities
- Our area will be a safer place to live

The CPP will be working to achieve these priorities and outcomes over the next five years. On this basis the HSCI Partnership's outcomes are embedded within the SOLD plan.

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:

- NHS Forth Valley Healthcare Strategic Plan (draft)
- NHS Forth Valley Clinical Services Review
- NHS Forth Valley Local Delivery Plan
- NHS Forth Valley Winter Plan
- Falkirk Council Corporate Plan
- Poverty Strategy: Towards a Fairer Falkirk
- Falkirk Joint Commissioning Plan for Older People
- Forth Valley Integrated Carers Strategy
- Drug and Alcohol Strategy
- Integrated Children Services Plan
- Local Housing Strategy
- Falkirk Council's Community Learning & Development Action Plan

There are a number of national strategies, including:

- National Clinical Strategy
- Mental Health Strategy
- Keys to Life Strategy (Learning Disabilities)

- Dementia Strategy
- Physical Activity Strategy.

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.

- **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.

The purpose of locality planning is to ensure that we drive change and deliver outcomes that are of particular importance to local communities, We will through a robust locality planning process underpinned by local community planning identify those communities that are not achieving the outcomes we want and identify alongside local people and providers how we can make progress on these.

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 is in line with the National Standards of Community Engagement, Falkirk Council's Plan for Local Involvement and the Scottish Health Council's Participation Standard.

The Participation and Engagement Strategy sets out principles for participation and engagement, which will make sure that people are involved, consulted with and actively engaged with the integration of health and social care. The principles for participation and engagement are relevant to staff, individuals, communities and agencies.

This will mean that we will put people first and involve them in how services are redesigned to meet their individual needs and the need across communities. This engagement with communities and partners working within the area will generate information which will set the scene for holistic provision. It will link to the work of the Community Planning Partnership to address the SOLD Plan priorities and outcomes and target for example health improvement activity and actions to reduce health inequalities and support people.

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	• Social work services for adults and older people • Services and support for adults with physical disabilities and learning disabilities

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.	• 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.
Current Hospital Services	
• Emergency Department • Inpatient hospital services (General Medicine/Geriatric Medicine/Rehab Medicine/Respiratory) • Hospital based Mental Health services • Psychiatry of Learning Disability.	

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.

The Integrated 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 Integrated 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 Integrated Workforce 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:

- Clinical and Care Governance Framework
- Participation and Engagement Strategy
- Integrated Workforce Plan
- Joint Strategic Needs Assessment
- Financial Plan
- Performance Management Framework
- Risk Management Plan
- Housing Contribution Statement
- Market Facilitation Plan

5.8 Financial Statement: Partnership Budget

The budget has been set taking into account the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, national guidance and the Integration Scheme for the partnership.

The budget is made up from contributions from:
NHS Forth Valley =
Falkirk Council =

The Falkirk HSCI Partnership budget for 2016/17 totals £XXXXm.

The partnership budgets have been set taking into account:

- A 'due diligence' process which examined the budgets and expenditure for the 3 financial years preceding the establishment of the partnership
- National guidance on budgets for Health and Social Care Partnerships from the Integrated Resource Advisory Group (IRAG)
- The financial settlements to NHS Boards and Local Authorities for 2016/17 from Scottish Government.

Financial and Economic Outlook

The UK Spending Review published in November 2015 and the subsequent Scottish Draft Budget set out the short to medium outlook for public finances of year on year real term reductions in overall public expenditure until 2020. This financial settlement

is set against the demographic pressures outlined within the Strategic Needs Assessment and the need to redesign services to meet our vision and outcomes. The Integration Joint Board is required to ensure that all of the redesigned and commissioned services are aligned to the Strategic Plan priorities.

The partnership will develop a Financial Plan to underpin the Strategic Plan setting out how it will intend to best utilise the resources available to meet the priorities stated within this plan. It is the intention to develop a Financial Plan covering 3 years to allow medium to longer term service planning.

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 complete an equality impact assessment when the Integration Joint Board (IJB) is making a decision which is likely to impact on people. This will cover any new or revisions to strategies, policies, strategic plans, major programmes, projects, budget and service decisions which are likely to impact on staff and /or service users. The IJB will also 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 Integrated Strategic Plan Summary 2016-2019

To enable people in Falkirk to live full and positive lives

within supportive communities

Foreword

We are pleased to introduce our first Strategic Plan on behalf of the Falkirk Health and Social Care Integration (HSCI) Partnership. This plan is of interest to people living in the Falkirk area as it describes why, what and how health and social care services for all adults will be organised and delivered. The plan will be reviewed every year.

To better support people to live more independent lives in their communities and address the challenges we face the Scottish Government has initiated a major programme of public reform. The *Public Bodies (Joint Working) (Scotland) Act 2014* requires that NHS Boards and Local Authorities establish new HSCI Partnerships from 1 April 2016.

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 Strategic Plan will ensure a joint contribution to encourage, support and maintain the health and wellbeing of people. The HSCI Partnership will build on our existing partnerships and develop new relationships with people, communities, our workforce and other stakeholders to deliver the Plan.

The HSCI Partnership has identified three locality areas for service planning purposes. This is a legal requirement, but will also allow services to meet local needs and be adept to local circumstances. These three localities within the Falkirk Council area are:

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

Consultation and engagement with service users, staff and the public have been key. This has 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.**

Allyson Black
Chair, Falkirk Integration Joint Board

Patricia Cassidy
Chief Officer

On behalf of Falkirk Health & Social Care Integration Partnership

Why change?

We should celebrate that people living in the Falkirk area 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.

There are also some people who experience inequalities within our local communities. We aim to address this by working with our partners to:

- prevent and reduce the impact of poverty
- promote equality of access
- improve health and well-being
- putting equality at the heart of everything that we do.

An ageing population also brings new challenges for health and social care services. These are demonstrated in the Joint Strategic Needs Assessment and include:

- rising number of older people with many conditions and complex care needs
- more people are living for longer with long term conditions
- providing support for carers
- factors that affect the health and wellbeing of people, such as housing, employment and poverty
- an ageing and changing workforce
- number of emergency hospital admissions
- unnecessary delays in people being discharged home.

The Falkirk HSCI Partnership is facing an increased demand on services. The resources will not be enough if we do not work together in a more joined up way. This provides an opportunity for the new HSCI Partnership to use our combined resources in a more effective, efficient and person-centred way.

A change is needed to support people to live more independent lives in their communities, rather than in a hospital setting.

What will Health and Social Care Integration look like?

Our Strategic Plan describes how the Falkirk Health and Social Care Partnership will continue to make changes and improvements to health and social care services for all adults. This will be done over the next three years. Integration will focus on health and social care services with third and independent sectors providing a valuable contribution. This integrated approach will realise our vision, **to enable people in Falkirk to live full and positive lives within supportive communities.**

Often service users and their carers are not clear how services are coordinated. This can result in a disjointed and fragmented approach. Figure 1 provides an illustration of this fragmented approach.

By bringing together health and social care services across the Falkirk area, a more coordinated approach can be taken to providing care. This will help improve outcomes for people, their carers and families. We will make sure that communication is improved, and the right services are provided when needed, by the most appropriate person. Figure 2 provides an illustration of how we will deliver joined up and coordinated care.

Plan for Falkirk area

The Falkirk's HSCI Partnership agreed vision is described as:

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

Our Local Outcomes	
Self-Management Individuals, carers and families are enabled to manage their own health, care and wellbeing	
What will this mean for people?	**What are we going to do?**
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.	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

What will this mean for our communities?	
Communities will feel they are involved in decisions that affect them. Their views are gathered and they are listened to. They know what services we are available to provide and have confidence in them.	We will implement our Integrated 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 We will provide information that enables people to manage their condition and is accessible and delivered consistently
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	
What will this mean for people?	**What are we going to do?**

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.	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
What will 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.	

Safe Health and social care support systems are in place, to help keep people safe and live well for longer	
What will this mean for people?	**What are we going to do?**
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.	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 and Care Governance framework
What will this mean for our communities?	

Communities are confident that systems are in place for the identification, reporting, and prevention of harm.	We will continue to invest in Technology Enabled Care as an effective and appropriate way to support care.
Service User Experience People have a fair and positive experience of health and social care	
What will this mean for people?	**What are we going to do?**
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.	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 We will pursue co-location of staff and services where appropriate to support integration
What will this mean for our communities?	
Communities will have the opportunity to be engaged and involved in service redesign and delivery within their local areas. This will be based on a clear understanding of local needs and available resources.	
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	
What will this mean for people?	**What are we going to do?**
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.	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
What will this mean for our communities?	We will build on existing strengths within local communities

Communities are informed, involved and supported to work cohesively to develop and manage community based supports.	We will provide information about community based support that is accessible and presented in a consistent manner

How will this plan be delivered?

The Falkirk HSCI Partnership is committed to engaging with individuals and communities to develop high quality, responsive and effective services that improve outcomes for people. We will deliver the Strategic Plan 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 is supported by a range of key documents, such as:

- Participation and Engagement Strategy
- Clinical and Care Governance Framework
- Integrated Workforce plan
- Financial plan
- Joint Strategic Needs Assessment
- Performance Management Framework
- Risk Management Strategy
- Housing Contribution Statement
- Market Facilitation Plan.

The Strategic Plan will set 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.

For further information, please go to http://nhsforthvalley.com/about-us/health-and-social-care-integration

Falkirk Council

NHS Forth Valley

Falkirk Health & Social Care Partnership

Draft

Joint Strategic Needs Assessment

March 2016

1. Table of Contents

Executive Summary

This needs assessment provides a comprehensive description of health and social care data relevant to Falkirk Health & Social Care Partnership.

The following key issues have emerged from the needs assessment:

- **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.

1. Introduction

1.1 Background

The integration of health & social care is a key Scottish Government Programme of reform designed to improve care and support for those who use health and social care services. The legislation relating to the integration of health and social care is set out in the Public Bodies (Joint Working) (Scotland) Act 2014.

A list of nine high-level statements of what health and social care partners are attempting to achieve through integration has been produced. These are known as the National Health and Wellbeing Outcomes.

By working with individuals and local communities, health and social care partnerships will support people to achieve the following outcomes:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Outcome 5: Health and social care services contribute to reducing health inequalities

Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

Outcome 7: People using health and social care services are safe from harm

Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services

Linking the Information presented to the Intended Outcomes

	Information Section					
Outcome:	**Population**	**Life Circumstances**	**Risk Factors**	**Population Health**	**Provision of Health and Social Care Services**	**Carers**
Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer	●[1]	●[2]	●[3]	●[4]	●[5]	●[6]
Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	●[7]	●[8]	●[9]	●[10]	●[11]	●[12]
Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected		●[13]			●[14]	
Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services		●[15]	●[16]		●[17]	
Outcome 5. Health and social care services contribute to reducing health inequalities		●[18]			●[19]	
Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being						●[20]
Outcome 7. People using health and social care services are safe from harm					●[21]	
Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide					●[22]	
Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services					●[23]	

Comments on connections and gaps:

1 The total population and demographic profile impacts on the number of people whose self-care and longevity are under consideration

2 Life circumstances impact on ability to look after oneself and improve health. This may be through mental wellbeing or less tangible concepts such as resilience

3 Health improvement often requires the addressing of risk factors

4 Longevity is strongly affected by the development of individual diseases and multiple conditions
5 Provision of health and social care should be enabling and health improving, and increase longevity
6 Carers can enable individuals to improve their health, reduce risk factors and live longer
7 The total population and demography impact on the number of people living at home or in homely settings
8 Life circumstances include a consideration of the home setting and extent to which housing needs can be and are met
9 People, including those with long term conditions have opportunities for health improvement through addressing risk factors
10 Population health includes a consideration of the epidemiology of long term conditions and frailty etc,
11 Provision of health and social care should be enabling and encourage rehabilitation
12 The role of carers is important and may be crucial in helping people continue to live at home
13 Life circumstances are an important factor in individuals' attitudes to and therefore use of health and social care services
14 Good information on health and social care service activity is available. Information on the quality of provision in terms of experience is collected through more qualitative means such as surveys (not presented here)
15 Health and social care services can have a positive impact on life circumstances
16 Health and social care services can be health improving through addressing risk factors
17 The provision of health and social care is based on evidence of effectiveness (which may be variable). Direct impact in terms of health and social outcomes may need to be inferred.
18 Experience of deprivation and other equality / inequality factors come under life circumstances
19 Health and social care services should reduce health inequalities through positive health and social outcomes for those experiencing deprivation. However the 'inverse care law' applies – those with less need are better able to access services (see items 2 and 13)
20 Carers have health and social care needs, which when met also have a positive impact on the person being cared for.

21 The information presented may not quite capture the 'safe from harm' aspect. More qualitative data from inspectorate reports or patient safety initiatives could provide further evidence
22 The information on workforce is fairly basic and quantitative. Further information from staff surveys etc. would be useful. Workforce development is key to achieving the nine outcomes.

23 The information presented does not quite capture effectiveness and efficiency – this may need to be implied or extrapolated. More complex methods such as benchmarking, data envelopment analysis or economic evaluation such as (social) return on investment may be required.

1.2 Joint Strategic Needs Assessment

Each health and social care partnership is required by the legislation to produce a detailed strategic plan. Falkirk's strategic plan will explain how the partnership will make changes and improvements to develop health and social services for adults over the coming years.

In order for the partnership to produce a detailed strategic plan that best meets the needs of its local population we first require a clear understanding of the health and care needs of the population, from both the perspective of the NHS and Local Authority, and other key stakeholders.

Need is the discrepancy between "what is" and "what should be". This document aims to bring together the available data in order to describe the current pattern and level of supply of these services and where possible identify the extent of the gap between need and supply.

Understanding the differing levels of need and service provision across the partnership will be key to future success. Therefore the ability to assess need at locality level is extremely important. This document will focus on information and analysis at partnership/local authority level and will sit alongside a locality profile document. The HSCI Partnership has identified its locality areas for service planning purposes. There will be three localities within the Falkirk Council area:

- **Falkirk**

  The Falkirk Locality is the smallest and most compact of the three Health 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**

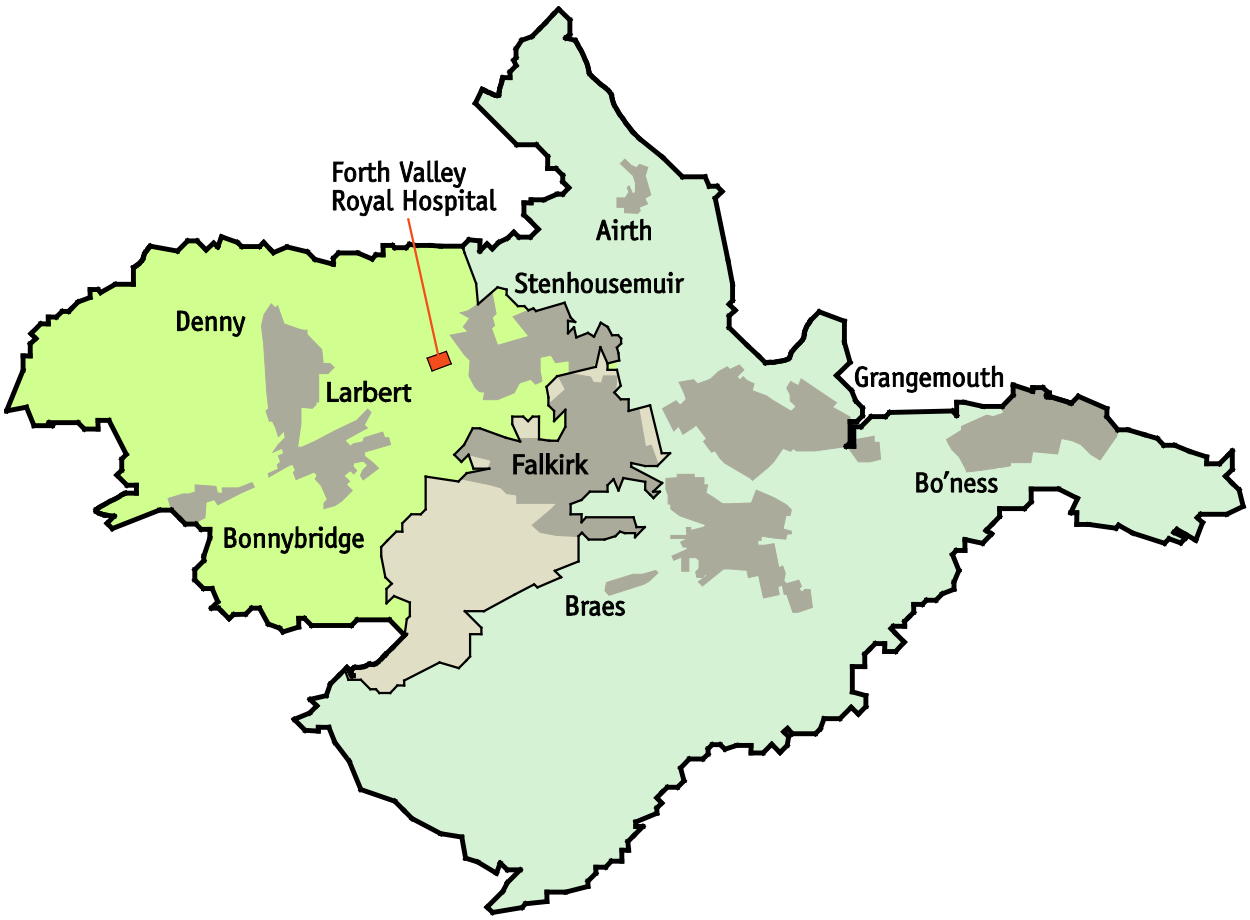
  This is the largest of the three Heath and Social Care Localities, both in terms of area (176 sq km) and population (over 65,000). It lies along the coastline of the River Forth and extends southwards into the higher land of the Slamannan Plateau. It contains the former burghs of Grangemouth and Bo'ness 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.

Figure 1.2a – Falkirk Health & Social Care Locality Areas



2. Population

2.1 Current Population

A key aspect for determining the need of many health and social cares services is the size and age distribution of the local population. Table 2.1a, below, illustrates the population profile in Falkirk. Falkirk has an estimated population of 157,640 made up of 77,022 (49%) males and 80,618 (51%) females.

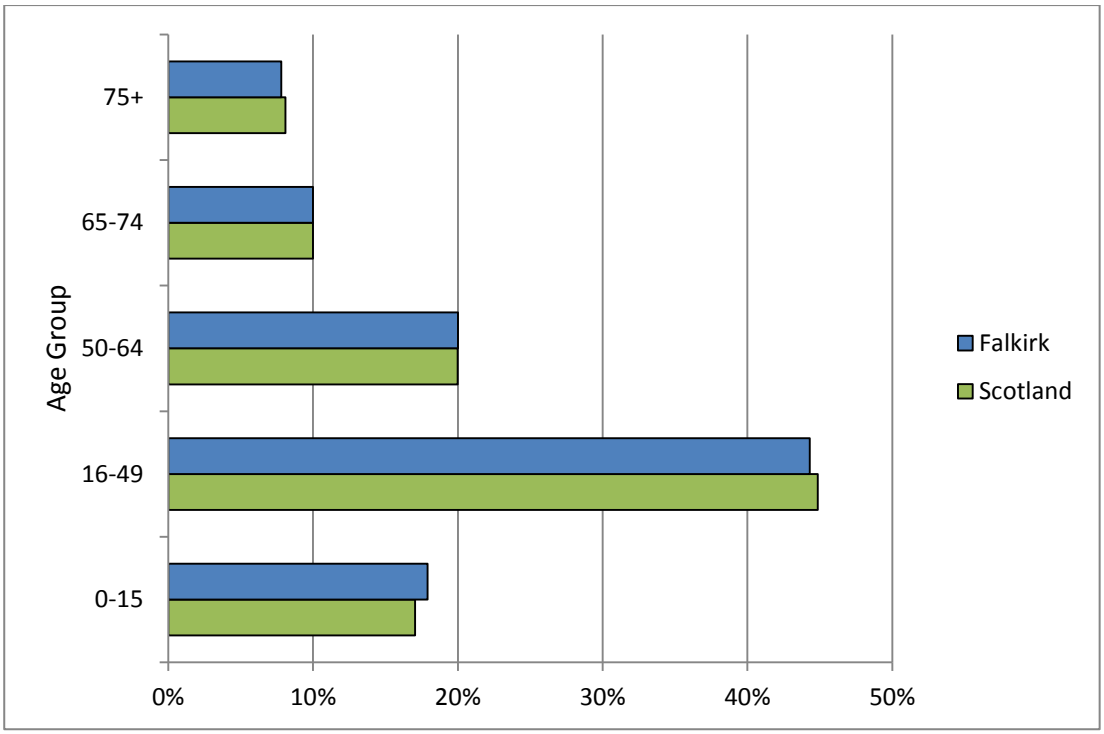
Table 2.1a Falkirk Population Profile

	Falkirk		
Age Group	**Total**	**Males**	**Females**
0-15	28,278	14,382	13,896
16-49	69,850	34,639	35,211
50-64	31,551	15,490	16,061
65-74	15,729	7,521	8,208
75+	12,232	4,990	7,242
Total	157,640	77,022	80,618

Source: NRS Population Estimates Mid-2014

Figure 2.1a, below, illustrates the age distribution in Falkirk compared to Scotland. The age profile is very similar to that of Scotland as a whole. Approximately 64% of the population are aged between 16 and 64, 17% under 16, 10% aged 65-74 and 8% aged over 75.

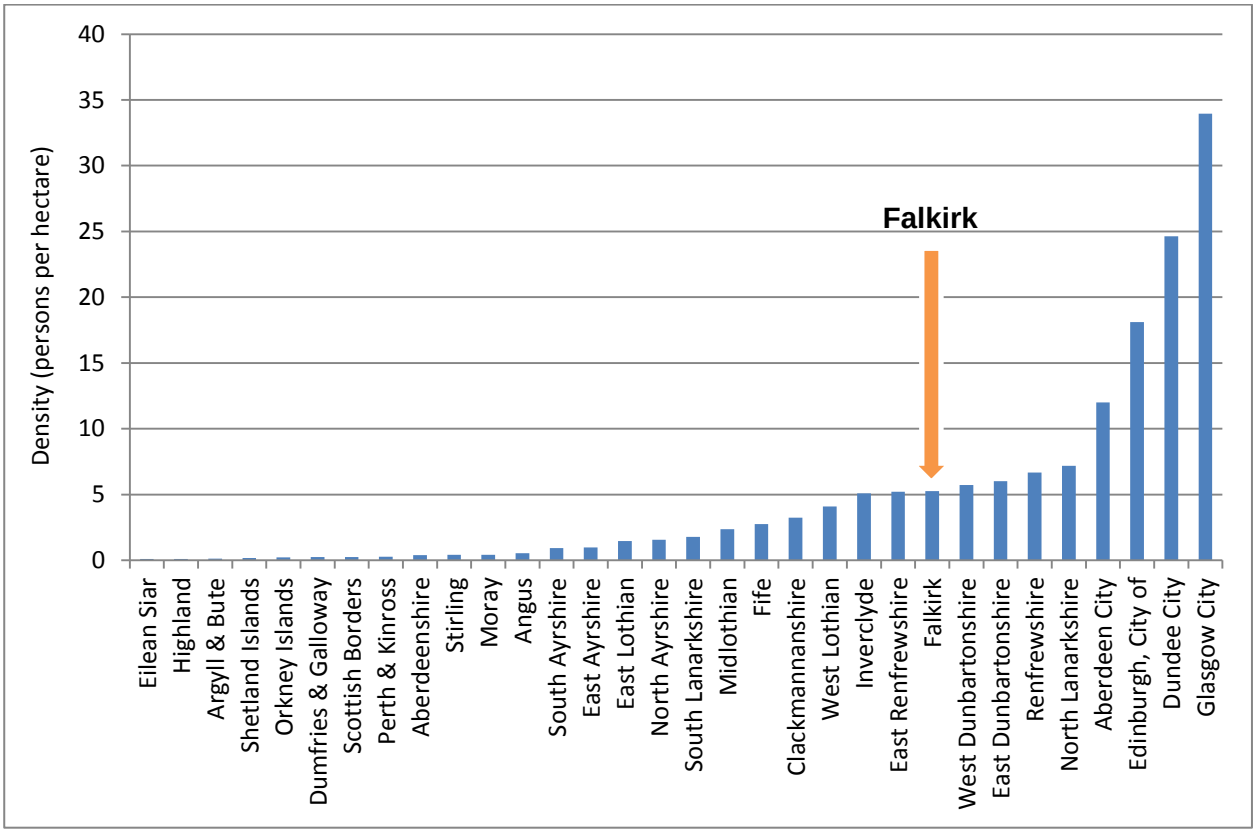
Figure 2.1a - Falkirk age distribution compared to Scotland



Source: NRS Population Estimates 2014

Figure 2.1b, below, illustrates the population density of Local Authorities across Scotland. Falkirk is the 9th most densely populated area in Scotland with 5.25 persons per hectare.

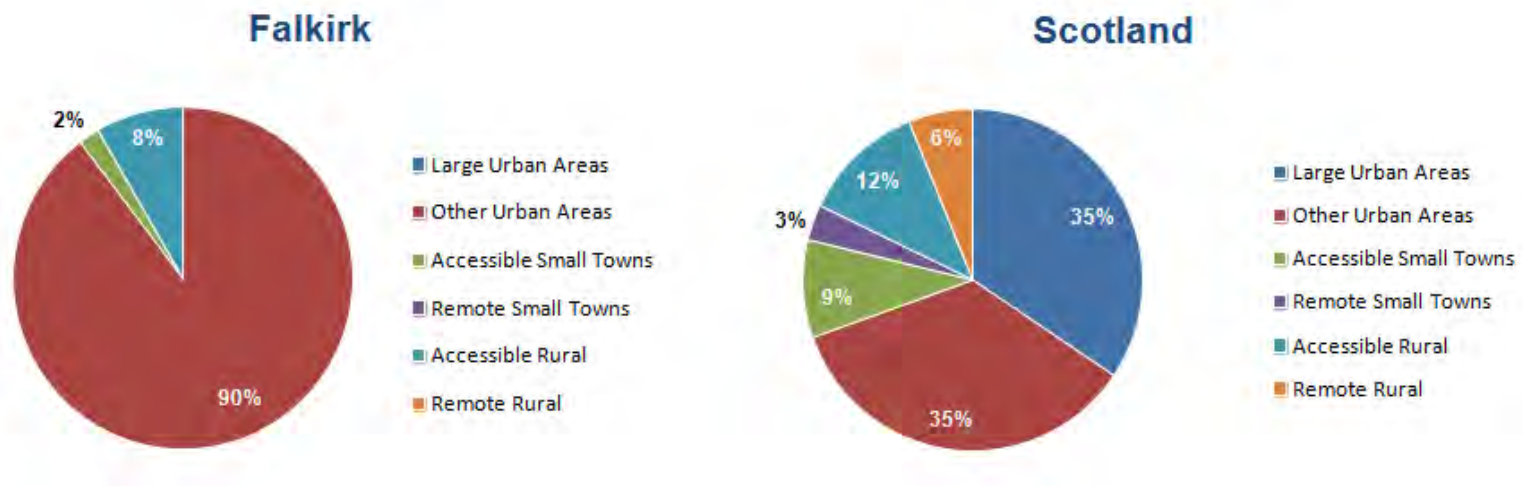
Figure 2.1b - Population Density (persons per hectare) 2011



Source: Census 2011

The vast majority (90%) of Falkirk's population live in Urban Areas of between 10,000 and 124,999 people (figure 2.1c). There are no Large Urban Areas in Falkirk. 2% of the population live in Accessible Small Towns and 8% live in Accessible Rural areas.

Figure 2.1c – Percentage of Population by urban/rural type, 2011



Source: Census 2011

Table 2.1b - Urban/Rural Classification

Category	Description
1 – Large Urban Areas	Settlements of 125,000 or more people.
2 – Other Urban Areas	Settlements of 10,000 to 124,999 people.
3 – Accessible Small Towns	Settlements of 3,000 to 9,999 people and within 30 minutes' drive of a settlement of 10,000 or more.
4 – Remote Small Towns	Settlements of 3,000 to 9,999 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 – Accessible Rural	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a settlement of 10,000 or more.
6 – Remote Rural	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more.

Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland.

Ethnic Origin

Table 2.1c shows that in the 2011 Census Falkirk had a less diverse population than Scotland on the whole, with a greater 'White – Scottish' population and a smaller proportion of BME (Black and Minority Ethnic) groups (1.9%) compared to 4.0% at national level.

Since the 2001 Census, the population had become slightly more diverse. In 2001 97.1% of the local population were either White-Scottish or White-British; by 2011 this had dropped to 95.8% of the population. (*Ethnicity Categories were changed for the 2011 census so it is not possible to do a direct comparison for all Ethnic Groups*)

Table 2.1c – Ethnicity in Falkirk and Scotland 2011

Ethnicity	Falkirk (%)	Scotland (%)
White - Scottish	91.3	84.0
White - Other British	4.5	7.9
White - Irish	0.6	1.0
White - Polish	0.7	1.2
White - Other	1.0	2.0
Asian, Asian Scottish or Asian British	1.3	2.7
Other ethnic groups	0.6	1.3

Source: 2011 Census

Religion

Of the Falkirk population, the largest group would consider themselves to be non-religious (39.0%) while the most common religious group in Falkirk is the Church of Scotland (36.5%). In both cases Falkirk has a larger percentage than Scotland on the whole; while the percentage of people from other religious backgrounds is less than the Scottish average.

Table 2.1d – Religion in Falkirk and Scotland 2011

Religion	Falkirk (%)	Scotland (%)
Church of Scotland	36.5	32.4
Roman Catholic	12.3	15.9
Other Christian	4.1	5.5
Muslim	0.9	1.4
Other religions	0.6	1.1
No religion	39.0	36.7
Not stated	6.6	7.0

Source: 2011 Census

Sexual Orientation

Information on sexual orientation, either at national or local level, is limited and it is likely that the numbers of LGBT (Lesbian, Gay, Bisexual and Transgender) are under-represented. The health needs of the LGBT population are not well understood since there is no robust data available.

The Scottish Household Survey 2014 included a question on Sexual Orientation and the results are shown in Table 2.1e below. The results should be interpreted with caution as the survey only covers a small sample of the Falkirk population; however 2.9% of females reported themselves as lesbian or bisexual with around 1.5% of the male population reporting themselves as Gay. In both cases this is slightly higher than the Scottish average, though it again be noted that the household survey only considers a small sample size.

Table 2.1e – Sexual Orientation by Gender for Falkirk and Scotland 2014

	Falkirk (%)		Scotland (%)	
Sexual Orientation	**Male**	**Female**	**Male**	**Female**
Heterosexual / Straight	98.0	97.1	98.1	98.6
Gay / Lesbian	1.5	0.9	1.0	0.6
Bisexual	-	2.1	0.2	0.2
Other	-	-	0.0	0.1
Refused	0.5	-	0.7	0.6
Don't Know	-	-	-	-
Base (Sample size)	*260*		*9800*	

Source: 2014 Scottish Household Survey

2.2 Projections of future population

The size and make-up of the population going forward will be a key consideration when planning and delivering health and social care services. The National Records of Scotland population projections (Table 2.2a) show the projected change in the population to 2037.

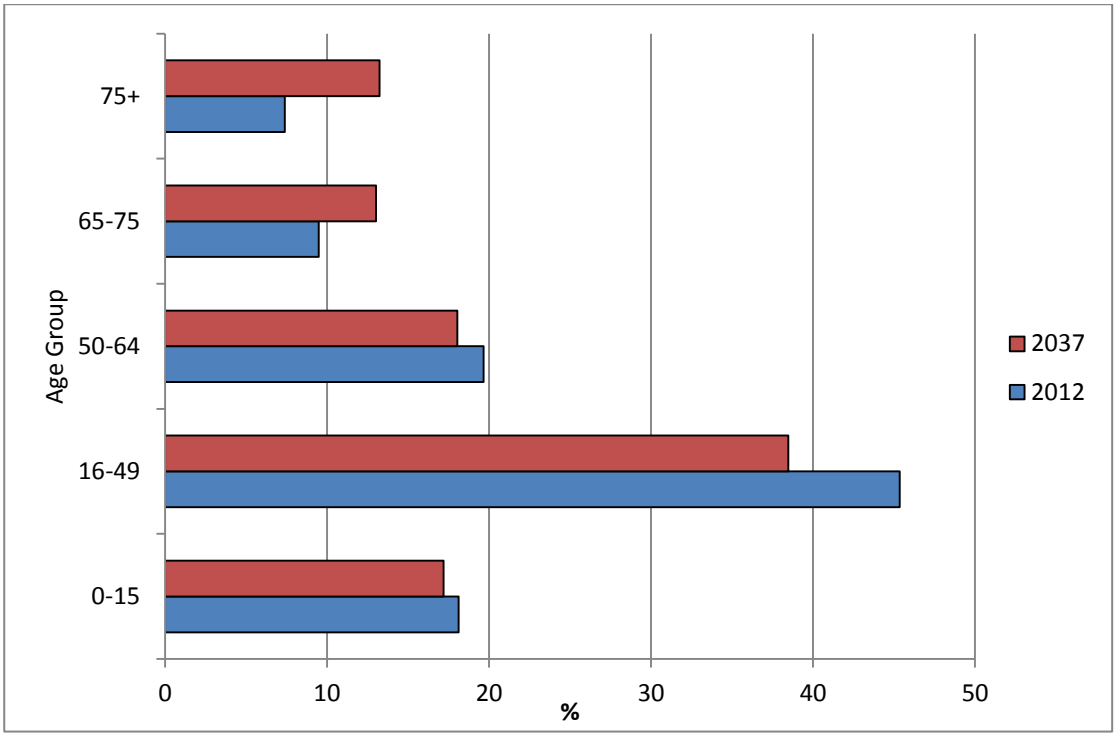
Table 2.2a - Falkirk Population projections to 2037

	2012		2032		2037	
Age Group	No	%	No	%	No	%
0-15	28,423	18.1	29,525	17.3	29,771	17.2
16-49	71,097	45.3	66,086	38.7	66,623	38.5
50-64	30,820	19.7	33,433	19.6	31,253	18.1
65-75	14,871	9.5	21,457	12.6	22,560	13.0
75+	11,589	7.4	20,117	11.8	22,923	13.2
Total	156,800	100	170,618	100	173,130	100

Source: NRS Population Projections (2012-Based)

The size and age structure of the Falkirk population is projected to experience significant change between now and 2037. The overall population is projected to increase by over 16,000 to 173,130. The age distribution is also projected to experience significant changes. The number of individuals aged 75+ is expected to double to 22,923 and the number of individuals aged 65-75 is also expected to rise from 14,871 to 22,560.

Figure 2.2a – Projected Population Age distribution in Falkirk, 2012 to 2037



Source: NRS Population Projections (2012 based)

Figure 2.2a, above, illustrates the projected change in the distribution in the population as opposed to the change in the actual size as just discussed. The chart shows that the working age groups (16-49 and 50-64) make up a smaller proportion of the population in 2037 than they do in 2012.

2.3 Dependency Ratio

The dependency ratio is a measure of the proportion of the population seen as economically 'dependant' upon the working age population. The definition generally used in Scotland is: 'those aged under 16 or of state pensionable age, per 100 working age population'. Table 2.3a illustrates the projected change in dependency ratio for Falkirk and Scotland to 2037.

Table 2.3a – Projected Dependency Ratios to 2037

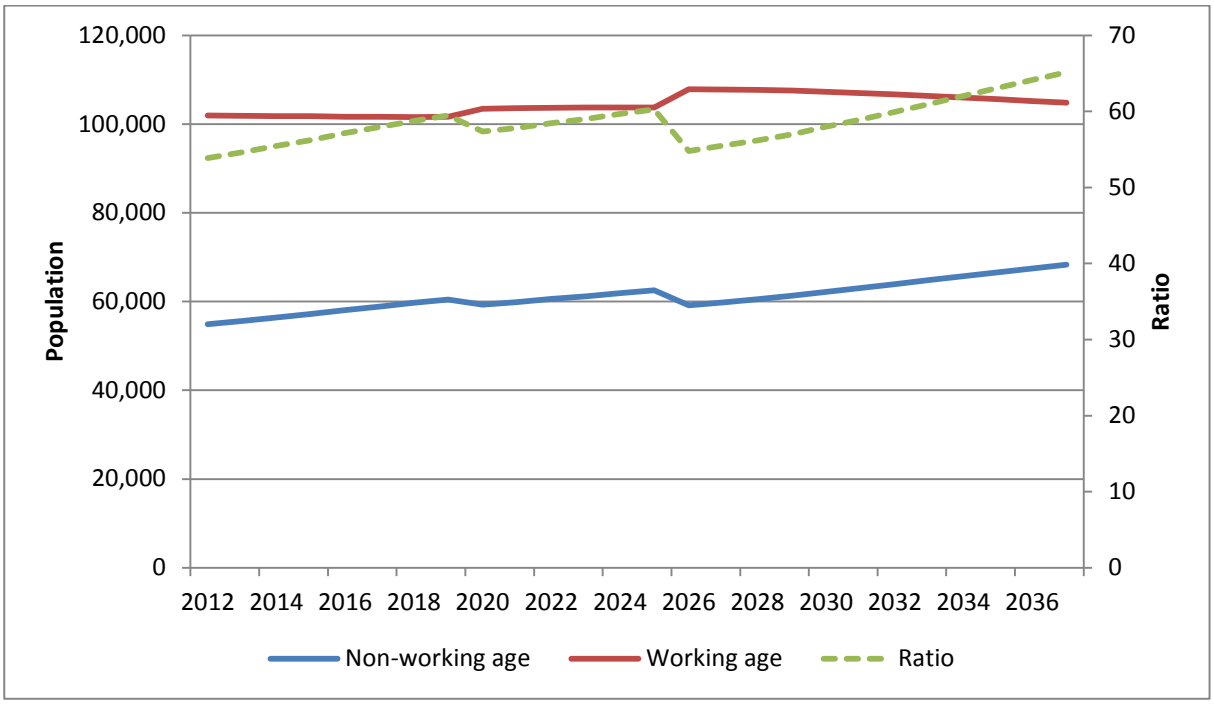
Year	2012	2015	2020	2025	2030	2035	2037
Falkirk	53.9	56.2	57.4	60.3	58.0	63.1	65.2
Scotland	53.0	54.8	55.8	59.8	57.8	61.7	62.9

Source: NRS Population Projections (2012 based)

Falkirk is projected to follow a similar trend to Scotland but will have a slightly higher projected dependency ratio in 2037. Figure 2.3a examines this trend more closely. The projected increases in dependency ratio could potentially have a significant impact on the area. Falkirk is projected to have more individuals of a non-working age as a proportion of

those of a working age and this will impact upon the services required locally as well as on the economy. Note that the kinks in the graph reflect the planned changes in pension age.

Figure 2.3a – Falkirk Projected Dependency Ratios to 2037



Source: NRS Population Projections (2012-based)

2.4 Population Considerations/Implications

- Older people are generally high users of services. The number, and percentage, of older people across Falkirk is projected to double and this could impact significantly on demand for services.
- There is a projected increase in the ratio of non working aged people to people of working age. This may impact on the local economy as well as the ability to recruit in order to deliver services.

3. Life Circumstances

3.1 Scottish Index of Multiple Deprivation

The terms 'deprivation' and 'poverty' are sometimes used interchangeably. However, in this context, deprivation is defined more widely as the range of problems that arise due to lack of resources or opportunities, covering health, safety, education, employment, housing and access to services, as well as financial aspects.

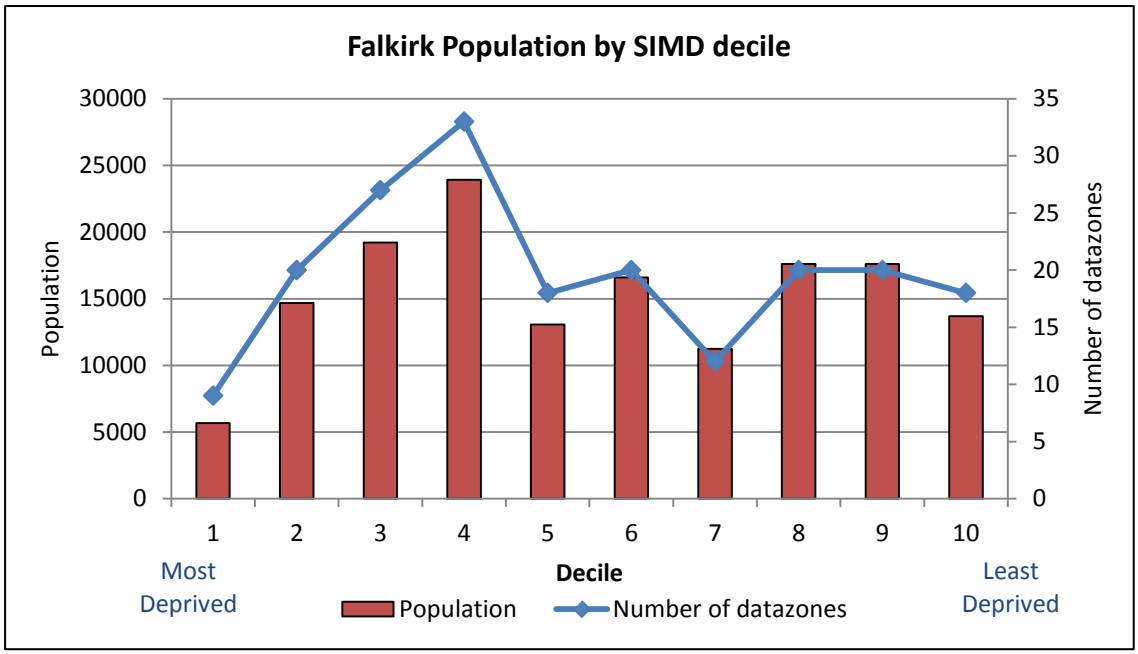
The Scottish Index of Multiple Deprivation (SIMD) is the Scottish Government's official tool for identifying those places in Scotland suffering from deprivation. It incorporates several different aspects of, combining them into a single index. It divides Scotland into 6,505 small areas, called datazones, each containing around 350 households. The Index provides a relative ranking for each datazone, from 1 (most deprived) to 6,505 (least deprived). By identifying small areas where there are concentrations of multiple deprivation, the SIMD can be used to target policies and resources at the places with greatest need.

One way ISD (Information Services Scotland) uses these is to divide all of the datazones in Scotland into 10 equal deprivation deciles, by calculating each individual zone's decile from the distribution of all ranks. For example if a zone in Falkirk is ranked 517, it is in the bottom 7.9% of all zones so would be in the first decile which encompasses values between 0 and 10%. If a zone is ranked 1985, it would be in the bottom 30.5%, and in the fourth decile for values between 30% and 40%.

Within the deciles, 1 is the most deprived and 10 the least deprived (this categorisation is applicable for SIMD 2009v2, SIMD2012 and future releases). Figure 3.1a below 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. The population in the lowest five deciles are spread across a greater number of datazones, with 76,540 people in 107 datazones. In contrast, the 76,740 people in the highest five deciles are in 90 datazones. Four percent of the population in Falkirk are in the lowest decile group, this is approximately 5,600 people. The lowest scoring datazone is in Dunipace, the other zones in this decile include areas in Camelon, and Bainsford and Langlees.

Figure 3.1a - Falkirk population by SIMD decile



Source: SIMD 2012

The distribution of the population in Falkirk across the different decile groups is relatively even, excepting those in the lowest decile. The percentage of the population in the decile groups from 2 to 10 ranges from 7% in the seventh, to 16% in the fourth.

3.2 Housing

In relation to strategic planning, the Local Housing Strategy (LHS) is the sole housing strategic document for the local area. The LHS 2011-16 highlighted 5 key areas in relation to older people and those with disabilities:

- There needs to be a co-ordinated approach between housing, social care and health to enable older people to live in the community for longer
- There is a need for accommodation for older people with particular needs
- The current model of housing with care does not meet current aspirations.
- There is an increasing demand for aids, adaptations, support and advice
- There have been advances in technology to enable people to live in their own home which should be utilised.

Investment in specialist housing, housing improvements, care & repair services, adaptations and housing support services has significant potential to bring about positive health and quality of life outcomes for older people and their carers.

The following section provides an overview of housing in Falkirk.

- The National Records of Scotland household projections predict that household numbers will increase from 69,230 to 80,210 between 2012 and 2037 with Falkirk's increase being lower (16%) than Scotland's (17%).

- The number of those households headed by someone aged 75 and over is estimated to increase from 2012 to 2037 by 89% in Falkirk, greater than that in Scotland which is estimated to increase by 82%.
- In 2013 owner occupation 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%.
- Between 1999 and 2013 there was a 7% increase in private renting and a 14% decrease in social renting in Falkirk (Scottish Household Survey 2013).
- In Scotland, private renting has increased by 7% and social renting has decreased by 9% over the same period.
- There are a greater proportion of houses than flats in Falkirk (73% compared to 27%) than in Scotland (63% compared to 37%).
- The same proportion of dwellings were built before 1945 in Falkirk as in Scotland, which is 20% (Scottish House Conditions Survey 2013).
- The Falkirk Local Housing Strategy 2011-2016 set out a number of key target outcomes for housing in the area. As well as establishing that best use was to be made of existing housing stock to address local needs, the strategy outlined that new affordable housing stock was required. By 2016, there were to be 725 new residencies per year, and of that 100 were to be new-build affordable housing and 133 that were to make best use of existing housing stock.
  https://www.falkirk.gov.uk/services/homes-property/policies-strategies/local-housing-strategy.aspx

3.3 Fuel Poverty

Fuel poverty is a measure based on a calculated spend on energy and fuel compared to the annual household income. The term fuel poverty refers to a situation where a household is unable to heat its home at a reasonable cost. A person is living in fuel poverty if, to heat their home to a satisfactory standard, they need to spend more than 10% of their household income on fuel. Extreme fuel poverty is where they need to spend more than 20% of their household income on fuel. This affects households greatly especially during the winter months, as the colder outside temperature and lack of suitable heating inside increases the risk of developing health problems such as cardiovascular and respiratory conditions. Fuel poverty also means that the dwelling is more susceptible to issues such as damp and mould, which in turn affects the quality of life and health of the people living in that environment.

Table 3.3a below shows the percentage of households in Falkirk that can be considered fuel poor and extremely fuel poor compared to the Scottish average. All households in Falkirk are below the Scottish average for both measures.

Table 3.3a – Fuel Poverty in Falkirk and Scotland 2011-2013 (All Households)

All households	Fuel Poverty	Extreme Fuel Poverty
Falkirk	32%	5%
Scotland	36%	10%

Source: Scottish House Condition Survey Local Authority Tables 2011-2013

Table 3.3b shows the percentage of pensioner households in Falkirk that are fuel poor and extremely fuel poor. Whilst half of pensioner households are fuel poor, only 8% are extremely fuel poor. These are lower than the figures for Scotland as a whole, but higher than the figures for the whole population.

Table 3.3b – Fuel Poverty in Falkirk and Scotland 2011-2013 (Pensioner Households)

Pensioner households	Fuel Poverty	Extreme Fuel Poverty
Falkirk	50%	8%
Scotland	54%	15%

Source: Scottish House Condition Survey Local Authority Tables 2011-2013

There are a number of factors that contribute to fuel poverty.

- In Falkirk, 21% of the dwellings were built before 1945, and older properties are more likely to have no insulation or be poorly insulated. This increases heating and fuel costs as well as affecting the quality of life for inhabitants. Between 2011/13 an average of 70% of the dwellings in Falkirk were wall insulated (cavity and solid/other).
  In comparison, across Scotland 32% of properties were built before 1945, and only 52% of all dwellings had wall insulation in 2011/13.

- The Falkirk area also includes a higher proportion of urban households (89.6%) compared to Scotland as whole (69.6%). This means that fuel poverty is likely to be lower as urban properties tend to be newer properties, and their location makes them less exposed to the elements than those in rural areas. Exposure to wind, rain, and snow, which is more likely in rural locations, makes the household more expensive to heat.
  Additionally, rural locations are less likely to be connected to the mains gas lines, with energy being provided by other methods including heating oil and gas bottles. These types of energy supply are less efficient than mains gas, thus increasing fuel costs. In Falkirk in 2011/13, 15% of properties were off the gas grid.

- The energy efficiency of the dwelling also affects the fuel costs. The lower the efficiency of the dwelling, the higher the fuel costs. In Falkirk 2% of properties are in the lowest groupings for energy efficiency, this is lower than the Scotland average which in 2011/13 was 4%.

3.4 Employment, Benefits and Financial Issues

The 2011 Census details the economic activity of respondents. This is categorised into those who are economically active (in or seeking employment) and those who are economically inactive (not in or seeking employment).
Table 3.4a 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 few 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.

Table 3.4a Percentage of total population by economic activity

Area	Economically active	Unemployed - seeking work (included in economically active)	Economically inactive	Long-term sick or disabled (included in economically inactive)
Falkirk	65.0%	5.2%	35.0%	4.8%
Scotland	62.8%	5.1%	37.2%	4.8%

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.

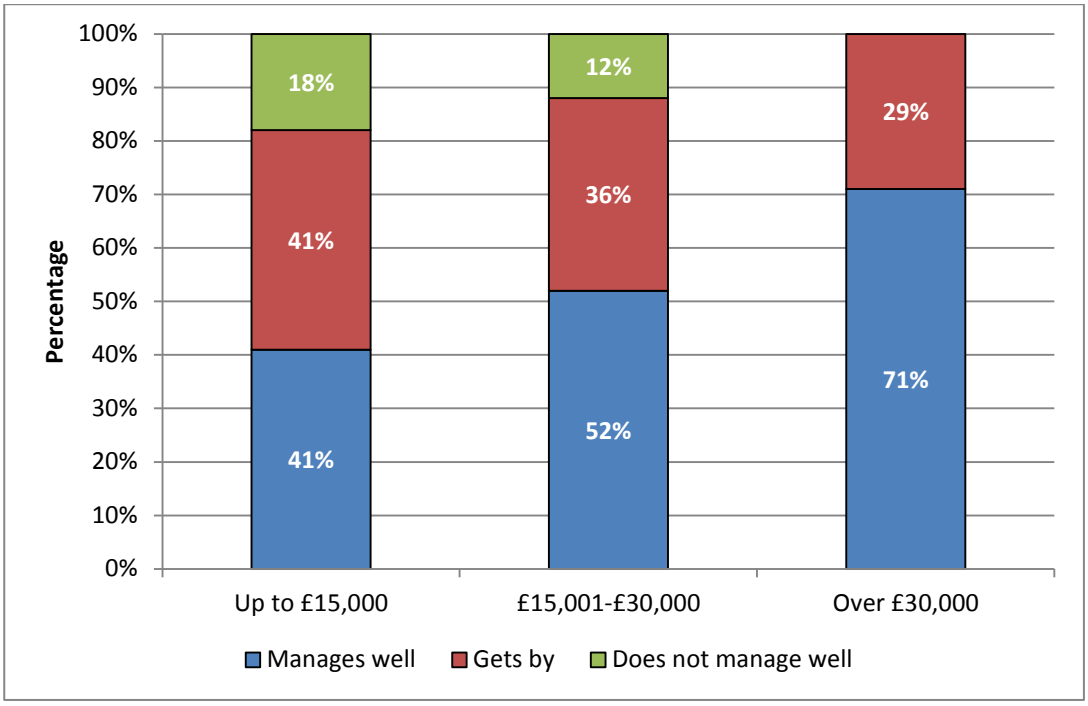
Table 3.4b Housing benefit claims by local authority May 2015

Housing benefit claims	May 2015
Falkirk	13,104

Source: Department for Work and Pensions Stat-Xplore

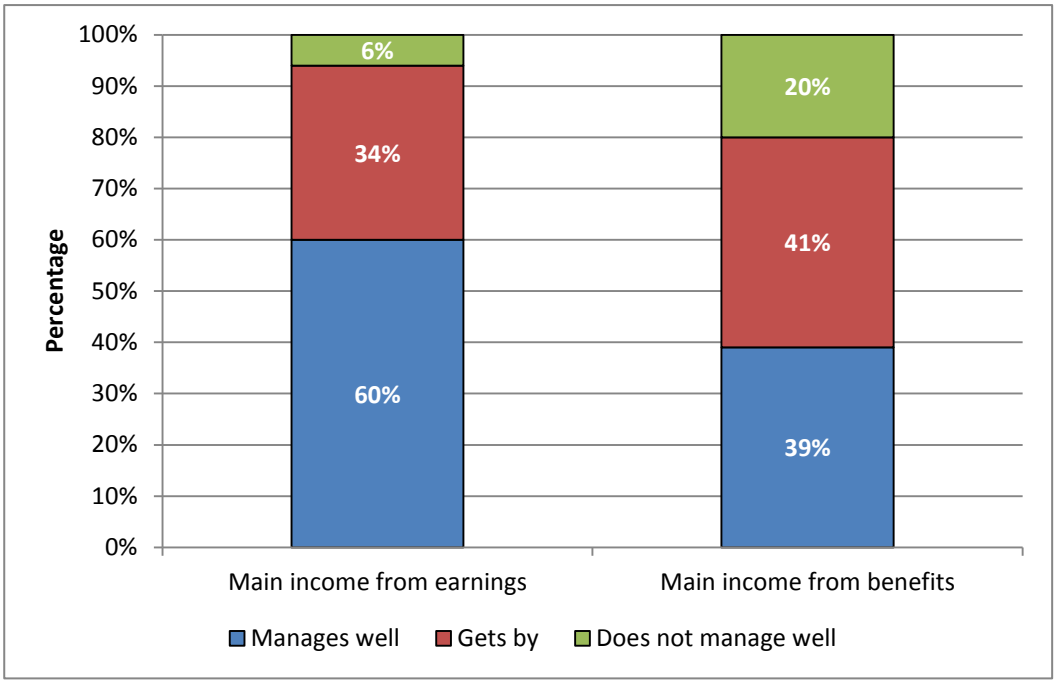
Financial issues and concerns can cause health and social problems. Job insecurity, redundancy, debt and financial problems can all cause emotional distress, affect a person's mental health and contribute to other health issues. Information from the 2013 Scottish Household Survey shows statistics for how well households manage finances. The charts below show how well households managed their finances by amount of income, and also by the main source of income. 18% of households in Falkirk where the income is less than £15,000 do not manage their households well. Similarly, of the households whose main income is through benefits, 20% do not manage well.

Figure 3.4c - Household management by annual household income – Falkirk 2013



Source: Scottish Household Survey

Figure 3.4d - Household management by income type – Falkirk 2013



Source: Scottish Household Survey

3.5 Life Circumstances Considerations/Implications

- Deprivation can be a key contributing factor in the health of a population.
- The percentage of those households headed by someone aged 75 and over is estimated to increase from 2012 to 2037 by 89% in Falkirk, greater than that in Scotland which is estimated to increase by 83%.
- The Falkirk Local Housing Strategy 2011-2016 set out a number of key target outcomes for housing in the area. As well as establishing that best use was to be made of existing housing stock to address local needs, the strategy outlined that new affordable housing stock was required. By 2016, there were to be 725 new residencies per year, and of that 100 were to be new-build affordable housing and 133 that were to make best use of existing housing stock.

4. Lifestyle/Risk Factors

Lifestyle and risk factors have an important effect on a person's health and well-being. Behaviours such as smoking, alcohol consumption, drug use, and poor diet can have an adverse effect on health. People from less well-off and more deprived areas and communities are more likely to have these behaviours which have a negative impact on health.

4.1 Smoking

Smoking related illnesses not only affect an individual's health but also put a strain on services. It is estimated that in NHS Forth Valley in 2009 there were 2,187 hospital admissions are a result of smoking and that over £15 million was spent treating smoking related illness.[1] Continued focus on prevention is important to improve health and to reduce pressures on services.

Table 4.1a shows the percentage of the adult population who smoke in Falkirk compared with the Scotland average from 1999 to 2013

Table 4.1a - Percentage adult smokers 1999-2013

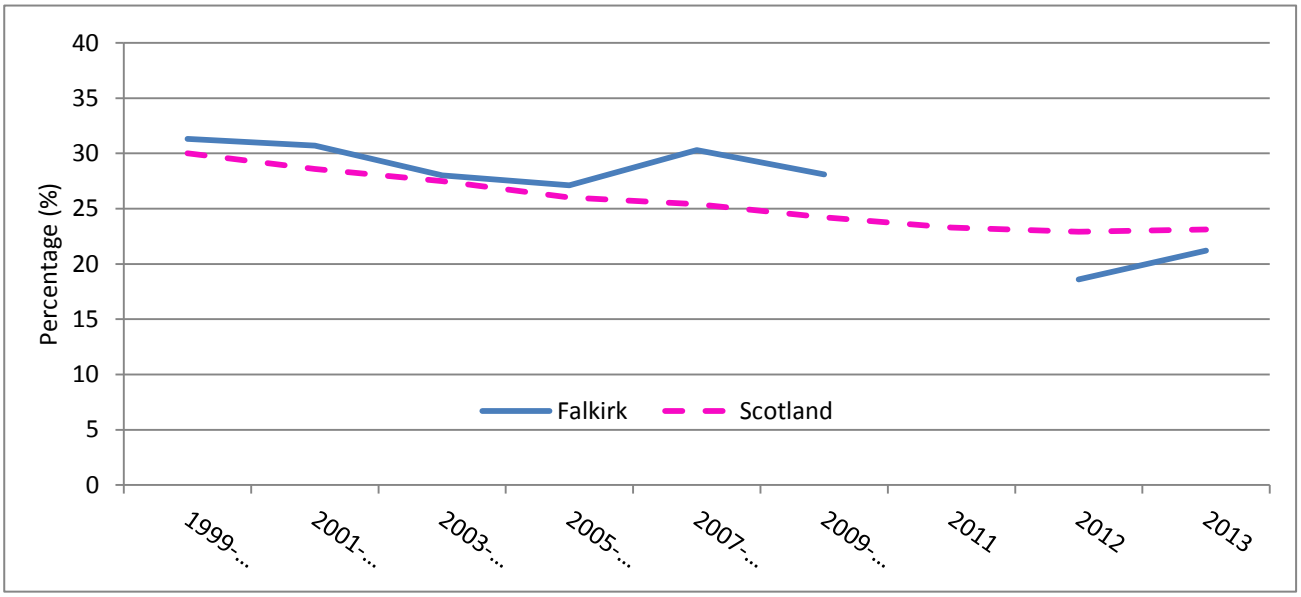
Area	1999-2000	2001-2002	2003-2004	2005-2006	2007-2008	2009-2010	2011	2012	2013
Falkirk	31.3	30.7	28.0	27.1	30.3	28.1	n/a	18.6	21.2
Scotland	30.0	28.6	27.5	26.0	25.4	24.2	23.3	22.9	23.1

Source: Scottish Household Survey - Annual Report 2013 - LA Tables

In 1999, 31.3% of adults in Falkirk smoked; by 2013 this had fallen to 21.2%. This is comparable to the trend for the total Scotland figures in the years between 1999 and 2013. In 2012, the percentage of adults who smoked in Falkirk fell below the Scottish average. The percentage of adult smokers increased the next year but it still was less than the Scottish average.

[1] ScotPHO Smoking Ready Reckoner – 2011 Edition

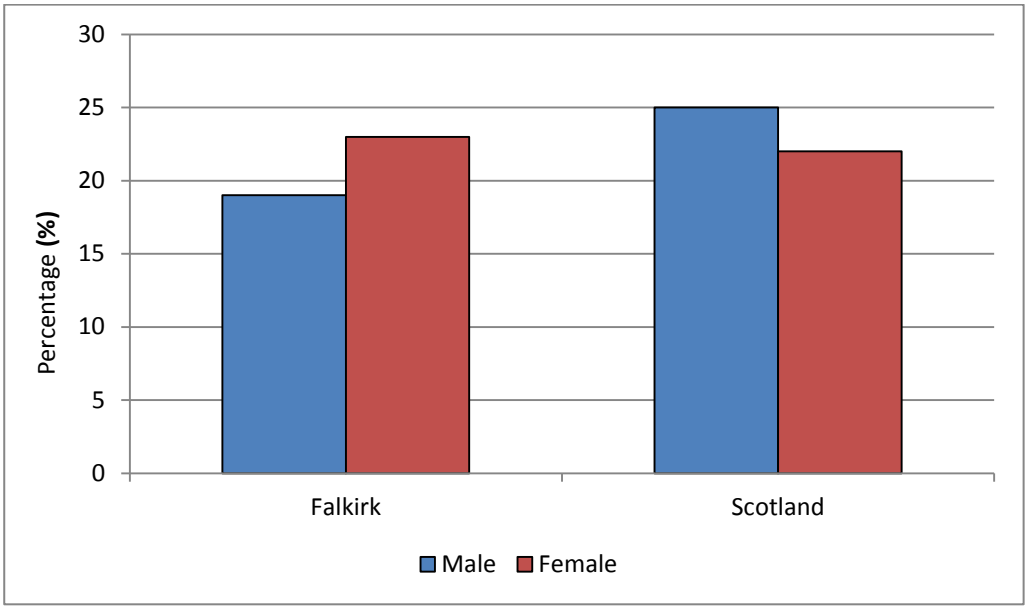
Figure 4.1a - Percentage of adults who smoke - 1999/2000 to 2013



Source: Scottish Household Survey - Annual Report 2013 - LA Tables

Figure 4.1b shows a breakdown of those who smoked in 2013 by sex. In 2013, a higher percentage of women in Falkirk smoked than men. In Scotland as a whole, the reverse is true, more men smoke than women.

Figure 4.1b - Smoking by sex, 2013



Source: Scottish Household Survey - Annual Report 2013 - LA Tables

Table 4.1c shows the rates of smoking related illnesses in Falkirk compared to the Scotland rate. In Falkirk in 2012 the rates for smoking related deaths, lung cancer deaths and COPD deaths were higher than the Scottish rate.

Table 4.1c - Age standardised[1] rate (per 100,000) of smoking related illnesses

Measure	Year	Falkirk	Scotland
Smoking attributable admissions	2012	2,208.7	3149.4
Smoking attributable deaths	2012	340.6	325.9
Lung cancer registrations	2011	132.0	133.3
Lung cancer deaths	2012	114.8	107.1
COPD incidence	2012	400.3	391.1
COPD deaths	2012	97.0	77.9

Source: ScotPHO Tobacco Control Profile

1. Age-sex standardised rate per 100,000 population to ESP2013 (European Standard Population 2013)

4.2 Alcohol

Alcohol related health issues are a major concern for public health in Scotland. Excessive consumption of alcohol can cause both short-term and long-term health and social problems. This includes liver and brain damage, as well as mental health issues, and it is also a contributing factor in cancer, stroke and heart disease. A recent needs assessment carried out on Alcohol Related Brain Damage (ARBD) in Forth Valley recognised that the number being diagnosed underestimates the number with the condition and further work will be carried out on coordinating services to better meet the needs of this cohort in the future.

The rate of alcohol related hospital admissions in Falkirk has increased slightly in the five years between 2009/10 and 2013/14 from 503.5 to 513.7 per 100,000. The number of hospital stays fell in 2010/11 but have gradually been increasing since. In 2013 there were 791 stays related to alcohol.

Table 4.2a shows the figures for the different measures from 2009/10 to 2013/14.

Table 4.2a - Alcohol Related Hospital Statistics 2013/14

Falkirk	EASR Standardised rate (per 100,000 population)	Number of hospital stays
2009/10	503.5	759
2010/11	374.0	570
2011/12	423.7	649
2012/13	441.9	682
2013/14	513.7	791

Source: ISD Scotland

EASR - Age-sex standardised rate per 100,000 population to ESP2013 (European Standard Population 2013)

Table 4.2b displays the age standardised mortality rates for Falkirk compared to the national average between 2009 and 2013. The figures are also presented in the form of a chart in Figure 4.2a.

The alcohol related mortality rate in Falkirk in 2013 at 18.16, was not significantly different from than the average rate of 21.43 for Scotland. Alcohol related mortality is the rate per 100,000 people where alcohol is the underlying cause of death.

The alcohol related mortality rate has been below the Scottish average in each year from 2009 to 2013.

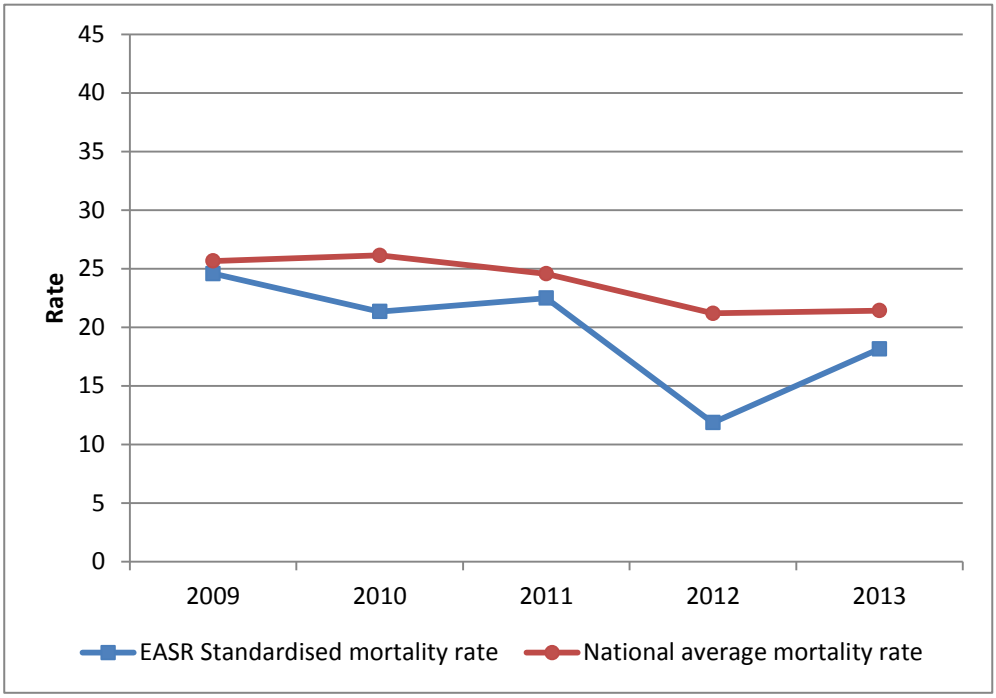
Table 4.2b - Alcohol related mortality

Falkirk	EASR Standardised mortality rate (per 100,000 population)	National average mortality rate
2009	24.58	25.65
2010	21.34	26.14
2011	22.49	24.56
2012	11.86	21.19
2013	18.16	21.43

Source: ISD Scotland/National Records of Scotland

EASR - Age-sex standardised rate per 100,000 population to ESP2013 (European Standard Population 2013)

Figure 4.2a - Alcohol related mortality (per 100,000 population)



Source: ISD Scotland/National Records of Scotland

4.3 Drugs

In 2012/2013 across Falkirk there were an estimated 1,700 people aged 15-64 with a problem drug use. Problem drug use can lead to a number of health and social problems.

The estimated prevalence of those with a problem drug use has increased in Falkirk when comparing the data from 2009/10 and 2012/13. This is in contrast to Scotland as a whole, where the estimated percentage of the population with a problem drug use has remained constant. This increase can be correlated to a substantial increase in male problem drug use in Falkirk since 2009/10, and a sizable increase in the corresponding female figure.

Table 4.3a - Estimated prevalence of problem drug use (ages 15-64)

		Falkirk %	Scotland %
All	2009/10	1.0	1.7
	2012/13	1.6	1.7
Male	2009/10	1.6	2.5
	2012/13	2.5	2.4
Female	2009/10	0.5	1.0
	2012/13	0.8	1.0

Source: ISD Scotland

Key Figures:

- 2013/14 data shows that the rate, per 100,000 population, of child protection with parental drug misuse is higher in Falkirk than the national average (10.7 vs 6.7 per 100,000 population).
- The percentage of people waiting more than 3 weeks between referral to a specialist drug service and commencement of treatment is much lower in Falkirk (0%) than Scotland (5.6%).
- The percentage of people at specialist drug treatment services in Falkirk who report funding their drug use through crime (21.7%) is higher than the national average (20.9%).
- Drug-related mortality has fluctuated over the past five years (2010-2014) but reached a low in 2014. The age-Standardised rate for Falkirk in 2014 was 5.7 per 100,000 population, less than half the Scottish average of 11.6 per 100,000.

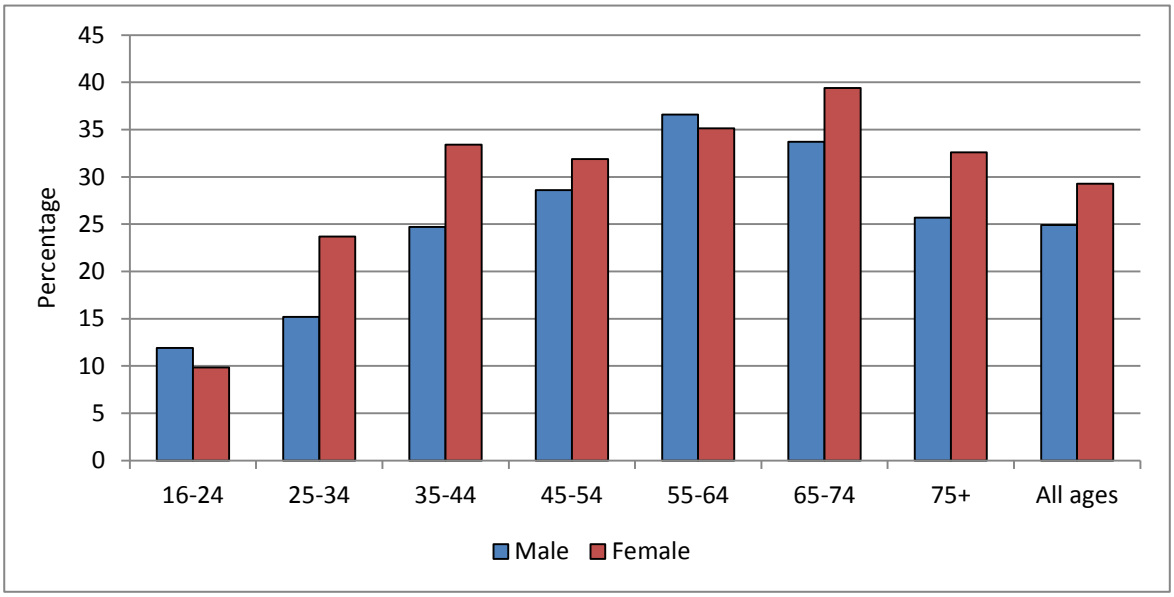
Source: ScotPHO Drugs Profile

4.4 Diet and Obesity

Obesity is when a person's weight increases to an extent that it could potentially cause health problems. Obesity is linked to a number of health problems and diseases. Common complaints include cardiovascular disease and diabetes. One of the major factors that leads to obesity is poor diet.

For Scotland in 2013 it was estimated that 27% of the adult population aged 16+ were obese (a Body Mass Index (BMI) of 30 or more). When this is broken down into different age groups and by sex, it shows that obesity is highest for men between the ages of 55 and 64, and for women between the ages of 65 and 74.

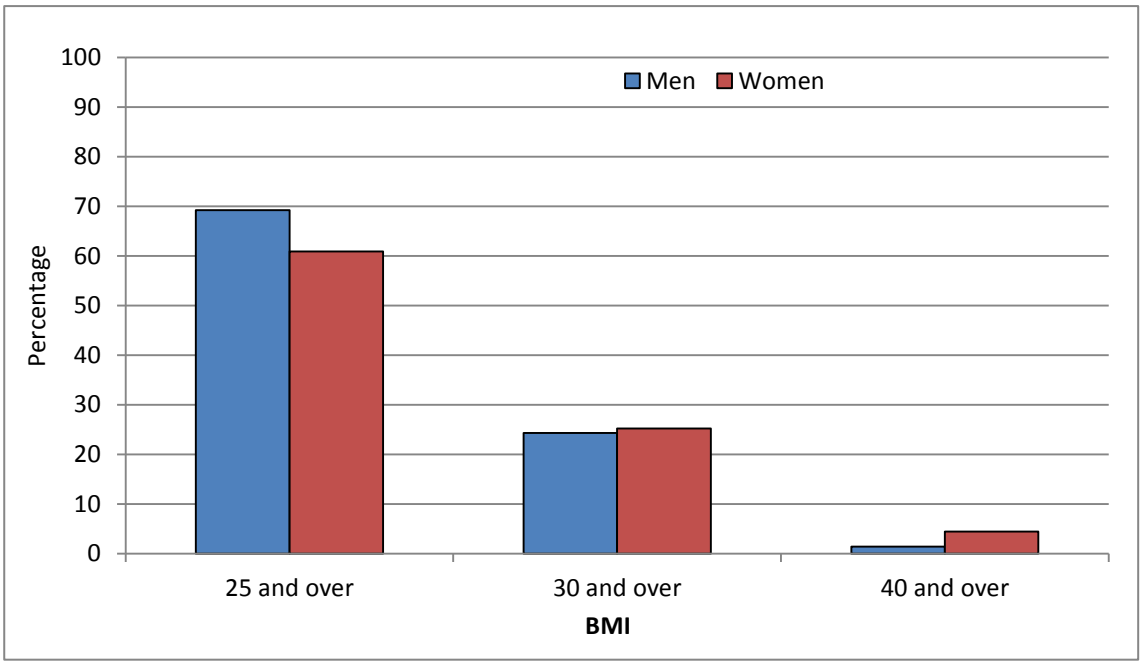
Figure 4.4a - Percentage of population with a BMI of 30 plus – 2013



Source: The Scottish Health Survey 2013

Data and information concerning diet and obesity is not regularly published at local authority or health board levels. Information from the Scottish Health Survey in 2011 showed a four year average of obesity rates in NHS Forth Valley. This information is shown in figure 4.4b.

Figure 4.4b - Percentage of the adult population in Forth Valley with a BMI of 25 plus, 30 plus and 40 plus - 2008-2011.



Source: The Scottish Health Survey 2013

4.5 Lifestyle/Risk Factor Considerations/Implications

- Despite the introduction of the smoking ban in public places in 2006, latest estimates suggest around 1-in-5 people in Falkirk still smoke. Tobacco smoking is the main risk factor for lung cancer, accounting for an estimated 80-90% of cases in developed countries and is linked to other cancers and COPD.
- Alcohol related mortality rates remain lower than the National average however alcohol can be a key factor in Emergency Department admissions. Targeting alcohol misuse could lead to benefits in unscheduled care.
- In recent years Falkirk has been successful in meeting the Government target for drug treatment waiting times, however the estimated prevalence of drug misuse in Falkirk has increased in previous years.
- Obesity is a major problem nationally and the most recent data suggests approximately 25% of the Falkirk population are considered obese. Obesity is known to be a key contributor to long term conditions such as Type 2 Diabetes and coronary heart disease, both of which are life-limiting for the patient and costly to the joint services.

5. Population Health

5.1 General Health

According to the 2011 Census the general health of people in Falkirk closely aligns with that of Scotland. The majority of people in Falkirk consider their health to be good or very good (Table 5.1) with only a small percentage bad or very bad.

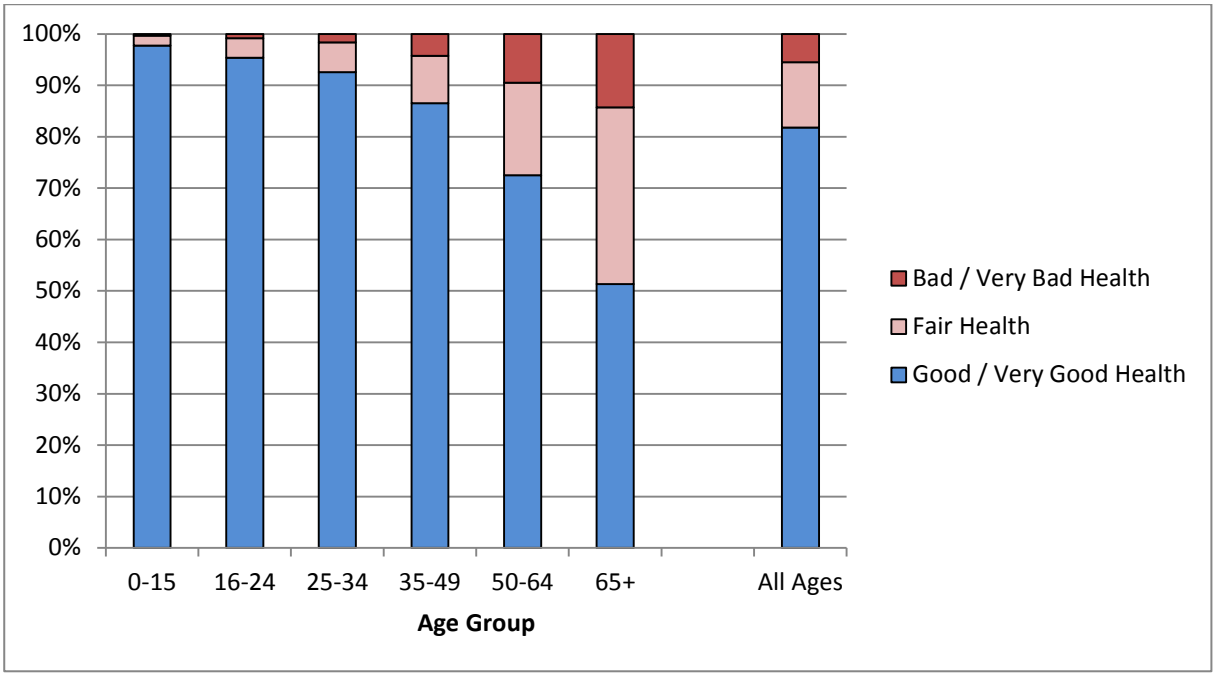
Table 5.1 – General Health by population and age

	Good/Very Good Health (%)	Fair Health (%)	Bad/Very Bad Health (%)
Falkirk	81.8	12.7	5.5
Scotland	82.2	12.2	5.6

Source: Scotland's Census 2011 - National Records of Scotland

Figure 5.1 shows that with increasing age, there is a considerable increase in the percentage of people who consider themselves to be in bad or very bad health. With the projected increase in elderly population, the proportion of people who consider themselves to be in bad or very bad health is expected to increase accordingly.

Figure 5.1 – Health Status by age group, Falkirk 2011



Source: Scotland's Census 2011 - National Records of Scotland

5.2 Life Expectancy and Healthy Life Expectancy

Life expectancy is an estimate of how many years a person might be expected to live. Figure 5.2a shows female life expectancy at birth is higher than for males both at Falkirk and Scotland level. Life expectancy is slightly lower in Falkirk than Scotland for both males and females. The estimate of female life expectancy has increased directly in line with Scotland between 2001-2003 and 2011-2013. The estimate of male life expectancy has increased by nearly a year more over the same period, though it has not increased at the same rate as Scotland on the whole.

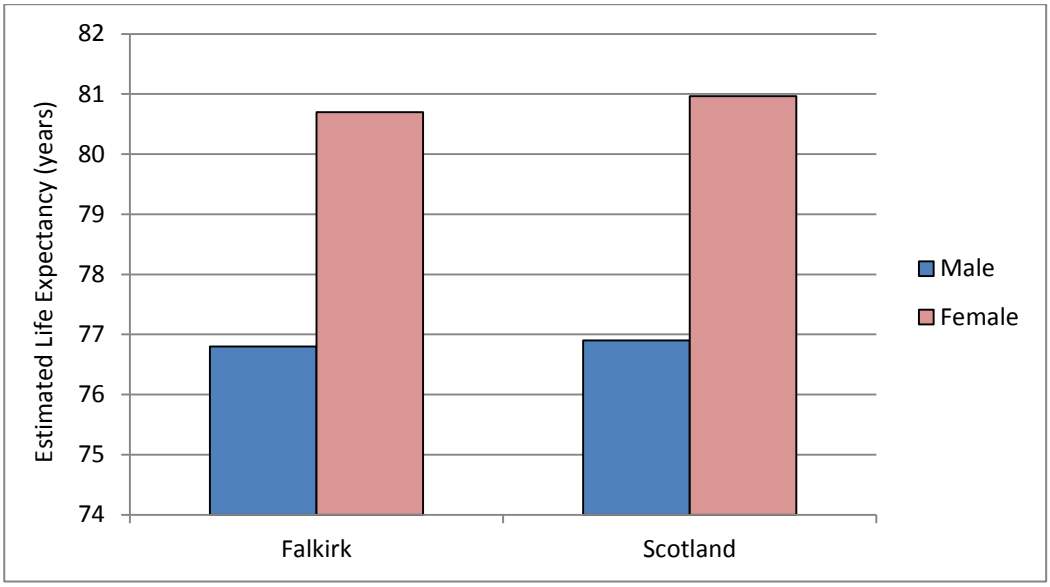
Table 5.2a - Life Expectancy at Birth, Falkirk and Scotland 2001-03 and 2011-13

	Falkirk		Scotland	
	Male	Female	Male	Female
2011-2013	76.8	80.7	76.9	81.0
2001-2003	73.8	78.6	73.5	78.8
Increase over 10 years	3.0	2.1	3.4	2.2

Source: National Records of Scotland

Figure 5.2a shows that estimated life expectancy at birth is just slightly under that of Scotland for both males and females in Falkirk.

Figure 5.2a - Life Expectancy at Birth, Falkirk and Scotland 2011-13



Source: National Records of Scotland

Healthy life expectancy is an estimate of how many years a person might live in a 'healthy' state. The difference between life expectancy and healthy life expectancy for Falkirk and Scotland is presented in Table 5.2b and Figure 5.2b below. Healthy life expectancy for males is very similar at Falkirk and Scotland level while female life expectancy is less than the Scotland level. The difference between life expectancy and healthy life expectancy gives an estimate of years in "poor health". At both Falkirk and Scotland level there is a considerable difference in years not healthy between males and females, Females are expected to live approximately 2 years longer in poor health than males (Table 5.2b).

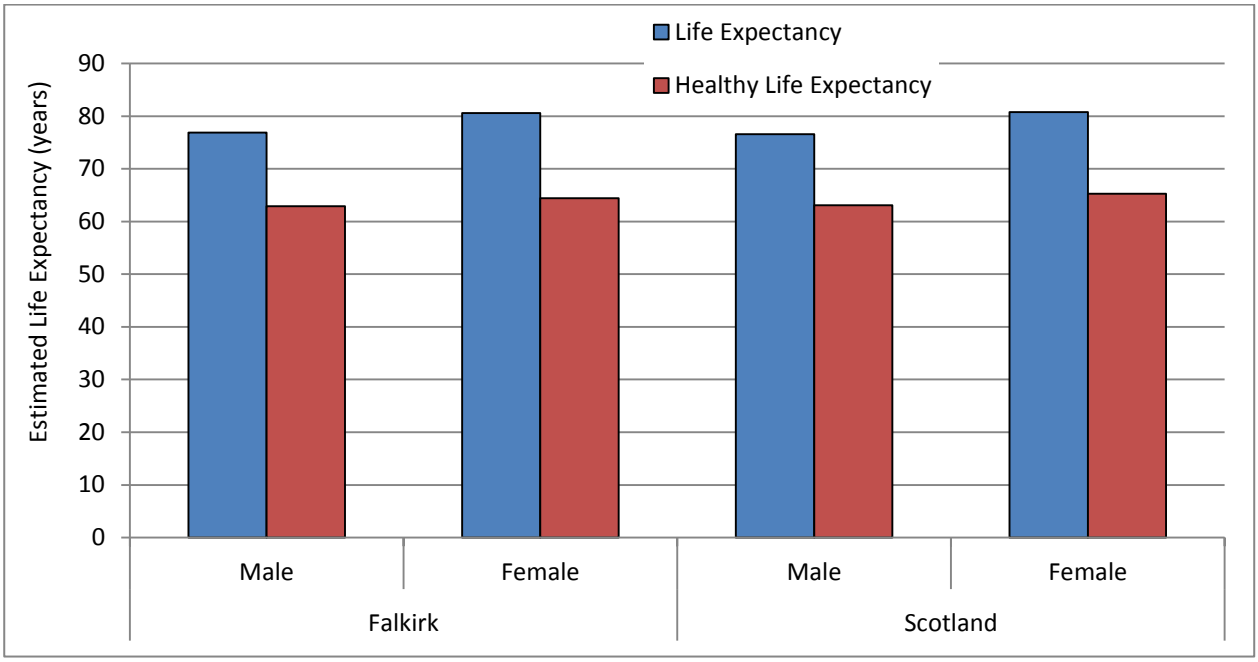
Table 5.2b - Life Expectancy & Healthy Life Expectancy, Falkirk Community Health Partnership and Scotland for the 5-year period 2009-2013

	Falkirk		Scotland	
	Male	Female	Male	Female
Life Expectancy	76.9	80.6	76.6	80.8
Healthy Life Expectancy	62.9	64.4	63.1	65.3
Expected Years "Not healthy"	14.0	16.1	13.5	15.6

Source:
a) National Records of Scotland (NRS) mid-year population estimates (see section 1.2 of the HLE technical paper for further details)
b) NRS death registrations (by year of registration of death)
c) self-assessed health (SAH) from Census 2011.

The estimated years "Not healthy" for the Falkirk population are higher than the Scotland figures and but considerably lower than in some other areas in Scotland.

Figure 5.2b - Life Expectancy & Healthy Life Expectancy, Falkirk Community Health Partnership and Scotland for the 5-year period 2009-2013



Source:
a) National Records of Scotland (NRS) mid-year population estimates (see section 1.2 of the HLE technical paper for further details)
b) NRS death registrations (by year of registration of death)
c) self-assessed health (SAH) from Census 2011.

5.3 Long Term Health Conditions

Long term conditions (LTCs) are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support. LTCs can have a serious impact upon a person's personal life but can also have a serious economic impact on health and social care services. 60 per cent of all deaths are attributable to long term conditions and they account for 80 per cent of all GP consultations (http://www.gov.scot/Topics/Health/Services/Long-Term-Conditions).

As part of the Quality and Outcomes Framework (QOF), GP practices across the UK are funded to keep registers of all of their patients that they know to have certain health conditions. Table 5.3a illustrates the number of patients, in Falkirk, known to GP practices having selected long term conditions as at March 2014 and comparisons with 2012 and 2013.

Table 5.3a - Numbers of patients on selected QOF registers of Falkirk GP practices

QOF register	Numbers as at March 14	% of all practice patients As at March 14	Numbers as at March 13	Numbers as at March 12
Asthma	9,949	6.29	8,743	9,596
Atrial Fibrillation	2,415	1.53	2,086	2,203
Cancer	3,381	2.14	2,808	2,953
CHD (Coronary Heart Disease)	7,362	4.65	6,616	7,478
CKD (Chronic Kidney Disease)	5,662	3.58	4,851	5,288
COPD (Chronic Obstructive Pulmonary Disease)	3,708	2.34	3,130	3,389
CVD (Primary Prevention of Cardiovascular Disease)	4,390	2.77	3,035	2,551
Dementia	1,304	0.82	1,113	1,141
Diabetes	7,984	5.05	6,794	7,279
Epilepsy	1,115	0.70	992	1,097
Heart Failure	1,163	0.73	926	996
Hypertension	23,264	14.70	20,556	22,289
Hypothyroidism	5,308	3.35	4,624	5,014
Learning Disabilities	719	0.45	642	702
LVD (Left Ventricular Dysfunction)	357	0.23	630	702
Mental Health	1,257	0.79	1,095	1,193
Obesity	14,384	9.09	12,981	13,865
Osteoporosis	290	0.18	N/A	N/A
Palliative Care	391	0.25	330	312
Peripheral Arterial Disease	1,338	0.85	N/A	N/A
Rheumatoid arthritis	838	0.53	N/A	N/A
"Smoking" (conditions assessed for smoking)	41,193	26.03	36,189	39,342
Stroke & Transient Ischaemic Attack (TIA)	3,474	2.20	3,030	3,336

Source: Quality and Outcomes Framework (QOF) www.isdscotland.org/qof

The following subsections will look at particular LTCs in more detail:

5.3.1 Dementia

Dementia presents a significant challenge to individuals, their carers and health and social care services across Scotland. As at March 2014 there were 1,304 individuals known to GP practices as having dementia in Falkirk. This equates to 0.82% of all patients registered to a GP practice in Falkirk.

However, it is suspected that dementia is under diagnosed in Scotland. Alzheimer Scotland has produced estimates, by local authority, of the number of people living in Scotland in 2015 with Dementia (Table 5.3.1a).

Table 5.3.1a – Estimated number of people in Falkirk with Dementia in 2015

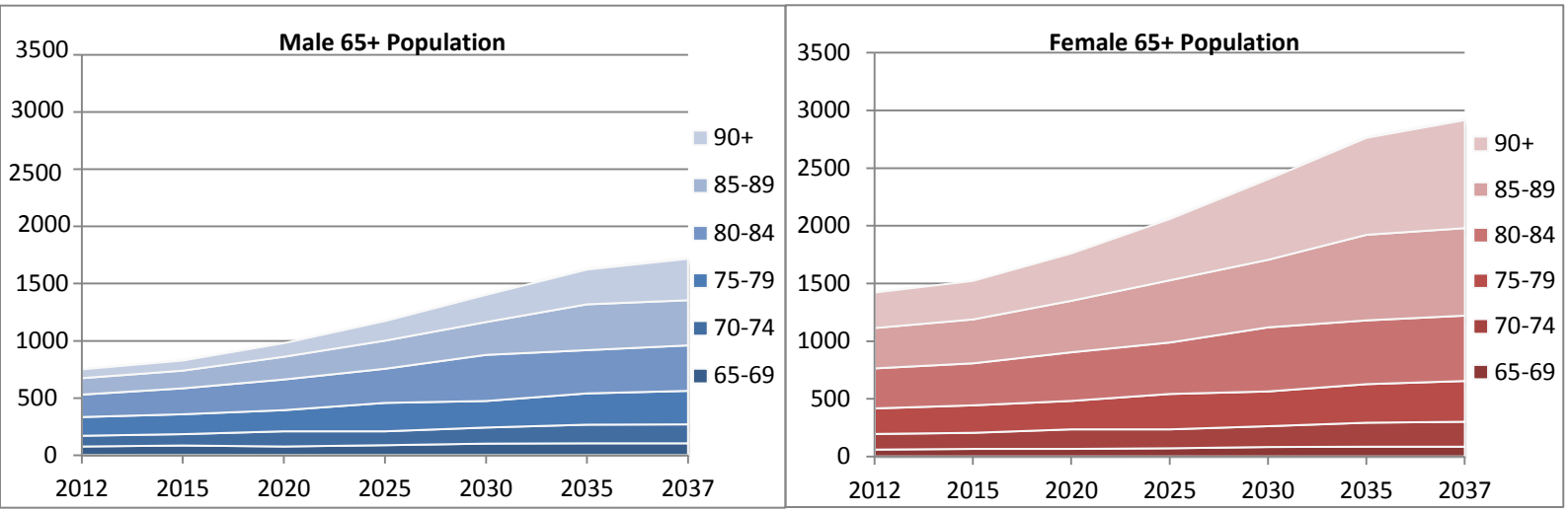
	under 65	65+	Total
Falkirk	95	2,386	2,480

Source: Alzheimer Scotland

If similar prevalence rates for dementia continue to occur we can expect to have significantly more cases of dementia in the local area due to the projected increase in people over the age of 65 to 2037. This is likely to have a significant impact across health and social care services due to the complex nature of care required.

Crude projections have been estimated below using Dementia Prevalence rates from Alzheimer's Scotland and National Records of Scotland population projections. These estimates rely on dementia prevalence remaining the same up to 2037. (Over 60's rates are calculated with prevalence rates from EuroCode[1], for under 60's prevalence rates are from Harvey[2]). These figures not only demonstrate that there will be a lot more people with a dementia if we see the expected increase in older adult population, but also the significant difference in the number of female cases compared to males. This variation can be attributed to higher dementia prevalence rates for females (particularly in the 90+ age group) and the projection that there will be more females aged 90+.

Figure 5.3.1 – Male and Female Dementia Projections for Falkirk, 2012-2037



Source: NRS Population Projections (2012-Based) and Alzheimer's Scotland

[1] Alzheimer Europe (2009) *EuroCoDe: prevalence of dementia in Europe* http://www.alzheimer-europe.org/index.php?lm3=CEE66BE91B37

[2] Harvey R (1998) *Young onset dementia: epidemiology, clinical symptoms, family burden, support and outcome* Imperial College London

5.3.2 Cancer

In 2013 there were 1,665 diagnoses of cancer in Forth Valley. This was a slight increase from the year before, and also meant that the number of registrations in 2013 was the highest it had been in ten years. The number of people diagnosed with cancer is predicted to rise in the future. The risk of developing cancer increases as a person gets older, and this, coupled with an increasing older adult population means that the number of cancer registrations is set to rise.

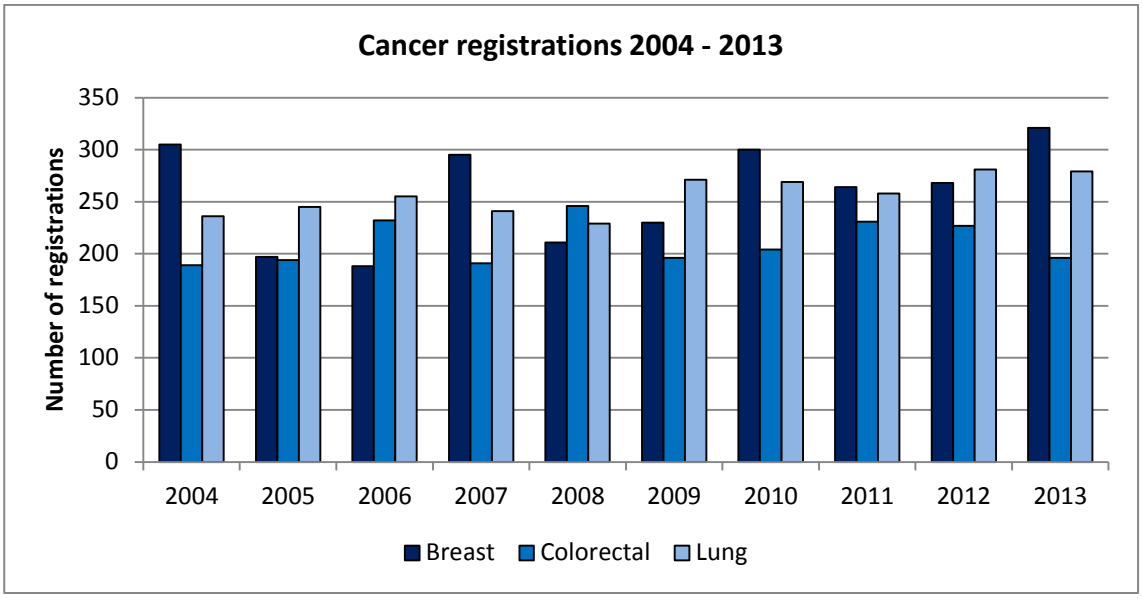
Table 5.3.2 - Cancer registrations in NHS Forth Valley from 2004-2013

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
All cancers	1,611	1,445	1,530	1,512	1,606	1,648	1,660	1,605	1,624	1,665

Source: Scottish Cancer Registry, ISD Scotland

Figure 5.3.2 shows the number of registrations for breast, colorectal and lung cancer from 2004 to 2013. These three cancers account for approximately 45% of all cancer diagnoses in NHS Forth Valley.

Figure 5.3.2 Cancer registrations in NHS Forth Valley from 2004-2013



Source: Scottish Cancer Registry, ISD Scotland

The rate of cancer registrations in NHS Forth Valley is below the Scottish average although it is not significantly so. In 2013, the crude rate across Scotland was 630 per 100,000 people, in NHS Forth Valley it was 556 per 100,000 people.
The mortality rate for cancer in Forth Valley is very close to the rate for Scotland as a whole. In 2013, the figure for Scotland was 296 per 100,000 people, and in Forth Valley it was 290 per 100,000 people. The mortality rate in Forth Valley was relatively stable between 2004 and 2013; it was at its lowest in 2008 at 259, and highest in 2012 when it was 309. Despite an overall increase in the number of new registrations of people with cancer, they are able to live longer with the disease and this affects the mortality rate.

Cancer incidence in Scotland is projected to rise by a third over the next 10 years. In the five years between 2023 and 2027, it is estimated that there will be over 204,000 new cases of cancer across the whole country.
Presently, about 5% of new cancer diagnoses in Scotland are registered in NHS Forth Valley and if this was to continue to be true by 2027, it would mean that there would be over 2,100 new cancer cases in the area annually.

5.4 Projected Long Term Conditions

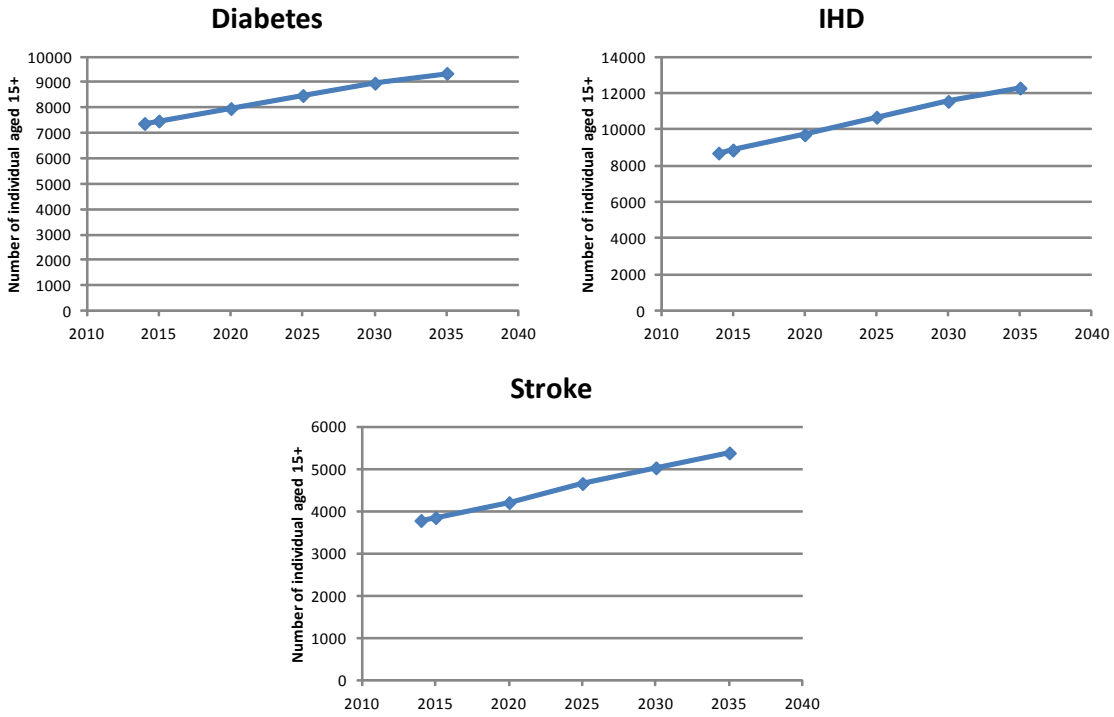
Forecasting disease prevalence can provide information regarding where resources might be needed in the future or where preventative interventions could reduce disease. There are a range of factors which influence the prevalence of disease. These are:

- Age - in general most conditions are age-related. Even if other risk factors are decreasing the effect of demographic change can be overwhelming.
- Genes – most diseases have at least some genetic component.

- Environment – physical and social.
- Deprivation – even accounting for differences in behaviour, most diseases are deprivation related.
- Health related behaviours.
- Underlying mental wellbeing/resilience/self-efficacy/confidence/motivation.
- Real engagement with life in general and personal wellbeing in particular.
- Options for intervention and organisation of this.

It is easy to assume that disease trends will continue. However the trends could change. To apply a crude method consisting of application of age-specific prevalence rates to Falkirk population projections gives the forecast demonstrated in Figure 5.4a, for Diabetes, Ischaemic Heart Disease (IHD) and Stroke. The figures show an increase in the forecast prevalence of disease. The assumption has been made that the age-specific prevalence remains constant.

Figure 5.4 – Estimated projections of Diabetes, IHD and Stroke in Falkirk.

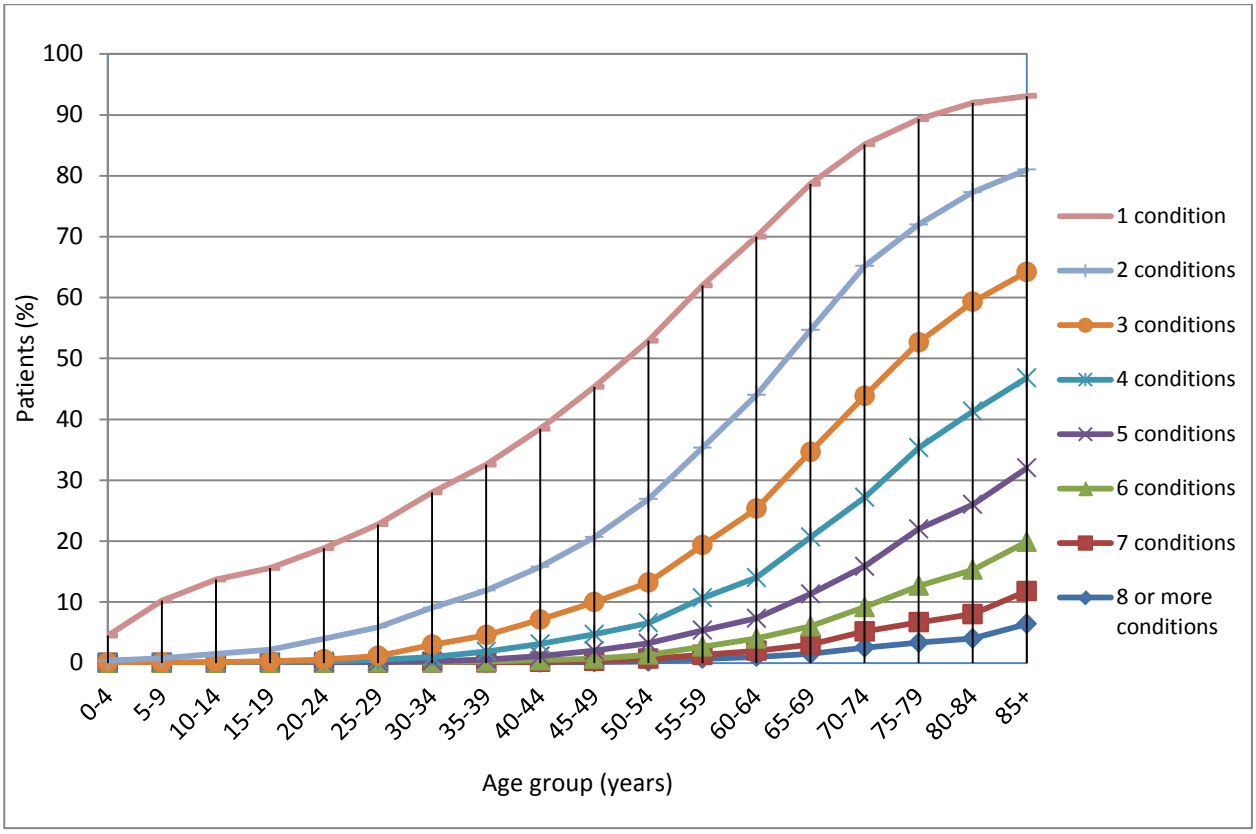


Source: Scottish Health Survey (prevalence rates) and NRS population Estimates

5.5 Multi-Morbidity

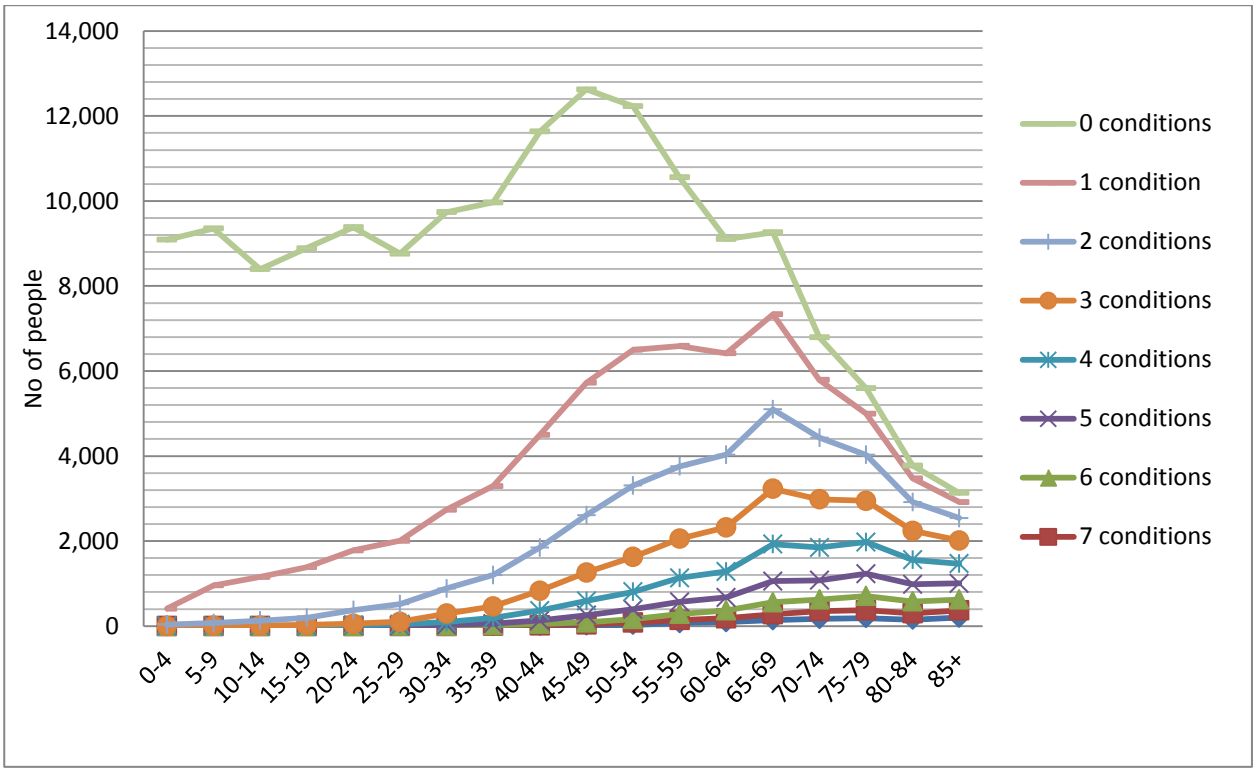
In light of an ageing population, Falkirk is facing more people with multiple long term conditions (also referred to as multi-morbidities). Figure 5.5a demonstrates that patients have more conditions as they age. The estimated number of patients within Falkirk with various numbers of long term conditions is forecasted to increase between 2015 (figure 5.5b) and 2037 (figure 5.5c).

Figure 5.5a – Estimated number of conditions by age group.



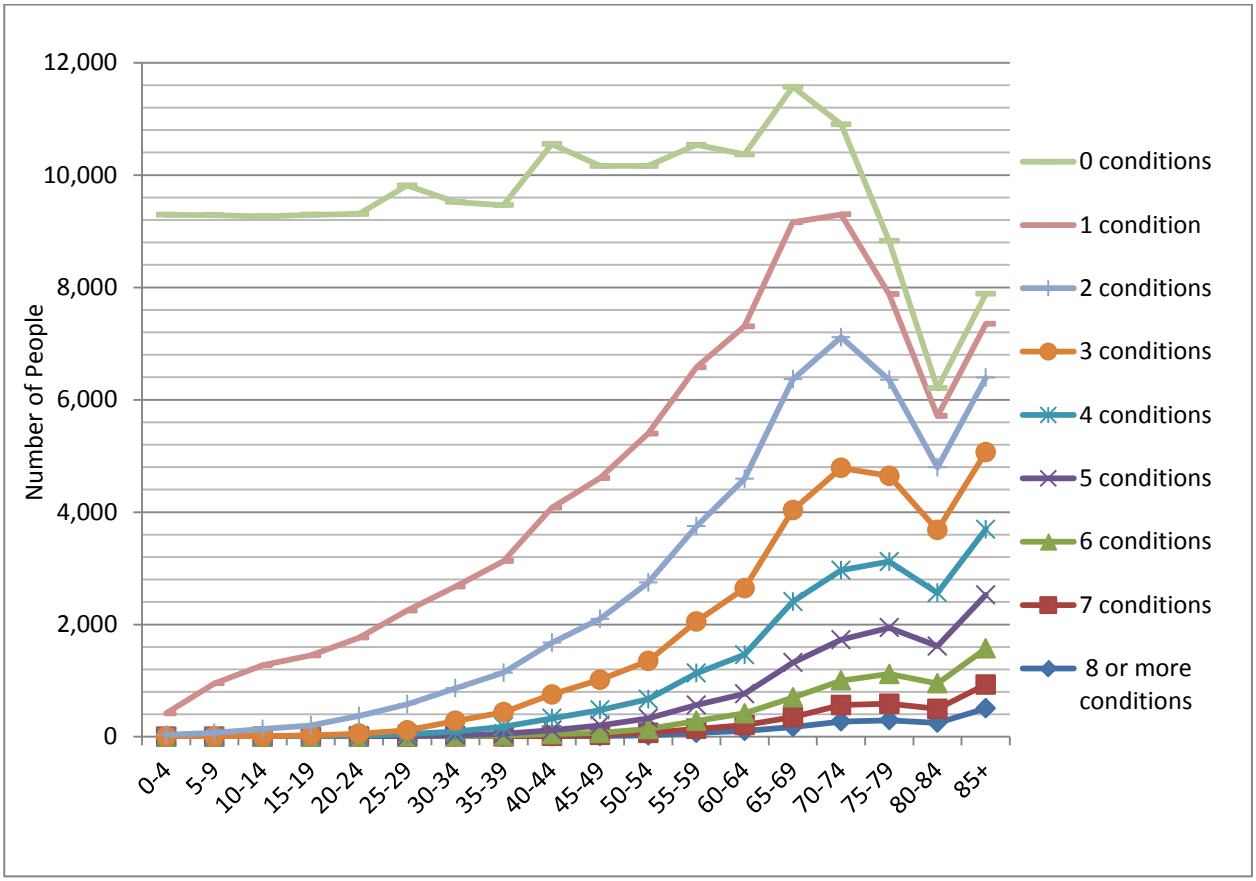
Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer

Figure 5.5b - Estimated number of people within Falkirk with various numbers of conditions (2015)



Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population estimates for Falkirk

Figure 5.5c - Estimated number of people within Falkirk HSCP with various numbers of conditions (2037)



Source: The Challenge of Multimorbidity in Scotland, Professor Stewart Mercer applied to NRS population projections for Falkirk.

The multiple morbidities demonstrated in Figure 5.5b and 5.5c bring both person-centred as well as financial challenges (Christie, 2011). Patients with several complex long term conditions are currently making multiple trips to hospital clinics to see a range of uncoordinated specialist services. A proposed way forward could be to look at developing new pathways and guidelines away from the current disease specific models to generic approaches focused on the holistic needs of patients (Lunt, 2013, p. 17). The latter ties in with the 2020 Vision and the values of designing the services around the patient. For example, we need to make sure that people do not have to unnecessarily attend five different, uncoordinated specialists for the five different conditions that they have.

5.6 High Resource Individuals

The term 'High Resource Individuals' (HRIs) refers to the population group who account for 50% of the total health expenditure. All service users are ranked highest to lowest in terms of their use of health resources and those at the top who collectively account for 50% of expenditure are categorised as High Resource Individuals.

ISD Scotland have undertaken cost per patient analysis on inpatient and day case hospital admissions (including all acute specialties, maternity, geriatric long stay inpatient care, and psychiatric inpatient care), A&E attendances, consultant led outpatient clinics and community prescribing.

A high resource individual in one area might not fall into the same category at Scotland level or indeed another local area. Further analysis, and therefore a greater understanding, of this cohort of individuals could lead to more effective and efficient planning and delivery of services to high resource individuals in the community.

Analysis for the financial year 2012/13 reported that **2,934** individuals accounted for 50% of health expenditure in the Falkirk area. There were 130,435 patients for that same period in Falkirk meaning that **2.2%** of patients accounted for 50% of health expenditure. Table 5.6a shows the figures relating to HRIs in Falkirk.

Table 5.6a – Breakdown of all activities for HRIs and all patients in Falkirk 2013/14

Financial Year 2013/14		Falkirk
Number of patients	HRIs	2,934
	All Patients	130,435
	% HRI	2.2%
Number of bed days	HRIs	149,009
	All Patients	189,478
	% HRI	78.6%
Episodes/Attendances[1]	HRIs	204,060
	All Patients	2,901,251
	% HRI	7.0%
Cost (£)	HRIs	£72,869,044
	All Patients	£72,878,302
	% HRI	50%
Cost per capita (£)	HRIs	£24,836
	All Patients	£1,117

Source: The Health and Social care dashboard – ISD Scotland

1 - Episodes and attendances apply to inpatient, day case, outpatient and A&E activity.

This same cohort of individuals (2.2%) accounted for 78.6% of the bed days in 2013/14 and 7.0% of episodes/attendances. High resource individuals pose different issues for different specialities, for example, this cohort of patients account for 96% of Mental Health bed days in Falkirk but only 10% of community prescribing expenditure. High resource individuals are predominantly older people and Table below shows rates of HRI's by age band.

Table 5.6b – Breakdown of HRIs by age group in Falkirk, 2013/14

	Age 18-64	Age 65+
Number of HRIs	1081	1712
All Service Users	79,746	26,681
Rate per 1,000 population	13.6	64.2

Source: The Health and Social care dashboard, ISD Scotland

5.7 Disability

Learning disabilities

The Learning Disabilities Statistics Scotland Report 2014 looked at the numbers of adults known to have learning difficulties across Scotland (adults with learning disabilities who are known to local authorities from contact in the last 3 years). The report also looked at the accommodation, education and employment situation for people with learning difficulties. In 2014 there were 990 people with learning disabilities known to the Falkirk local authority. The rate per 1000 population is shown in Table 5.7a below.

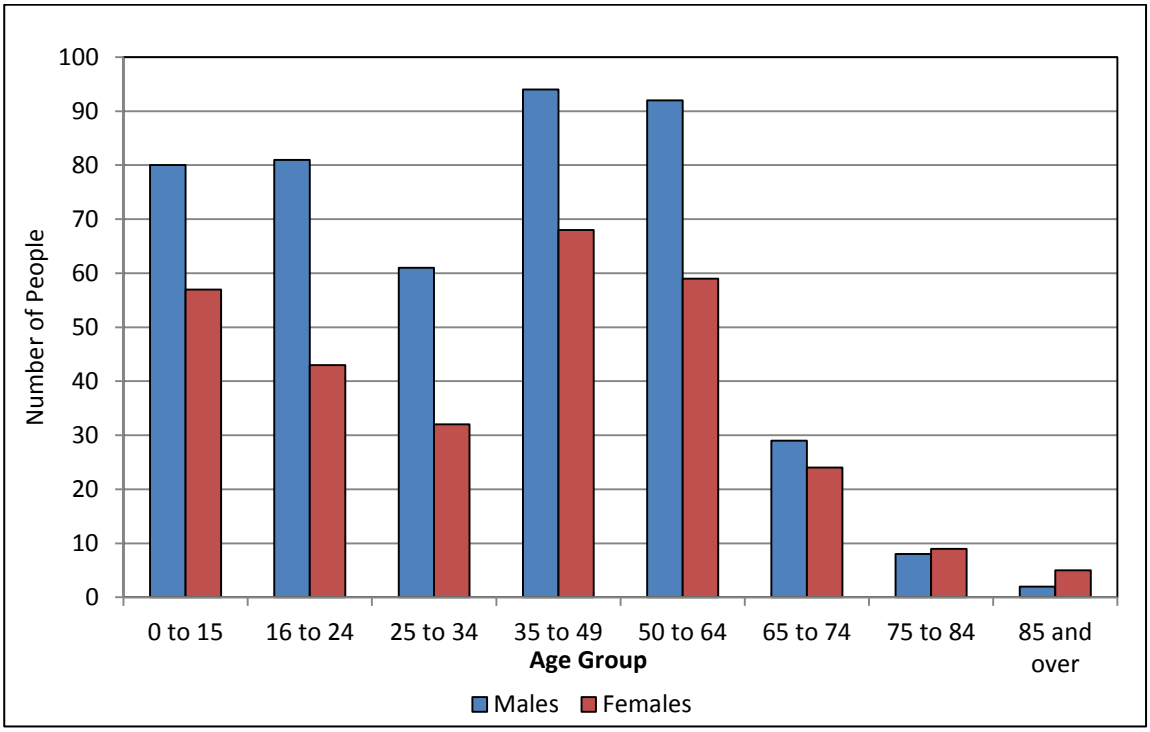
Table 5.7a Number of adults with learning disabilities known to local authorities per 1,000 population 2010 - 2014

Area	2010	2011	2012	2013	2014
Falkirk	6.0	5.3	5.6	5.8	7.7
Scotland	6.4	6.0	6.0	5.9	6.0

Source: Learning Disabilities Statistics Scotland, National Records of Scotland

The chart below shows the number of people who were recorded as having a learning disability by sex and age group at the time of the Census in 2011. The age group with the highest number of people with a learning disability for both sexes is the 35-49 age group. The numbers fall slightly for those aged 59 to 64 but drop by 68% for males and 59% for females in the next age group, those aged 65 to 74. The number of people declines steadily for both men and women after age 65; there were only a small number of people aged 85 and over in the Falkirk area with a learning disability in 2011.

Figure 5.7b - Number of people in Falkirk with a learning disability by age and sex, 2011



Source: Scotland Census 2011

Life expectancy

Due to significant developments in health care life expectancy of people with learning disabilities has improved considerably, in the 1930's life expectancy for a person with Down's syndrome was seven years, but it is now in the region of 50 to 60 years. Still people with learning disabilities are 58 times more likely to die before the age of 50 than the rest of the population (Emerson and Baines 2010)[2].

Autism

In 2014, 14.3% of those known to the local authority with a learning disability were on the Autism Spectrum (this is likely an under-representation of Autism numbers as it's possible to be on the autism spectrum without having a learning disability).

Life Circumstances

Table 5.7b provides a summary of the key figures from the 2014 report by the Scottish Consortium of Learning Disability (SCLD). The proportion of people with learning disabilities who live in mainstream accommodation in Falkirk is substantially lower in Scotland, additionally there are a greater percentage of people with learning disabilities who live in a Falkirk Care home or supported accommodation. Figures for employment and day centre attendance also fall below the Scotland level, so there is scope for improvement to allow more people with learning disabilities to live independently in the community.

Table 5.7b – Summary of Learning Disability Statistics, Falkirk and Scotland 2014

	Falkirk	Scotland
Live with a Family carer (%)	31.6	34.7
Living in mainstream accommodation (with or without support) (%)	51.1	60.3
Living in Supported Accommodation or a Registered Adult care home (%)	23.8	17.6
In employment or training for employment (TFE) (%)	10.2	13.6
Attends a local day centre (%)	18.1	20.0

Source: Learning Disability Statistics Scotland, 2014

Physical disabilities

http://news.scotland.gov.uk/News/Taking-action-on-disability-1cb3.aspx

The Scottish Government has recently announced (September 2015) a plan to tackle inequality and advance disabled people's human rights.

In healthcare some of the key aspects of the plan are:

[2] Health Inequalities & People with Learning Disabilities in the UK: 2010 - Eric Emerson and Susannah Baines

- More support for independent living for all disabled people who will have more say about how their support will be managed and provided
- Health, social care and other support services working together to remove the barriers faced by all disabled people
- Increased opportunities for disabled people to be involved in community development and service delivery

In the 2011 Census there were over 10,800 people in Falkirk recorded as having a physical disability.

Table 5.7b - Number of people with a physical disability in Falkirk

Area	Physical disability	Percentage of total population
Falkirk	10,868	7.0%

Source: 2011 Census

The majority of those who have a physical disability in Falkirk are over the age of 50, 80% of the total can be found in this age group. Table 5.7c below also shows that the proportion of those with a physical disability increases as people age. Only 1.2 % of the population aged 16-24 had a physical disability in 2011, compared to 32.8% for those aged 85 and over.

Table 5.7c - Number of people in Falkirk with a physical disability by age and sex

Age	Male	Female	Total	Percentage of total with physical disability	Percentage of age group with physical disability
0-15	122	112	234	2.2%	0.8%
16-24	105	98	203	1.9%	1.2%
25-34	163	161	324	3.0%	1.7%
35-49	678	732	1,410	13.0%	3.9%
50-64	1,540	1,689	3,229	29.7%	10.6%
65-74	1,194	1,279	2,473	22.8%	17.6%
75-84	846	1,235	2,081	19.1%	24.6%
85+	257	657	914	8.4%	32.8%

Source: 2011 Census

5.8 Mental Health and Wellbeing

http://www.gov.scot/Topics/Health/Services/Mental-Health/Strategy

Mental health and wellbeing strategies and targets were established by the Scottish Government in 2012 to cover the period 2012-2015. Among the key areas of change outlined were:

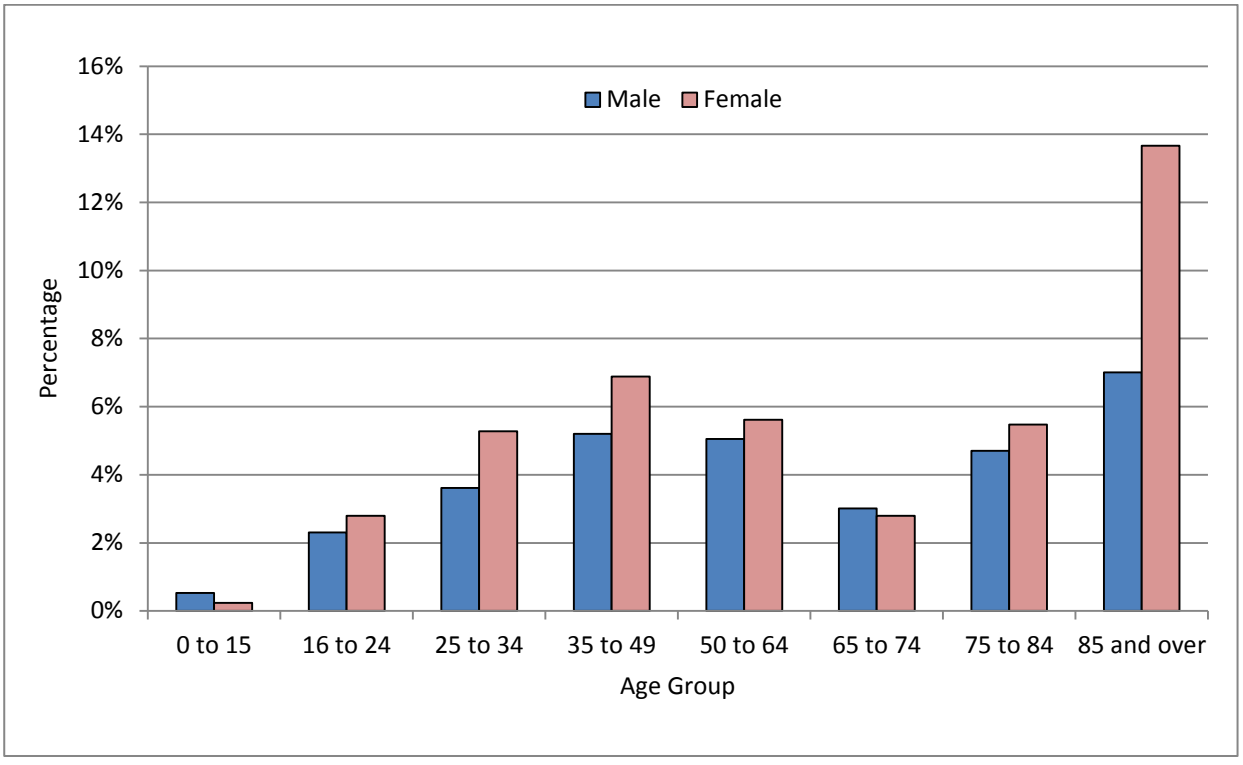
- Community, inpatient and crisis mental health services
- Work with other services and populations with specific needs.

A well functioning mental health system has a range of community, inpatient and crisis mental health services that support people with severe and enduring mental illness. Across Scotland there were variations in the pace of change, the delivery and the models of service for mental health as health boards attempted to move from predominantly inpatient services to services where care and treatment can be delivered mostly in the community.

Health issues that are included within the area of mental health range from common problems such as dementia, stress and depression, to more severe issues like schizophrenia, bipolar affective disorder and other psychoses.

In the 2011 Census, 6,375 people in Falkirk identified themselves as having a mental health condition. This is 4.1% of the total population. The distribution of this group by age group and sex is shown in Figure 5.8a.

Figure 5.8a - Percentage of population with long term mental health condition in Falkirk by age group and sex 2011



Source: 2011 Census

Further information on mental health and illnesses comes from the Quality and Outcomes Framework (QOF) for general practices. Participation by general practices in the Quality and Outcomes Framework is voluntary but it measures achievement for general practitioners against a range of evidence-based indicators, and includes prevalence data for a range of conditions.
A crude prevalence rate of the number of people in Falkirk and Scotland with a mental health condition is shown in Table 5.8a. It shows that in Falkirk the rate of people with a new diagnosis of depression is higher than the Scottish rate but that the rate for schizophrenia, bipolar affective disorder and other psychoses is lower.

Table 5.8a - Percentage of people with mental health issues in Falkirk and Scotland 2014/15

Area	Depression (%)	Schizophrenia, Bipolar affective disorder and other psychoses (%)
Falkirk	7.19	0.81
Scotland	6.28	0.88

Source: QOF, ISD Scotland

Depression
Estimating the true prevalence of Depression remains a challenge, but we can gain some insight from the QOF data. Historical data available on the GP QOF should be interpreted with caution as there were changes to the way depression was defined in 2012/13 which resulted in a drop in the prevalence.
Table 5.8b below contains the past 4 years data and clearly shows the drop prevalence in 2012/13 due to the introduction of a new definition for Depression. It is uncertain whether the increase over the past two years is a down to a familiarisation with the new definition or a true rise in the prevalence of depression. Nonetheless, it is important to note that over the past three years there has been a larger percentage of the population with Depression in Falkirk than Scotland.

Table 5.8b - Percentage of people Depression in Falkirk and Scotland 2014/15

	Prevalence of Dementia (%)			
Area	2011/12	2012/13	2013/14	2014/15
Falkirk	10.90	5.89	6.64	7.19
Scotland	9.02	5.31	5.81	6.28

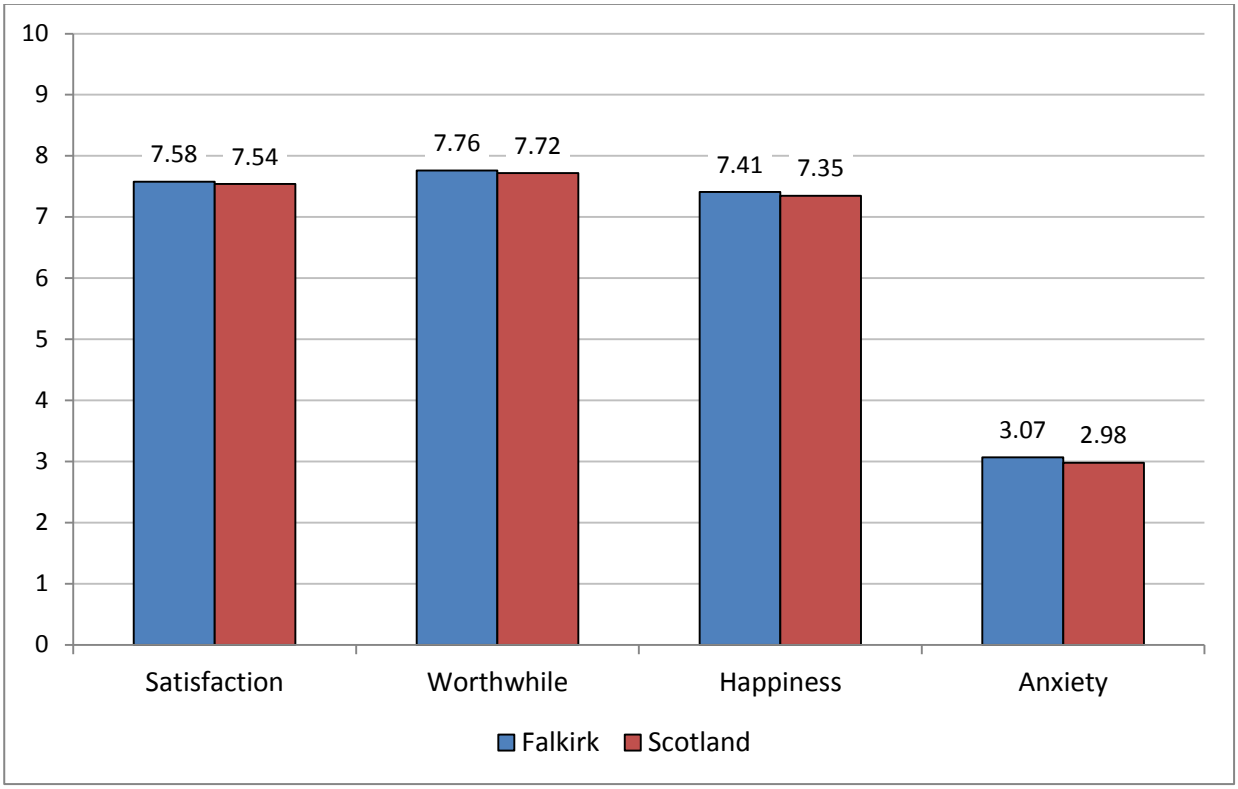
Source: QOF, ISD Scotland

Wellbeing
Wellbeing is linked to mental health in that it attempts to measure how happy and content people are in their everyday lives. This data has been collected by the Office for National Statistics as part of their UK Annual Population Survey since 2011. Four questions are

asked concerning wellbeing and are rated on a scale of 0 to 10.
These are:
1) Overall, how satisfied are you with your life nowadays? Where 0 is 'not at all satisfied' and 10 is 'completely satisfied'.
2) Overall, to what extent do you feel the things you do in your life are worthwhile? Where 0 is 'not at all worthwhile' and 10 is 'completely worthwhile'.
3) Overall, how happy did you feel yesterday? Where 0 is 'not at all happy' and 10 is 'completely happy'.
4) Overall, how anxious did you feel yesterday? Where 0 is 'not at all anxious' and 10 is 'completely anxious'.

The average scores for Falkirk and Scotland between 2011 and 2014 are shown in Figure 5.8b below. Falkirk has a marginally better average score than the whole of Scotland except in the anxiety score where it is only slightly worse.

Figure 5.8b - Wellbeing scores 2011-2014



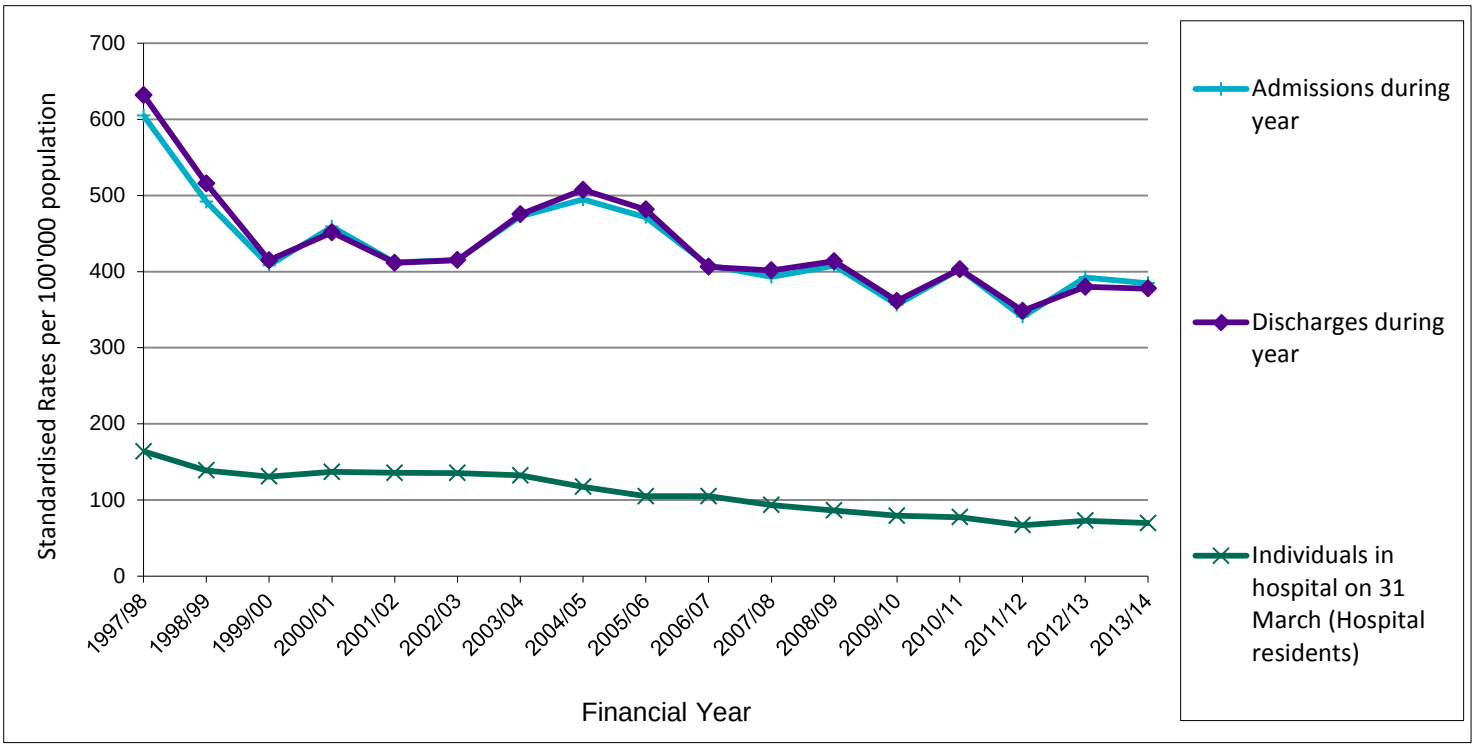
Source: Office for National Statistics

Mental Health Inpatients

Mental health inpatient stay data is recorded by ISD Scotland on the SMR04 database, data is available back to 1997/98 although there is some fluctuation in the rate (see Figure 5.8c), there is a clear downwards trend for mental health inpatient admissions and discharges in Falkirk. In alignment with this trend, the number of individuals resident in hospital at 31st March has also steadily decreased over the years.

These patterns reflect the shift in recent years in the care of people with mental health problems away from inpatient treatment towards various forms of care in the community e.g. community mental health teams and GP services.

Figure 5.8c - Mental health admissions and discharges in Falkirk, 1997/98 to 2013/14



* Admissions and Discharges in this chart refer to episodes rather than patients, a patient can have a number of episodes before being discharged home. If a patient is moved from one speciality to another, this will count as a discharge from the original speciality and an admission to the new speciality.

Source: Mental Health Hospital Inpatient Care Report (SMR04) (ISD)

5.9 Premature Mortality

Premature mortality is a measure of the number of deaths that occur under the age of 75 and can be used as an indicator of poor health of a population. The fewer deaths that occur under the age of 75, the healthier the population is judged to be. In 2014 there were 578 deaths under the age of 75 across Falkirk, 38.1% of the total deaths. This is marginally higher than the Scottish figure in 2014, which was 36.8%.

Table 5.9a Deaths under the age of 75, 2014

Area	Male	Female	Total
Falkirk	330	248	578

Source: National Records of Scotland

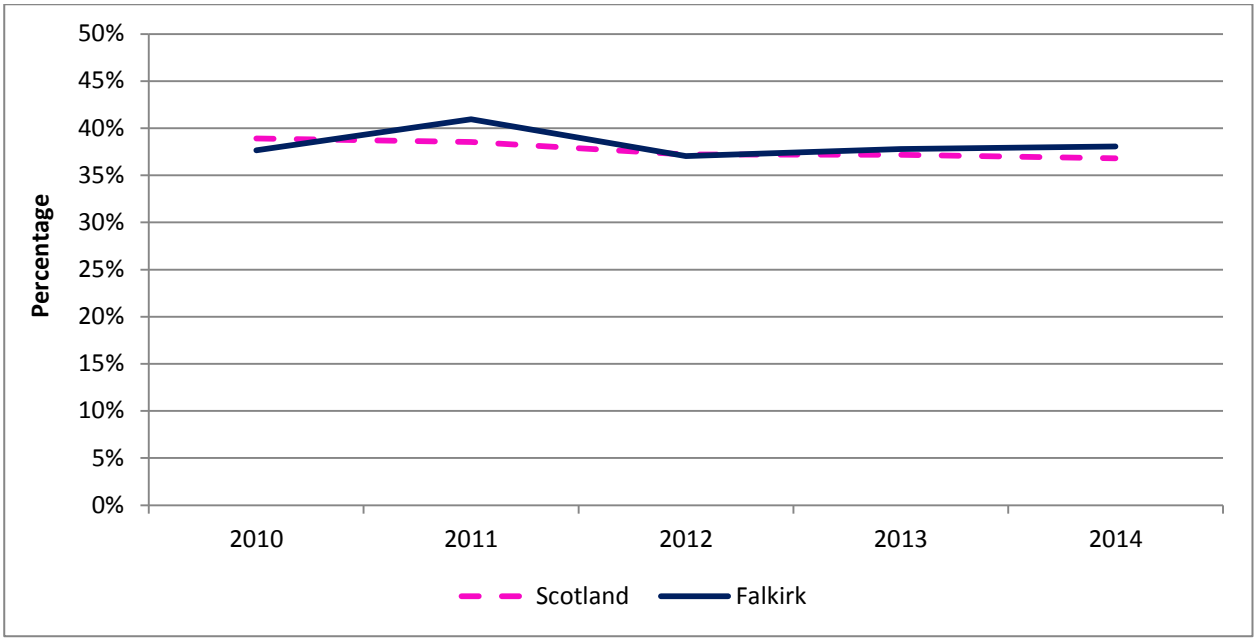
Table 5.9b Deaths under the age of 75 as percentage of all deaths, 2014

Area	Deaths under age 75	Total Deaths	% Deaths under age 75
Falkirk	578	1,519	38.1%
Scotland	19,961	54,239	36.8%

Source: National Records of Scotland

The percentage of deaths occurring under the age of 75 has been gradually decreasing across Scotland between 2010 and 2014. Over the same time period the percentage of deaths under 75 in Falkirk rose initially before falling. In 2014, it was slightly higher than the 2010 figure, but not significantly different than the Scotland percentage.

Figure 5.9 - Deaths under age 75 as percentage of all deaths 2010-2014, Falkirk and Scotland



5.10 Cause of Death

In 2014 there were 1,519 deaths registered in Falkirk. 57.1% of those deaths were caused by cancer and diseases of the circulatory system (including cardiovascular disease and strokes).

Table 5.10a - Number and percentage of deaths in Falkirk by cause 2014

Cause of death	N	%	Scotland %
Cancer	462	30.4%	29.8%
Mental and behavioural disorders	132	8.7%	7.3%
Diseases of the nervous system	68	4.5%	4.8%
Diseases of the circulatory system	406	26.7%	27.7%
Diseases of the respiratory system	198	13.0%	12.4%

Diseases of the digestive system	68	4.5%	5.4%
External causes	62	4.1%	4.7%
Other	123	8.1%	7.9%
Total	1,519	100.0%	100.0%

Source: National Records of Scotland

The percentage of all deaths caused by cancer and diseases of the circulatory system in Falkirk has not significantly changed in the years between 2010 and 2014.

Table 5.10b - Number and percentage of deaths caused by cancer and diseases of the circulatory system in Falkirk between 2010 and 2014.

Falkirk	2010		2011		2012		2013		2014	
Cause of death	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Cancer	443	29.4	444	28.7	509	32.3	461	29.1	462	30.4
Diseases of the circulatory system	459	30.5	497	32.1	439	27.9	452	28.6	408	26.7

Source: National Records of Scotland

5.11 Population Health Considerations/Implications

- Assuming age-specific prevalence remains constant for LTCs it is projected we will see greater numbers of individuals with these conditions as the proportion of older adults in the population rises. This will impact on both health and care services.
- It is also projected that the number of people with multi-morbidities will increase. This means there will be more individuals attending hospital with complex needs. Currently services are un-coordinated and may mean people are making multiple visits to hospital. A re-organisation of services to ensure a more joined up approach could help to reduce the number of visits to a hospital and improve efficiency in line with Outcome 9.
- Currently around 2% of the population account for 50% of the hospital and GP prescribing spend. Gaining a better understanding about this cohort of people could allow for more effective planning and delivery of services and an improved service user experience.

6. Current Provision of Health and Social Care Services

6.1 Workforce

In order to aid strategic planning of the integration of health and social care services it is important to understand more about the workforce.

A data collection exercise was undertaken in order to consolidate information about the in-scope workforce for health and social care integration in Falkirk. Data was gathered as at 30th September 2015.

Table 6.1a below provides an overview of the staff relevant to the Falkirk Health and Social Care Integration Partnership.

Table 6.1a - Number of staff (Headcount and WTE)

Employing Body	Headcount	WTE/FTE
Falkirk Council	1017	780.6
NHS Forth Valley	2484	2086.3

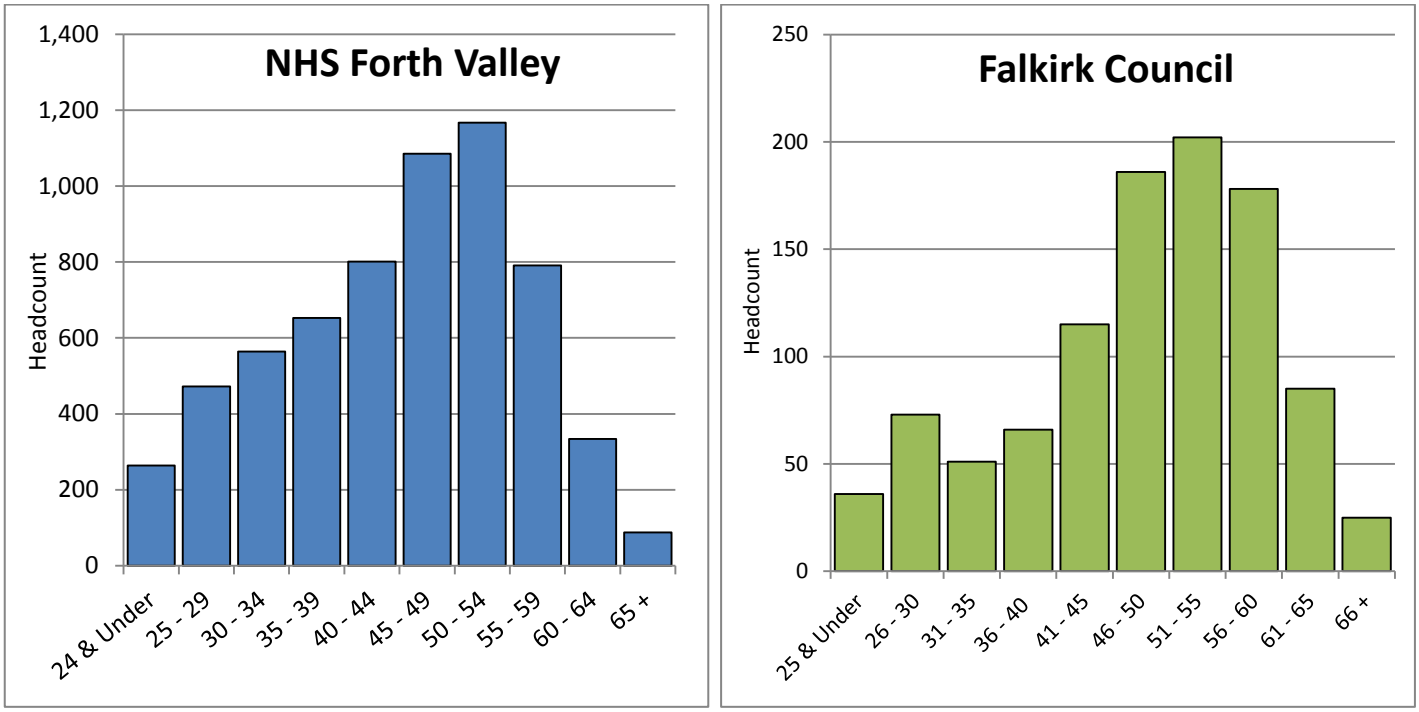
Source: Forth Valley Workforce Project

***Note – Forth Valley headcount/WTE refers to all staff and not just those considered relevant to the Falkirk population. The NHS Forth Valley figures refer to the workforce covering Falkirk, Stirling and Clackmannanshire.

Age Profiles

Age of the workforce must be considered to ensure that planned future services are sustainable. Although it was not possible to gather NHS and Local Authority workforce age data and group under the same age bandings (age bands have been aligned as best possible), the figure below shows a similar picture on both sides. The majority are aged between 45 – 60 years, symbolising a predominantly ageing workforce. In NHS forth Valley 48.9% of the workforce are aged 45-59, while 55.7% of the council workforce fit into the 46-50 age bracket.

Figure 6.1a – 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.

Information is not currently available on the size and profile of the workforce not employed by NHS Forth Valley or Falkirk Council but who provide care through private organisations. However, this is an important part of care delivery and it is recommended that future versions of this document consider the external workforce.

6.2 GP Services

General practitioner and primary care services are an integral aspect of the provision of healthcare. In 2014 in the Falkirk area there were 26 practices served by 132 General Practitioners.

Table 6.2a Number of GPs in Falkirk 2006-2014

Number of GPs (All GPs, headcount)	2006	2007	2008	2009	2010	2011	2012	2013	2014
	109	118	122	123	120	124	129	132	132

Source: ISD Scotland

The number of GP's in Falkirk has risen considerably over the past 9 years, however this only gives part of the picture as GP's are increasingly working fewer sessions than before and there are a substantial number of GP vacancies in the Falkirk area.

In 2014, the average practice size in Falkirk was 6,108 people.
Two practices in Falkirk served areas where approximately 40% of the population were living in datazones defined as the 15% most deprived. These were Slamannan Medical

Practice and Carron Medical Centre. The practice in Slamannan is the only rural practice in the Falkirk area with 98% of the population living in a rural location, and in July 2015 it was operating under a 2C contract, which meant that it was being run by the health board.

The age of the practice population is rising and in 2014 Falkirk had a similar percentage of the practice population aged 65 and above to the average figure for Scotland.

Table 6.2b - Percentage of practice populations aged 65 plus - 2010 and 2014

Area	% of practice population aged 65+	
	2010	2014
Falkirk	15.7%	17.3%
Scotland	15.9%	17.2%

Source: ISD Scotland

6.3 Unscheduled Care

Unscheduled care is the unplanned treatment and care of a patient usually as a result of an emergency or urgent event. Most of the attention on unscheduled care is on accident and emergency attendances, and emergency admissions to hospital. The Scottish Government has made unscheduled care an important area of focus for the health service in Scotland, with reducing waiting times in A&E and reducing the number of emergency admissions as key targets.

6.3.1 Emergency Department Attendances

Since July 2011, Clackmannanshire, Stirling and Falkirk have been served by a single Accident and Emergency department at the Forth Valley Royal Hospital in Larbert. At this time the former A&E department in Stirling became a minor injury unit in Stirling Community Hospital. This provides minor injury services across the health board for people in Clackmannanshire, Falkirk and Stirling between 09:00 and 21:00 hours, 7 days a week. In June 2015, around 79.1% of accident and emergency attendees in NHS Forth Valley were at the A&E department. In June 2011, the month prior to the new structure being established, 76.9% of emergency attendances were to the A&E department.

The average monthly attendance at an emergency department between 2007 and 2015 rose from 5828.2 in 2007 to 6340.2 by June 2015. This represents an 8.8% increase in the average monthly attendance over the time period.

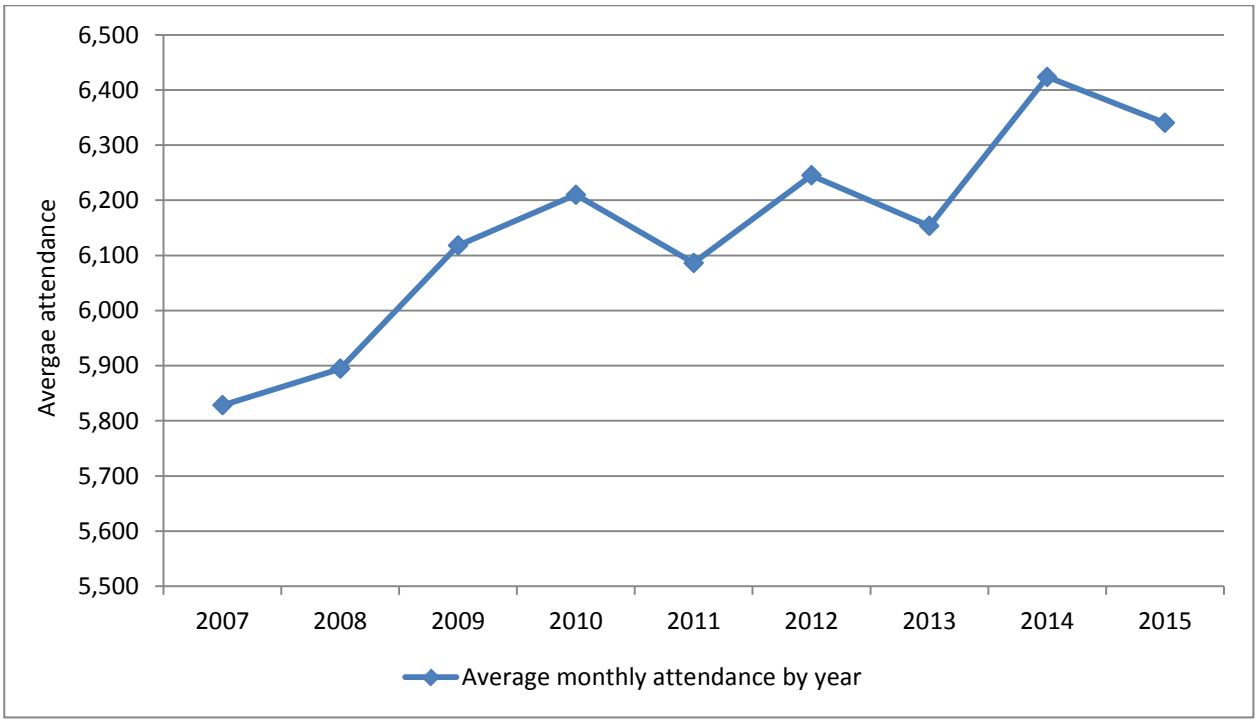
Table 6.3.1b - Average monthly attendance at emergency department (A&E and MIU) by year

Year	Average monthly attendance
2007 (Jul-Dec)	5,828.2
2008	5,894.3

2009	6,117.9
2010	6,209.8
2011	6,086.3
2012	6,244.9
2013	6,153.4
2014	6,423.4
2015 (Jan-Jun)	6,340.2

Source: ISD Scotland

Figure 6.3.1c - Average monthly attendance at emergency department by year



Source: ISD Scotland

The average monthly attendance at the A&E department at Forth Valley Royal Hospital had risen from 4603 in 2011 to 5023 by June 2015. This is an increase of 9.1%. During the same period the percentage of people who met the 4 hour waiting times target each month ranged from a high of 97% in February 2014 to a low of 81.2% in December 2014.

6.3.2 Emergency Admission to Hospital

The number of emergency admissions to hospital has risen in the years between 2004/5 and 2013/14. Despite this, the rate of emergency admissions to hospital (per 100,000 population) in the Falkirk area has been lower than the rate for Scotland. *Note - the figures for admissions are based on the person's home postcode.*

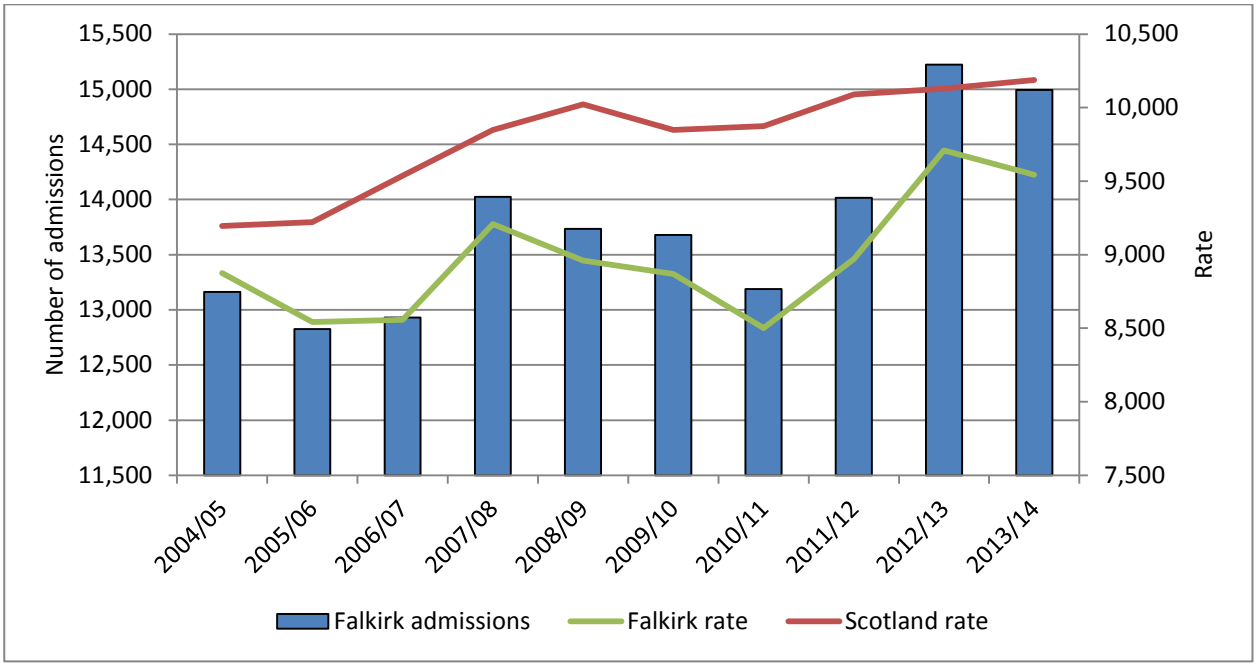
Table 6.3.2a Emergency admissions to hospital - Falkirk 2004/05 to 2013/14

Local Council Area	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Falkirk admissions	13,163	12,825	12,931	14,025	13,734	13,678	13,189	14,016	15,223	14,995
Falkirk rate (per 100,000 pop.)	8,876	8,543	8,558	9,208	8,959	8,870	8,501	8,970	9,709	9,542

Scotland rate (per 100,000 pop.)	9,196	9,222	9,537	9,849	10,021	9,849	9,874	10,090	10,130	10,188

Source: ISD Scotland

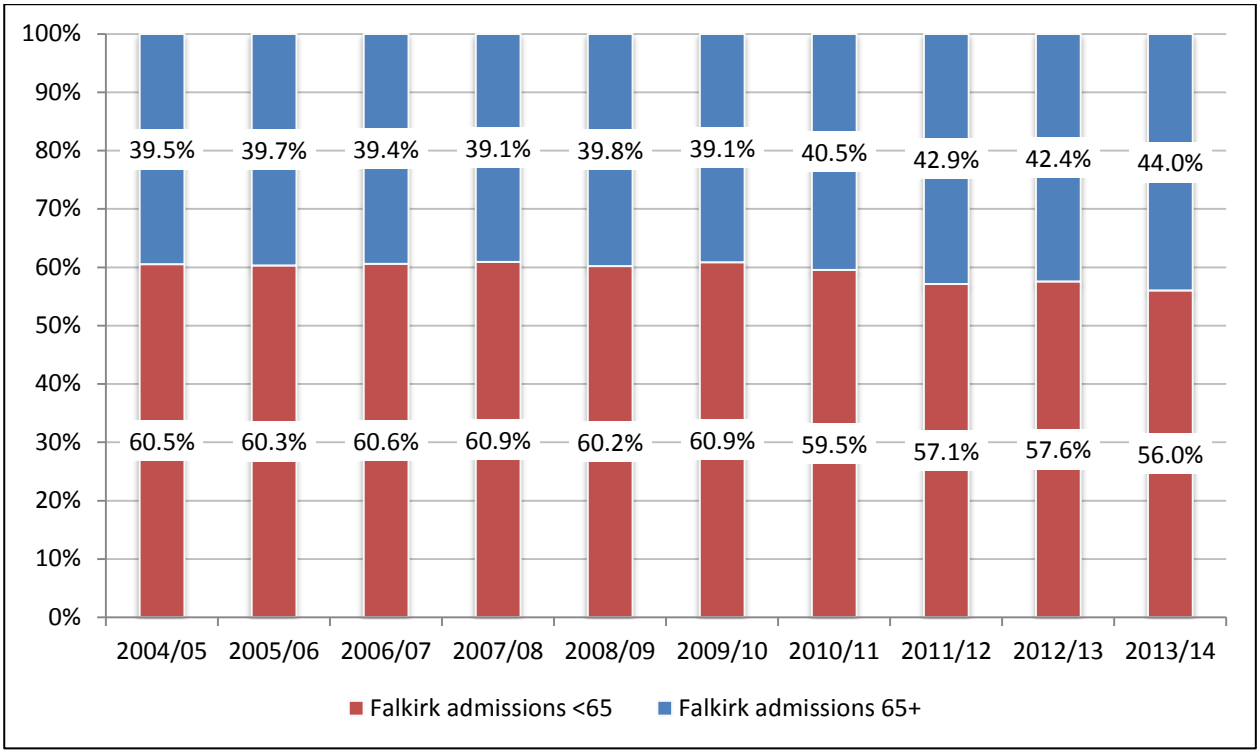
Figure 6.3.2a Emergency admissions to hospital – Falkirk 2004/05 to 2013/14



Source: ISD Scotland

Within the increase in the number of emergency admissions is an increase in the number of admissions for people aged 65 and above. A greater proportion of all admissions now come from this cohort of patients. Figure 6.3.2b below shows the increase of this group from 39.5% of all admissions in 2004/2005 to 44.0% in 2013/2014.

Figure 6.3.2b - Emergency admissions by age group Falkirk 2004/05 – 2013/14



Source: ISD Scotland

Multiple admissions

A primary focus of the work concerning emergency admissions is to reduce the number of patients who make multiple unplanned visits to hospital and who are then admitted.
In Scotland the rate of patients who have multiple emergency admissions (2 or more) has been increasing since 2004.

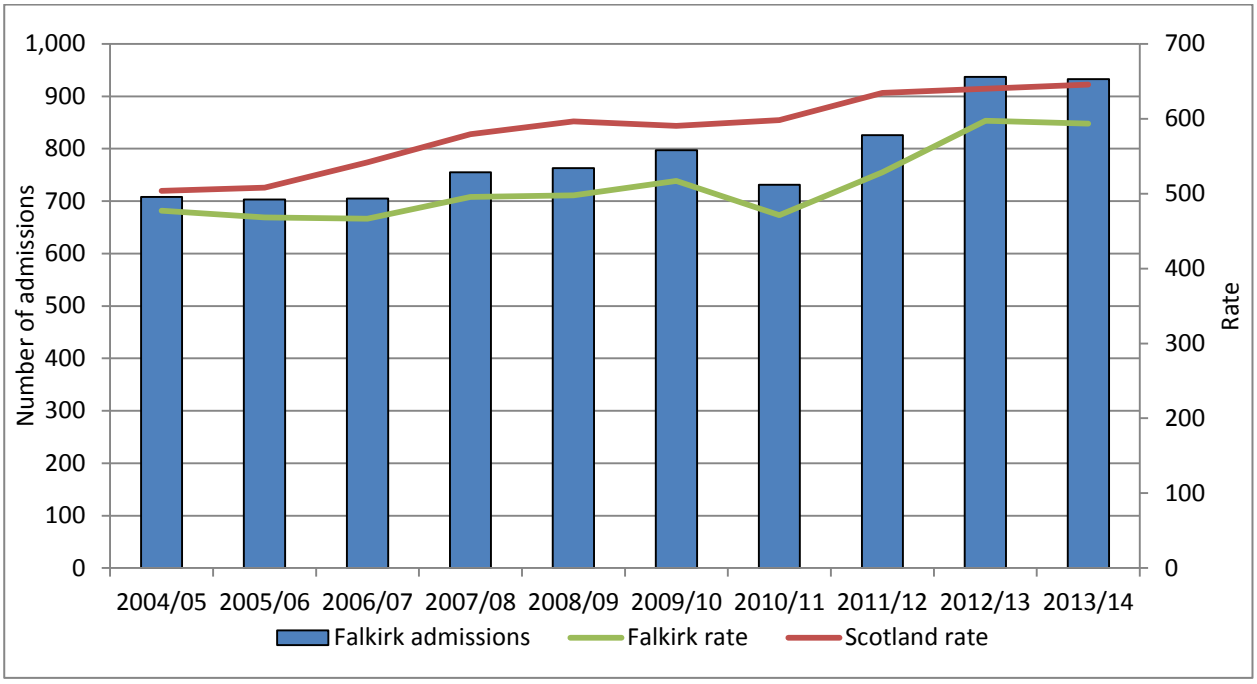
In Falkirk the rate for patients who have had 3 or more emergency admissions was higher in 2013/14 than in 2004/05. This information is shown in the table below.

Table 6.3.2b Rate and number of patients with two or more emergency admissions Falkirk 2004/05 – 2013/14

Local Council Area	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Falkirk admissions	708	703	705	755	763	797	731	826	937	933
Falkirk rate Per 100,000 pop.	477	468	467	496	498	517	471	529	598	594
Scotland rate Per 100,000 pop.	504	508	542	579	596	591	598	635	640	646

Source: ISD Scotland

Figure 6.3.2c – Rate (per 100,000 population) and number of patients with two or more emergency admissions Falkirk 2004/05 – 2013/14



Source: ISD Scotland

As with the number of total emergency admissions, the number of multiple emergency admissions for people aged 65 and above is also on increasing in Falkirk. The percentage increase of admissions for patients aged 65 plus is greater than the percentage increase for all ages.
The table below shows the percentage increase for all ages and those aged 65 plus between 2004/05 and 2013/2014.

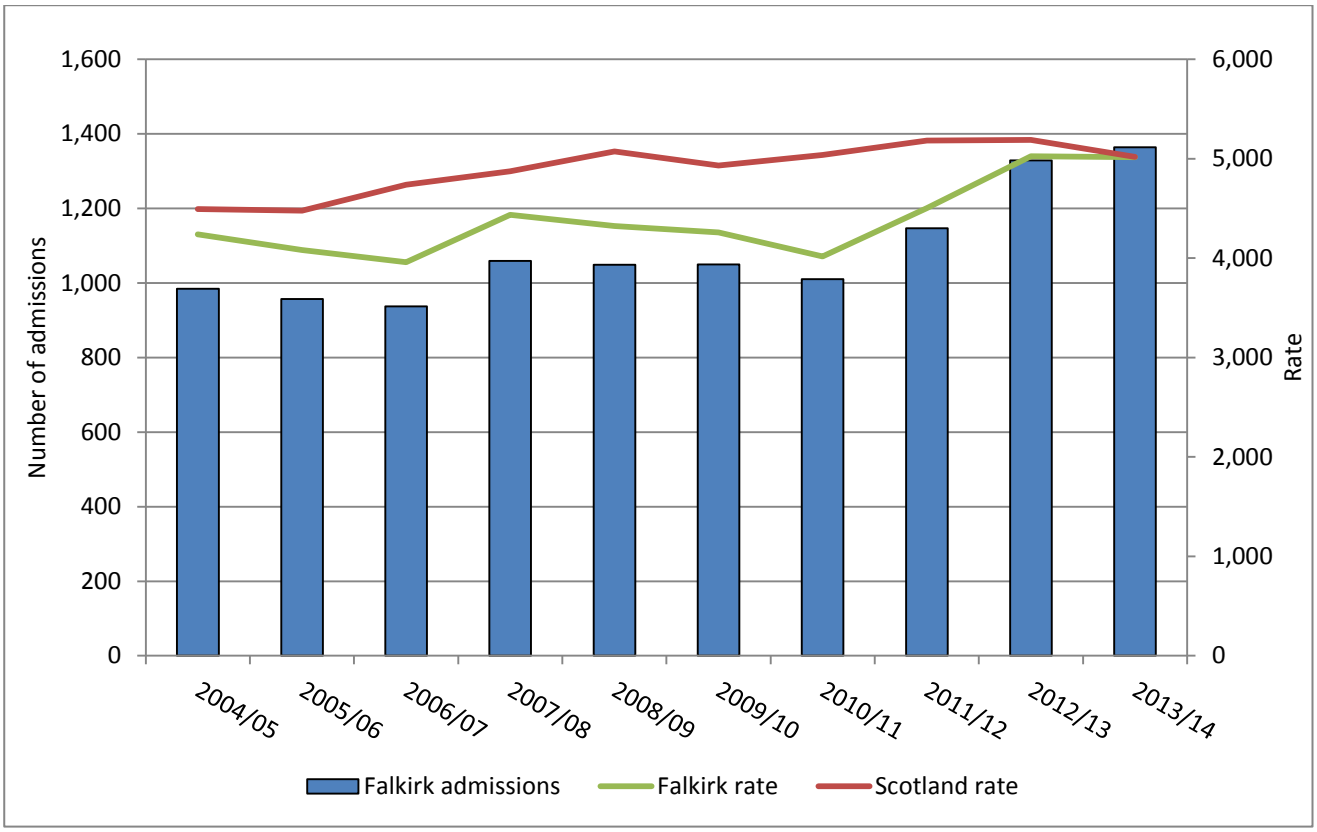
Table 6.3.2c - Increase in multiple emergency admissions 2004/05 to 2013/14

	All ages*		Age 65 +	
	No	%	No	%
Falkirk	474	22.3%	380	38.6%

*Patients with either 2 or more admissions
Source: ISD Scotland

Figure 6.3.2d below shows the trend of multiple admissions for people aged 65 and above from 2004/05 to 2013/14. It shows that in 2013/14 the number of multiple admissions in Falkirk was the highest it had been in a decade.

Figure 6.3.2d - Number and rate (per 100,000 population) of multiple emergency admissions for people aged 65+ in Falkirk 2004/05 to 2013/14.



Source: ISD Scotland

6.4 Delayed Discharges from hospital

A delayed discharge occurs when a patient, clinically ready for discharge, is prevented from being discharged back into the community because the necessary support or accommodation is not ready. Delayed discharge could be a result of social care issues, healthcare issues or patient/carer/family-related issues.

ISD Scotland routinely collects delayed discharge information in the Delayed Discharges Census and since June 2015 it has been reporting down to local authority level on a monthly basis. Table 6.4a below shows the figures for the most recent census in September 2015 at Falkirk and Scotland level. The table below focuses on longer delays but a delayed discharge is classed as the individual's discharge date minus the "Ready for Discharge" date.

The table shows for the September 2015 census a greater number of delayed discharges in Falkirk are 'over 2 weeks' (69%) compared to the Scotland average (59%). Falkirk compares more favourably in the longer delay categories where only a smaller percentage of people were delayed over 4 or 6 weeks in comparison to Scotland.

Table 6.4a – Number of delayed discharges in Falkirk and Scotland, ISD Census September 2015

	Total Standard Delays	Under 2 weeks	Over 2 weeks	Over 4 weeks	Over 6 weeks
Falkirk[1]	36	11	25	11	8
% of All Delays		30.6%	69.4%	30.6%	22.2%
Scotland	926	377	549	335	217
% of All Delays		40.7%	59.3%	36.2%	23.4%

Note: Percentages will not add to 100% as delays "over 6 weeks" are also over 2/4 weeks etc.
Source: ISD Scotland Delayed Discharges Census

1. Health Board figures are based on NHS board area of treatment. Local Authority figures are based on Local Authority of residence. There are a small number of patients experiencing a delay in discharge who are residents of local authorities out with the NHS board areas in which they are being treated. This may mean that the NHS board area of treatment is not responsible for the patient's post hospital discharge planning. This also means that the combined figures for local authorities within a particular NHS board area might not be equal to the corresponding total for that NHS board area.

Table 6.4b shows the number of standard and code 9 delays in Falkirk in the current financial year. Code 9 was introduced in July 2006, following discussions between ISD, the Scottish Government, health and local authority partners. This code was introduced for very limited circumstances where NHS Chief Executives and local authority Directors of Social Work (or their nominated representatives) could explain why the discharge of patients was out with their control.

Table 6.4b – All delayed discharges for Falkirk April 2015 to September 2015

Delay Type	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015
Standard Delay[1]	6	19	24	23	25	36
Code 9 Delay[1]	11	9	9	7	8	9
Total Delays	**17**	**28**	**33**	**30**	**33**	**45**

Source: ISD Scotland Delayed Discharges Census

Table 6.4c - Bed Days Occupied by Delayed Discharge Patients by age group and delay type – August 2015

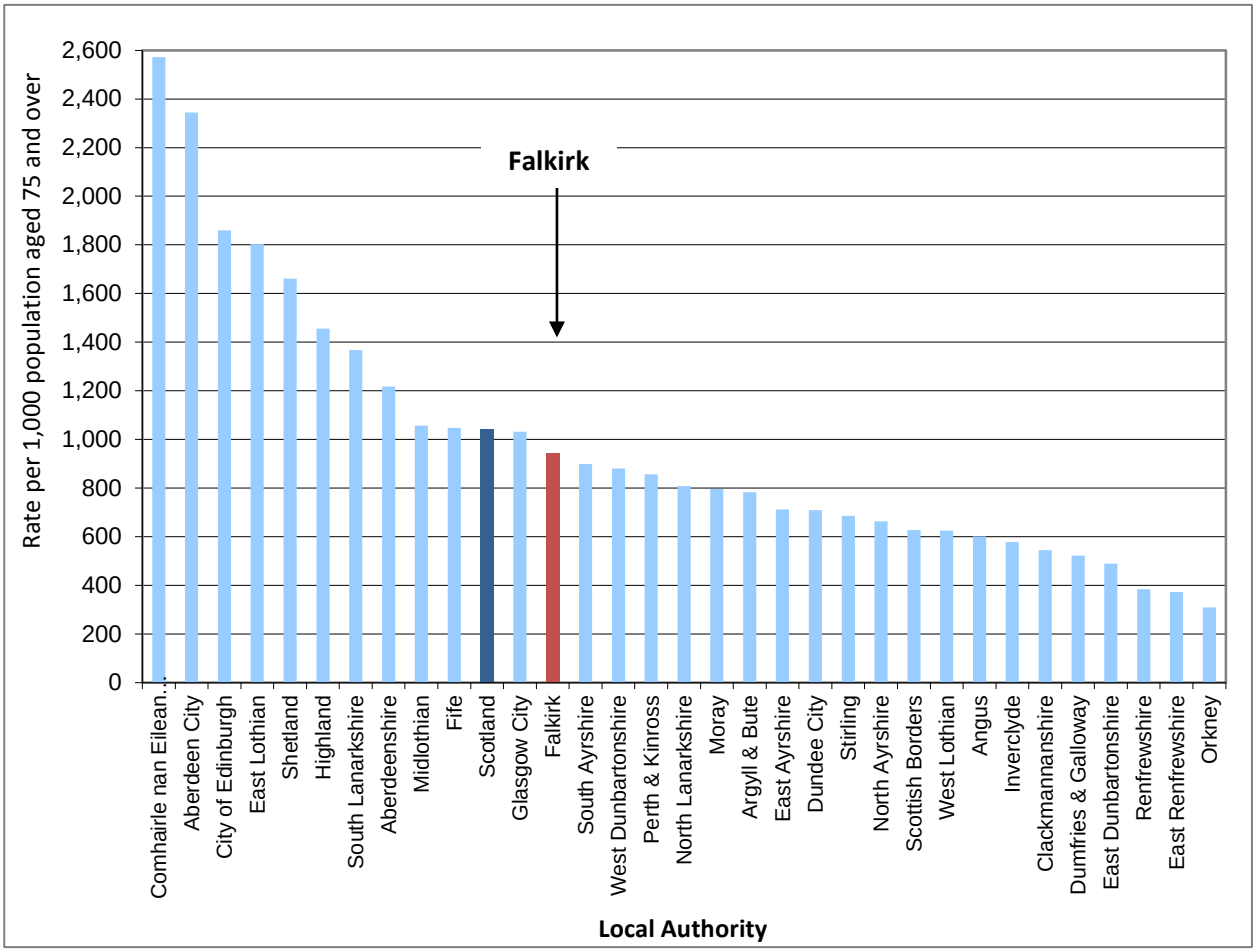
	All Ages					18 - 74 years					75 + years				
Local Authority of residence	Total	Standard	%	Code 9	%	Total	Standard	%	Code 9	%	Total	Standard	%	Code 9	%
Scotland	**48,526**	**38,144**	78.6	**10,382**	21.4	**14,435**	**10,468**	**72.5**	**3,967**	**27.5**	**34,091**	**27,676**	**81.2**	**6,415**	**18.8**
Falkirk	**1,125**	**918**	81.6	**207**	18.4	**196**	**196**	100.0	**-**	-	**929**	**722**	77.7	**207**	22.3

Source: ISD Scotland Delayed Discharges Census

The number of bed days occupied by delayed discharge patients in the August 2015 census is shown in the table above. There were in total 810 bed days occupied by delayed discharge patients in Falkirk with 84% of those patients aged over 75 years (compares to 69% at Scotland level). Code 9 delays made up a smaller proportion of 18-74 delays compared to Scotland though there was a greater percentage in the 75+ age group, on the whole Falkirk recorded a slightly greater percentage of Code 9 delays.

Figure 6.4a shows how the delayed discharge bed day rate (age 75+) for Falkirk compares to the Scotland average and neighbouring local authorities. The rate for Falkirk was slightly lower than Scotland on the whole.

Figure 6.4a –Delayed discharge bed day rate per 1,000 population aged 75+, April 2014 – March 2015



Source: ISD Scotland Delayed Discharges Census

Table 6.4d - Reasons for delayed discharges, Falkirk, April to September 2015

Month	Other	Healthcare arrangements	Awaiting place availability in a care home	Awaiting funding for a care home placement	Patients waiting to go home	Community Care Assessment reasons
April	1	0	2	0	1	2
May	1	0	9	0	2	7
June	0	0	16	0	2	6
July	1	0	15	0	1	6
August	1	0	14	0	4	6
September	0	0	28	0	2	6

Source: ISD Scotland Delayed Discharges Census

Table 6.4d shows gives a breakdown of the reasons for delayed discharges in Falkirk over the past 6 months. For the past 5 months there has been a significant increase in the number of delayed discharges due to care home availability. The most recent delayed

discharges census highlights a 100% increase in care home availability delays for Falkirk, emphasising that this must be considered a priority area for improvement.

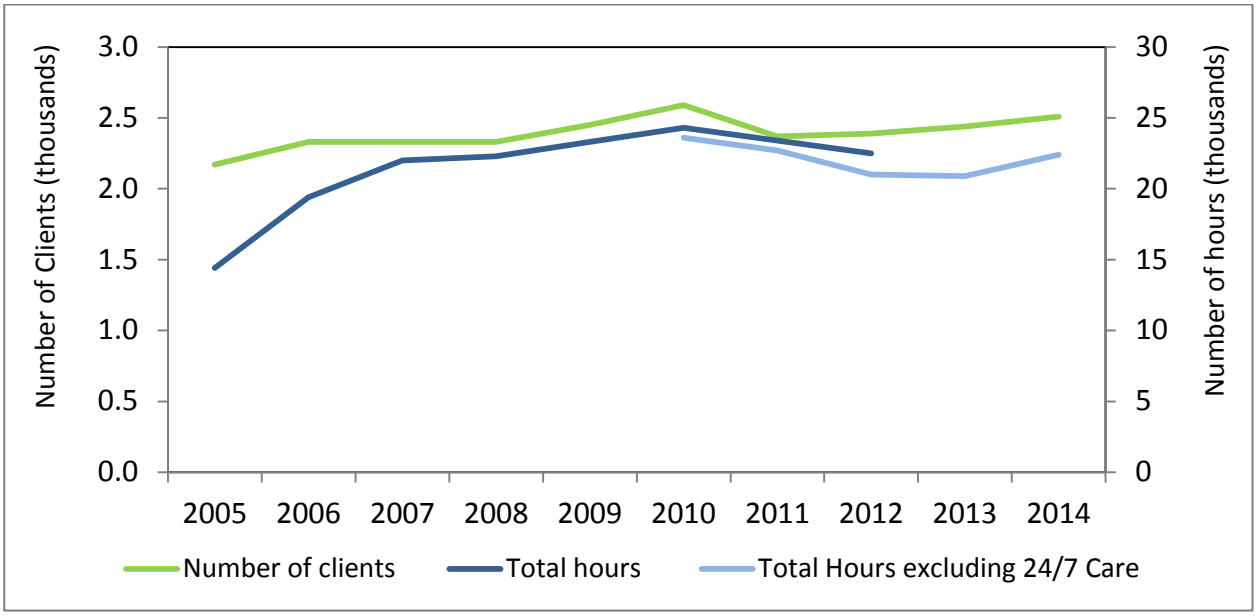
6.5 Care at Home

The 2014 Social Care Survey identified that there were 5,543 unique social care clients in the Falkirk area, of those clients, 2,511 were recorded as receiving care at home.

Figure 6.5a shows the number of people receiving care at home and the number of hours of home care provided over the period 2005-2014. Between 2005 and 2010 there was a clear rise in the number of hours of care at home which coincided with a rise in the number of people in the Falkirk area receiving care at home. In the following years there was a drop in people receiving care at home and a subsequent drop in hours of care provided. The number of people requiring care is again on the rise and in the past year the number of hours has followed suit.

In 2014 people receiving home care were provided with, on average 8.93 hours of home care.

Figure 6.5a – Number of people receiving care at home and hours provided, Falkirk 2005-2014



* from 2013 local authorities were asked to class 24-7 care as Housing Support, not Care at Home.
Source: Social Care Survey 2014

Table 6.5a: People receiving Care at home by age group, 2014

	0-64		65-74		75-84		85+		Total
Local Authority	No	%	No	%	No	%	No	%	
Falkirk	608	24.2	405	16.1	782	31.1	716	28.5	2,511

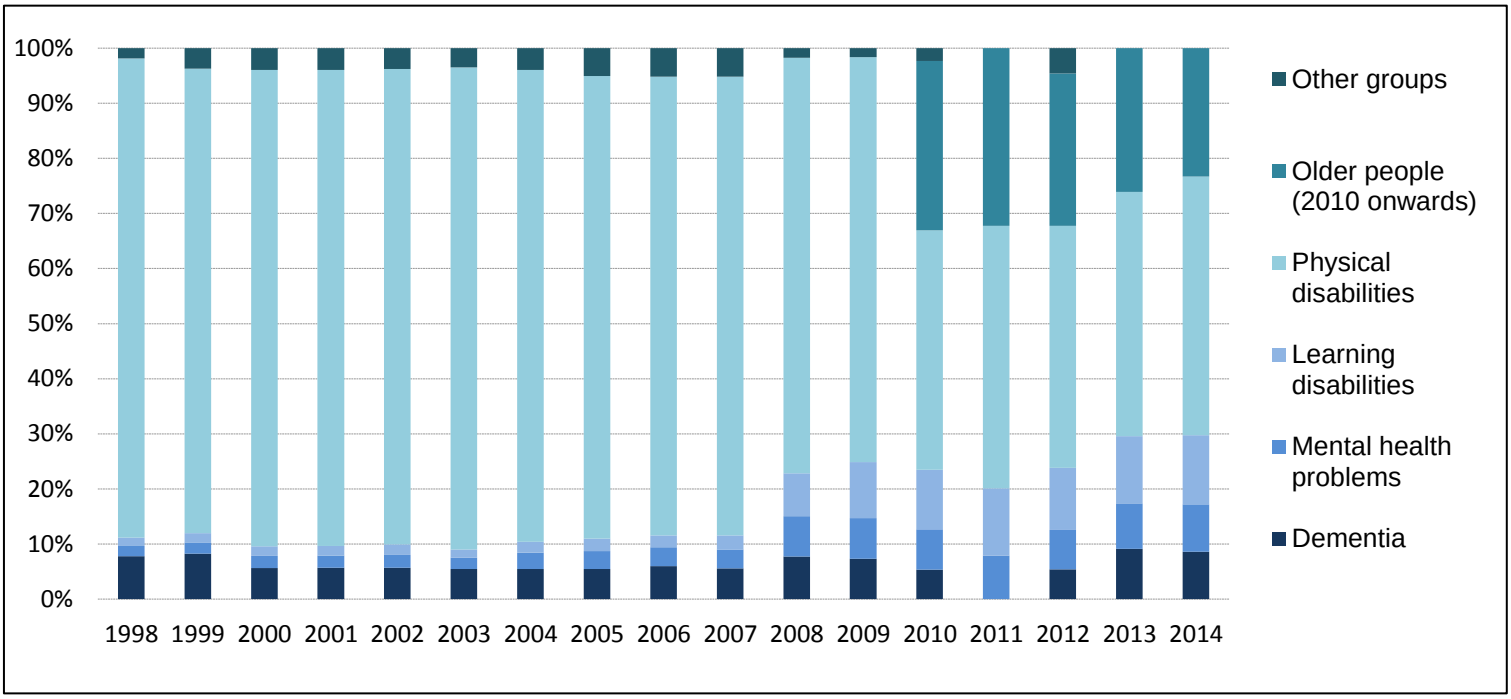
Source: Social Care Survey 2014

In 2014, nearly 60% of care at home clients were over 75 years and there was almost twice as many people receiving home care in the age bracket 75-84 years compared to 65-74 years.

The older age groups (65+) received 13,595 hours of care in 2014, on average 7.1 hours of home care per week in 2014, while those in aged 0-64 received on average twice as many hours home care per week (14.7 hours).

The chart shown below indicates that the people with a physical disability are the main users of home care services in the Falkirk area followed by older people. Dementia, mental health problems and people with learning disabilities make up around a third of the home care client base.

Figure 6.5b – Client group breakdown of home care services in Falkirk, 1998-2014



Source: Social Care Survey 2014

Note: Client group data is collected at initial assessment, it does not necessarily reflect the full needs of the patient. For example the patient may have physical disabilities and dementia, but could be designated in the physical disabilities client group.

Falkirk Social Work Services monitors a number of indicators which show the flexibility of home care services provided to the 65+ population. These are presented in the table below.

Table 6.5b – Falkirk home care performance indicators Age 65+, 2012/13 – 2014/15

	2012/13	2013/14	2014/15
Rate Home care hours per 1,000 population (65+)	490.2	526.5	483.6

% Receiving an Overnight Service	37.3%	42.4%	41.6%
% Receiving a Weekend service	77.4%	77.7%	77.9%
% Receiving a Personal Service	90.3%	91.6%	90.9%

Source: Audit Scotland – Community Care & Falkirk Social Work Annual Performance Statement

6.6 Self-Directed Support

Self Directed Support can help people live more independently by giving them choice, control, and flexibility over their support. In 2013 the Scottish Parliament passed a new law on social care support (the Social Care (Self-directed Support)(Scotland) Act 2013) which gives people a choice in how their social care and support is provided to them. Self-Directed Support (SDS) gives people control over an individual budget and allows them to choose how that money is spent on the support and services they need to meet their agreed health and social care outcomes. The options are described below:

Option 1: Taken as a Direct Payment (a cash payment)

Option 2: Allocated to a provider the individual chooses. The council or funder holds the budget but the person is in charge of how it is spent.

Option 3: The council can arrange a service chosen by the individual.

Option 4: The individual can chose a mix of these options.

The following table gives a breakdown of self-directed support options for the Falkirk population during the past year 2014/15. The vast majority of people chose option 3, only around 5% of people decided to take part or full ownership of their support funding.

Table 6.6a - SDS Breakdown for Falkirk - 1st April 2014 to 31st March 2015

SDS Options	No of Service Users (based on support plan)	%
Option 1	39	2.1
Option 2	27	1.4
Option 3	1788	95.2
Option 4	24	1.3
Total	1878	100

Source: Falkirk Council

6.7 Care Homes

The 2015 Care Home Census reported a total of 35 care homes currently operating in the Falkirk local authority with the facilities for 1,112 residents. The total number of residents in these care homes at the time of the Census was 977, giving an occupancy rate of 88%

(Scotland occupancy rate – 86%). The vast majority of patients were long-stay residents with only 5% short-stay residents across NHS/LA, Private and voluntary care homes.

Table 6.7a – Summary of care home facilities in Falkirk, 2015 (Year as at 31st March)

Care Home Type:	Number of care homes	Patient Capacity	Current Residents	Occupancy (%)
LA/NHS	8	184	145	79
Private	20	848	749	89
Voluntary	8	89	83	93
Total	36	1121	**977**	**88**

Source: Scottish Care Homes Census, 2015

For 2015 the number of long stay residents rose slightly compared to the previous two years but was lower than the figure in 2012. The census reported that 70% of the long-stay residents required nursing care and nearly 60% of care home residents suffer from medically diagnosed dementia.

Table 6.7b – Key statistics for long stay residents in care homes for Falkirk, 2012-2015 (Year as at 31st March)

Type of Resident	2012	2013	2014	2015
Total Number of Long Stay Residents	**982**	**927**	**932**	**925**
Characteristics of Long Stay Residents	**%**	**%**	**%**	**%**
Requiring Nursing Care	62	68	69	70
Visual Impairment	23	25	26	24
Hearing Impairment	14	15	17	15
Acquired Brain Injury	*	*	*	*
Other Phys.Dis. Or Chronic Illness[1]	35	38	41	38
Dementia (Medically Diagnosed)	53	57	56	59
Dementia (Not Medically Diagnosed)	*	*	*	*
Mental Health Problems	15	12	11	9
Learning Disability	15	12	9	8
Alcohol Related Problems	*	*	*	*
Drugs Related Problems	*	*	*	*
None of these	*	*	*	*

1. The guidance for the physical disability/chronic illness question changed in 2009/2010 to include all age groups, therefore comparison with previous years is not appropriate.
* Indicates values that have been suppressed due to the potential risk of disclosure and to help maintain resident confidentiality
Source: Scottish Care Homes Census, 2015

In 2015 the care home population in Falkirk was 69% female (31% male), identical to the Scotland population as a whole. The mean age of a care home resident in Falkirk was 81 years and the median age was 84 years. At the time of the 2015 census, the mean

complete length of stay at a Falkirk care home was 2.8 years while the incomplete length of stay (for those still living at the care home at the time of the census) was 3.4 years.

6.8 Telecare

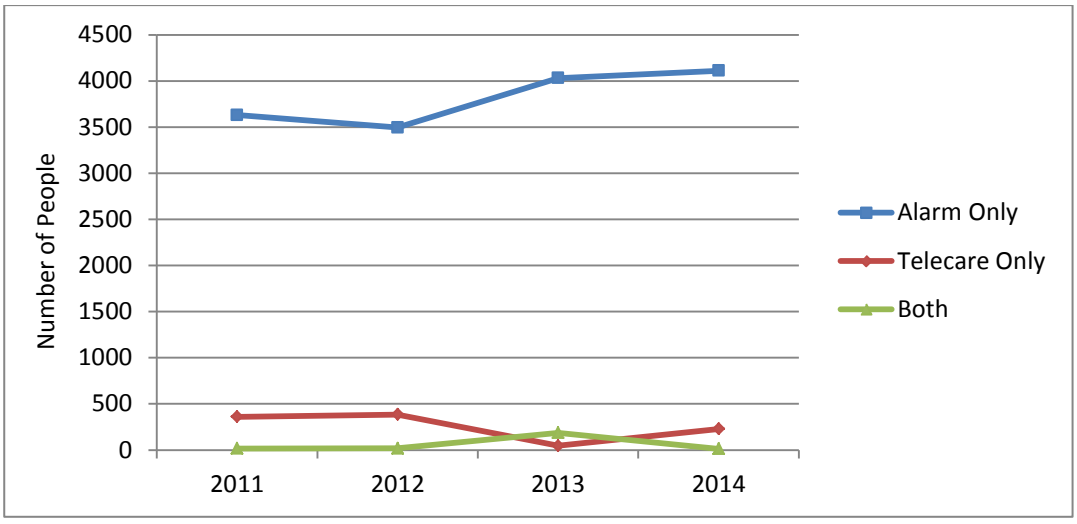
Telecare is a 24-hour remote monitoring system that uses a range of sensors and alarms to help people live safely and independently in their own home, with the reassurance that help is at hand in an emergency. Telecare systems can trigger a human response or shut down equipment to prevent hazards. The basic service is a community alarm (a basic package which consists of a communication hub plus a button/pull chords/pendant which transfers an alert/alarm/data to a monitoring centre or individual responder) while a more advanced Telecare package can be provided with technology such as linked Key Safes, linked smoke detectors or linked pill dispensers.

According to the 2014 Social Care Survey there were 4,353 people receiving some form of Telecare services in the Falkirk area in 2014, this is up by nearly 10% on the 2011 figure. The vast majority of these people (94%) had a community alarm in their home, and the remaining 6% had either Telecare only, or a combination of both.

The vast majority who receive Telecare services are elderly, disabled or vulnerable people. In 2014 85.5% of the recipients of the service in Falkirk were aged over 65.

The chart below shows the provision of Telecare services over the past 4 years.

Figure 6.8 – Breakdown of Telecare Services in Falkirk, 2011-2014



Source: Social Care Survey 2014

6.9 Equipment & Adaptations

Supplying elderly or disabled people with the appropriate equipment and/or aids can help them to live independently and safely at home. Equipment can also be of assistance to family or carers who care for someone who has, for example, difficulties with stairs or steps in their home.

Occupational Therapists work with people of all ages to help them overcome the effects of disability caused by physical or psychological illness, accident or ageing, and enable them to lead full and satisfying lives as independently as possible.

Falkirk social care services provided a total of 6,052 items of OT (Occupational Therapy) equipment in the last financial year. Despite an increase in 2012/13, the number of items provided has decreased over the past three years. In 2014/15, approximately a third of the items (66.8%) provided went to elderly people.

Table 6.9a - Number of OT equipment items provided, Falkirk 2011/12 to 2014/15

	Financial Year			
	2011/12	2012/13	2013/14	2014/15
Number of items	6,487	7,645	6,540	6,052
Rate per 1,000 Population (18+)	53.1	62.5	52.5	48.1

Source: Falkirk Social Services – Joint Loan Equipment Service (JLES)
OT – Occupational Therapy

If someone is having difficulty living in their current accommodation due to health or mobility problems, adaptations can be made to the property which helps to deal with these issues. Adaptations can take a number of forms such as grab rails or banisters, external lights or relocation of sockets for those who have trouble bending down.

Adaptations carried out by Falkirk Council over the past 5 years have been categorised in Table 6.9b below. Social Work funded adaptations are generally more simple adaptations, while owner occupier (grant-funded) and Council tenant activity refers to more expensive adaptations which have progressed via different funding routes.

The total number of adaptations has fluctuated over the past five years, but despite a drop in the last year, the number of adaptations has increased 9.5% since 2010/11.

Table 6.9b - Number of adaptations, Falkirk 2010/11 to 2014/15

Activity	2010/11	2011/12	2012/13	2013/14	2014/15
Social Work	566	552	719	682	714
Owner Occupiers	144	118	180	104	106
Falkirk Council Tenants	812	786	779	1,000	846
Total	1,522	1,456	1,678	1,786	1,666

Source: Falkirk Social Services – Abacus & Housing Service

6.10 Day Care

Table 6.10a shows the day care provided by the local authority in the past 3 years. There was a considerable rise in the number of day care days in 2014/15, though this reflects the even larger rise in people receiving day care services. On average the number of days per person has decreased from 3.3 days to 2.6 in the past 2 years.

Table 6.10a – Local authority day care provision, Falkirk 2012/13 to 2014/15

	2012/13	2013/14	2014/15
Days per week	560.5	551	791.5
Number of People	171	166	307
Days per person (Avg.)	3.3	3.3	2.6

Source: Falkirk Social Services (Abacus Financial System)

In addition to local authority day care, additional external day care was provided to 219 people in 2014/15 – this equates to 569 "sessions" per week.

6.11 Supported and Sheltered Housing

The Falkirk Housing Needs and Demand Assessment 2015 identified that there is a changing demographic profile in the area and the existing model of Housing with Care is not popular – the majority of older, vulnerable or disabled people would prefer to have their own home adapted and/or receive care at home (see associated rise in home care provision).

The main points from the Falkirk Housing Needs and Demand assessment are summarised below:

- In 2015 there were a total of 1,512 Housing with Care properties in Falkirk, most (758) were classified as Level 3 (Amenity), 673 were Level 2 (Sheltered) and 81 Level 1 (Very Sheltered).
- In addition to HWC properties there are also 20 elderly-specific properties.
- For 2013/14, a budget of c. £1.1m was committed towards adapting properties for people with disabilities or the elderly to meet their identified needs allowing them to remain in their homes.
- There are around 300 people with medical priority on the Council register. Using national research and the SHCS locally there is a need all tenure need for 510 wheelchair units locally[1].
- There was an increase of 21% in the number of people with learning disabilities known to the local authority over 2011-2014. Around 20% are over the age of 60. The majority of people with Learning Disabilities receiving services locally live in mainstream accommodation.

The housing support figures for the 2010/11 local housing budget is shown in the table below; they highlight an increase in expenditure on housing support for older people (9%) and those with a mental health issue (12%) compared to the 2007/08 budget.

Table 6.11 – Falkirk housing support expenditure 2007/08 – 2010/11

Group	2007/08 Budget	2010/11 Budget	% Change
Older People	£2,953,476	£3,208,495	9%
Sensory Impairment	£41,000	£41,820	2%
Learning Disabilities	£3,889,550	£3,859,304	-1%
Mental Health	£572,810	£642,996	12%
Physical Disability	£29,192	£29,661	2%

1 - Watson L et al (2012) *Mind the Step: an estimate of housing need among wheelchair users in Scotland*, Horizon Housing and Chartered Institute of Housing

6.12 Experience of Care Recipients

The Health and Care Experience Survey 2013/14 was commissioned by the Scottish Government as part of the Social Care Experience Survey Programme which aims to use the public's views on health and care services as a means to improve those services. This survey was sent to 15,146 people registered with a GP in the Falkirk area and received a total of 3,054 responses (44% Male, 56% Female). On the whole, service users responded very positively to the survey and the overall rating for help, care or support services was 87% positive.

A summary of the relevant indicators is presented below in Figure 6.12.

Figure 6.12 – Summary of care recipients experience in Falkirk – 2013/14

Source: Health and Care Experience Survey 2013/14

6.13 End of Life Care

End of life care is an important measure to indicate whether adequate plans and structures have been put in place to allow patients to spend their last six months of life at home or in the community and not in an acute hospital setting.

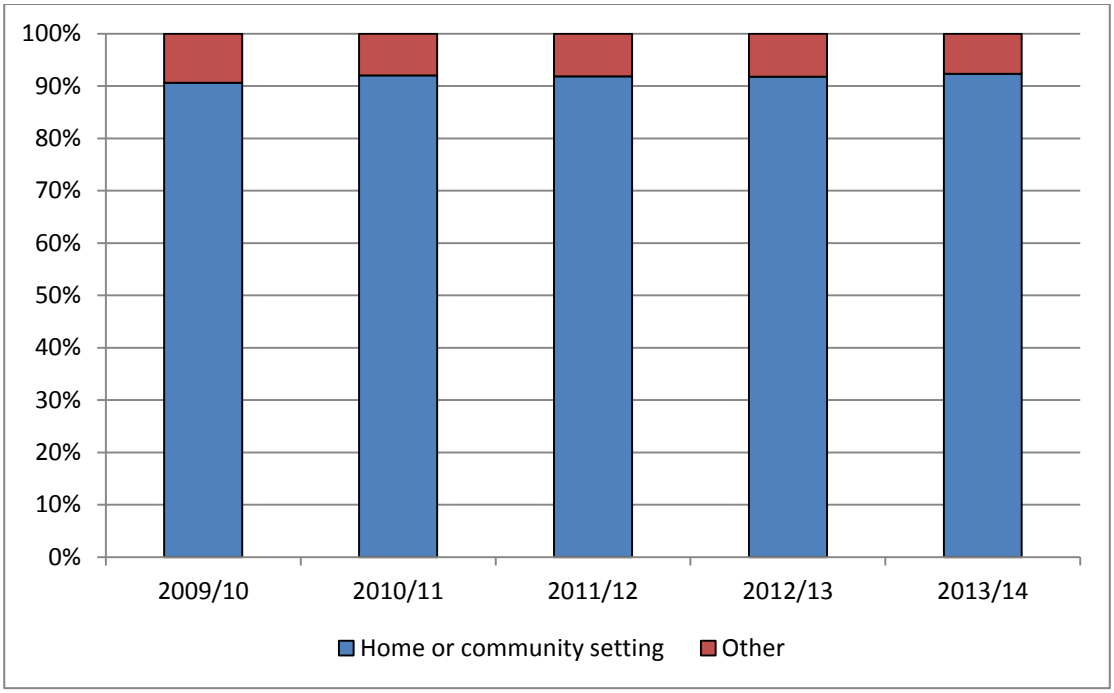
Just over 9 out of every 10 patients in Falkirk spend the last six months of their life at home or in the community, this has been the case for every year between 2009/10 and 2013/14. The percentage nationally is similar.

Table 6.13a - Percentage of last six months of life spent at home or in a community setting

Council Area	2009/10	2010/11	2011/12	2012/13	2013/14
Falkirk	90.6%	92.0%	91.9%	91.8%	92.3%
Scotland	90.5%	90.6%	91.0%	91.1%	90.8%

Source: ISD Scotland and National Records of Scotland

Figure 6.13a - Percentage of last six months of life spent at home or in a community setting in Falkirk



Source: ISD Scotland and National Records of Scotland

6.14 Respite Care

The government report; Respite Care Scotland 2014 documents the level of respite care provided by local authorities in Scotland. Due to changes in recording and methodology over the years, not all years of data are comparable, however 2012/13 and 2013/14 are considered comparable and the figures for Falkirk are presented below. The number of

daytime and overnight weeks of respite care decreased in Falkirk between 2012/13 and 2013/14, leading to an overall decrease of nearly 300 hours (8%).

Table 6.14a – Breakdown of total respite weeks provided in Falkirk 2012/13 – 2013/14

	Total Respite Weeks		Overnight Weeks		Daytime Weeks	
Local Authority	2012/13[1]	2013/14[1]	2012/13[1]	2013/14[1]	2012/13[1]	2013/14[1]
Falkirk	3,390	3,110	1,780	1,570	1,610	1,540

1 - Same methodology used in 2012/13 & 2013/14 making the figures comparable
Note – Figures are rounded to the nearest 10.
Source: Respite Care Scotland 2014

In 2013/14 the majority of respite care was provided to those aged over 65 (55.6%), more than the previous year (49.6%). There was also an increase in the number of overnight respite weeks for 65+ compared to the previous year. Respite care for the 0-17 age group is predominantly daytime respite care whereas there is significantly more overnight respite care provided for the 18-64 age group.

Table 6.14b – Breakdown of total respite weeks by age group, Falkirk 2012/13 – 2013/14

	Total Respite Weeks		Overnight Weeks		Daytime Weeks	
Age group	2012/13[1]	2013/14[1]	2012/13[1]	2013/14[1]	2012/13[1]	2013/14[1]
0-17	790	700	230	230	560	470
18-64	920	680	670	500	250	180
65+	1,680	1,730	890	840	790	890

1 - Same methodology used in 2012/13 & 2013/14 making the figures comparable
Note – Figures are rounded to the nearest 10.
Source: Respite Care Scotland 2014

Falkirk has one of the lowest levels of respite care provision and the rate per 1000 population is just over half of the Scotland figure. Increasing the provision of respite care in Falkirk could be fundamental in supporting, and providing relief for carers in the community.

6.15 Community Care Assessments

Community care teams conducted over 9,500 care assessments in the 2014/15 financial year, a slight increase on the past two years. Community care assessments are conducted for a number of reasons such as physical disability, visual impairment, elderly care and dementia.

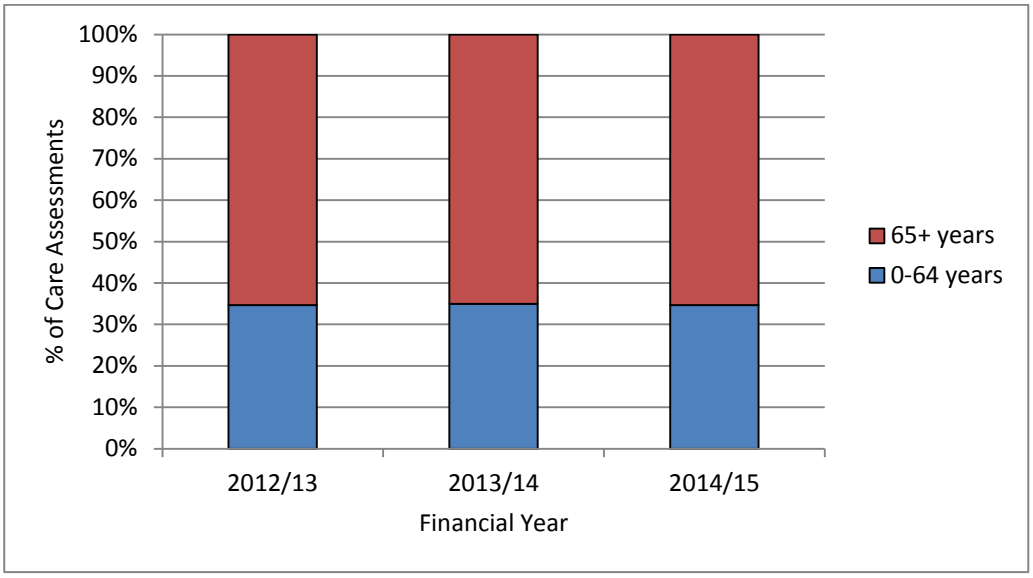
Table 6.15 shows that the number of community care assessments has increased over the past 3 years, though there has been little change in the proportions of assessments in the four age bands. Over 65's have accounted for roughly two thirds of care assessments in the past three years (Figure 6.15).

Table 6.15 – Number of community care assessments by age group, Falkirk 2012/13 – 2014/15

	Age Group				
	0-64	65-74	75-84	85+	Total
2012/13	3,099	1,622	2,473	1,740	8,934
% of Total	34.7	18.2	27.7	19.5	
2013/14	3,312	1,679	2,479	2,003	9,473
% of Total	35.0	17.7	26.2	21.1	
2014/15	3,293	1,566	2,667	1,978	9,504
% of Total	34.6	16.5	28.1	20.8	

Source: Falkirk Council Social Work Services
*Note that the figures above count initial assessments and reviews.

Figure 6.15 – Breakdown of care assessments by age Falkirk 2012/13 - 2014/15



Source: Falkirk Council Social Work Services

6.16 Adult Support and Protection

The Adult Support and Protection (Scotland) Act 2007 came into force in late 2008. The underlying ethos of the Act is the provision of timely support for adults at risk of harm. Falkirk Social Services submits adult protection data to the Forth Valley Adult Support and Protection Committee who produce an activity report based on submissions from Falkirk, Stirling and Clackmannanshire Councils. The key figures for Falkirk are shown in Table 6.16 below.

Table 6.16 – Adult Support and Protection Services, Falkirk 2012/13 to 2014/15

	2012/13	2013/14	2014/15
Number of Referrals	308	477	519
Number of Investigations	106	114	79
Number of Case Conferences	90	85	63
Number of Protection Plans in Place	26	17	21

Source: Forth Valley Adult Support & Protection Committee ASP activity report

The number of referrals for Falkirk has increased for the second year running and is up by 68.5% on the 2012/13 number. Despite the large increase in referrals,the corresponding numbers of investigations and case conferences are down over the past two years. The protection of vulnerable adults is top priority work; if extra social work resource is required to accommodate the increasing number of referrals then other resources in other areas of social work could be impacted.

In the latest report, the most prominent care groups for referrals were dementia and learning disability while physical and financial harm were the most common types of harm reported. The rate of referrals increases with age, with the 85+ group receiving the most referrals.

6.17 Substance Misuse Support Services

The national HEAT (Health improvement, Efficiency, Access, Treatment) target stated that by March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. This was established to ensure more people recover from drug and alcohol problems so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy.

Falkirk is achieving a high standard for drug and alcohol treatment times with 99% of people commencing treatment within 3 weeks, the figures show that Falkirk is performing considerably better than Scotland (95.7%). Table 6.17a splits drugs and alcohol waiting times and shows that in 2014/15 Falkirk managed to commence treatment on 100% of clients within 3 weeks.

Table 6.17a – Falkirk Alcohol & Drug treatment waiting times, 2014/15

National Indicators	Falkirk		Scotland	
	N	%	N	%
Number & percentage of clients waiting more than 3 weeks between referral to a specialist **drug service** and commencement of treatment.	107	0.0%	16,915	5.6%

Number & percentage of clients waiting more than 3 weeks between referral to a specialist **alcohol service** and commencement of treatment.	184	1.6%	29,515	3.6%

Source: Drug and Alcohol Treatment Waiting Times Database (ISD)

Falkirk Alcohol and Drug Partnership's (FADP) main task is to identify what the main concerns are regarding local substance issues (Alcohol, Drugs, Tobacco, Solvents, Gases, over the counter or prescribed medicines that are used inappropriately and all illegal drugs. They also have an input in decisions about how monies identified for substance misuse services are spent covering education, prevention, treatment, availability & enforcement

Smoking Cessation

NHS Forth Valley Stop Smoking Support provides drop-in clinics that smokers can access without a referral or an appointment. These clinics provide advice, specialist support and where appropriate, free Nicotine Replacement Therapy (NRT). In Falkirk a drop-in clinic is held every Wednesday at Camelon Health Centre, with further Outreach clinic's provided at other practices in the area. All community pharmacies in Forth Valley also provide stop smoking support.

This section presents information on quit outcomes in 2014 compared to previous years, based on client follow-up at one and three months after the agreed quit date. Client follow up can be carried out face to face, by telephone or by letter/questionnaire and information on successful quits may either be self reported or validated using carbon monoxide (CO) breath testing.

Quit attempts and success rates for Falkirk and Scotland at 1 and 3-month follow ups are shown in Tables 6.17b and 6.17c. With the exception of 2014, Falkirk has fared well in comparison to Scotland at the 1-month stage; however success rates at 3-month follow up are considerably poorer than Scotland over the past 4 years. It is essential that efforts focus on helping people to sustain their attempt to quit smoking

Table 6.17b - Quit attempts and success rate at 1 month follow up; Calendar years 2009 - 2014

	2009	2010	2011	2012	2013	2014
Falkirk - quit attempts made	1,639	1,420	2,097	2,708	2,100	1,347
Falkirk - success at 1 month follow-up	706	651	919	1,167	838	453
Quit Rate - Falkirk	43.1%	45.8%	43.8%	43.1%	39.9%	33.6%
Quit Rate - Scotland	38.1%	39.2%	37.6%	38.4%	37.6%	35.4%
Comparison with Scotland	↑	↑	↑	↑	↑	↓

Source: NHS Smoking Cessation Service Statistics (Scotland) (ISD)

Table 6.17c - Quit attempts and success rate at 3 month follow up; Calendar years 2009 - 2014

	2009	2010	2011	2012	2013	2014
Falkirk - quit attempts made	1,639	1,420	2,097	2,708	2,100	1,347
Falkirk - success at 1 month follow-up	305	217	187	172	146	135
Quit Rate - Falkirk	18.6%	15.3%	8.9%	6.4%	7.0%	10.0%
Quit Rate - Scotland	16.8%	17.0%	15.8%	15.6%	14.2%	16.0%
Comparison with Scotland	↑	↓	↓	↓	↓	↓

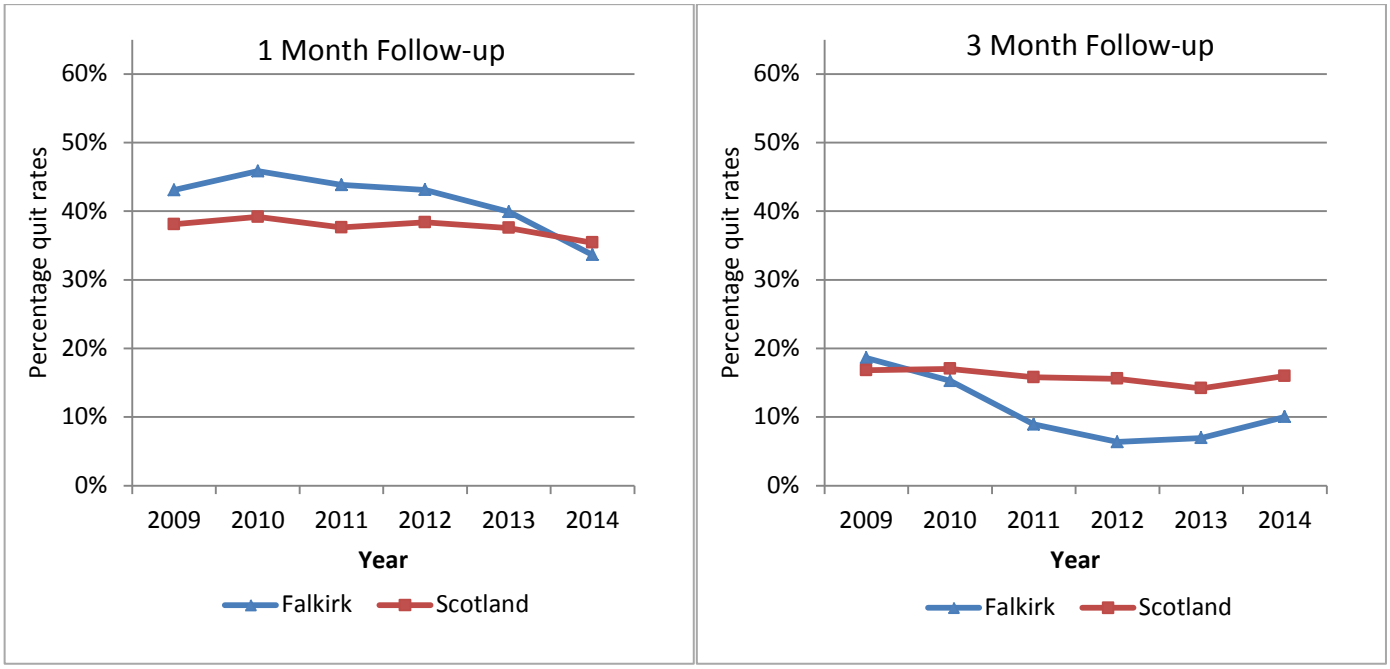
Source: NHS Smoking Cessation Service Statistics (Scotland) (ISD)

Key:

Achieved higher quit rate than Scotland	↑
Achieved lower quit rate than Scotland	↓

Tables 6.17b and 6.17c are presented below in a graphical format (Figure 6.17a), visibly showing that Falkirk smoking cessation services need to work towards sustaining the quit rate at 3-month follow ups.

Figure 6.17a - Quit success rates 1 and 3 month follow up, Falkirk and Scotland; Calendar years 2009 - 2014



Source: NHS Smoking Cessation Service Statistics (Scotland) (ISD)

6.18 Provision of Health and Social Care Services Considerations/Implications

- The number of GPs in the Falkirk area is on the rise (132 in 2014 compared to 109 in 2006), however the percentage of those aged over 65 is also increasing (up to 17.2% in 2014).
- The average monthly attendance at A&E and MIU has increased by 8.8% over the years 2007-2015. The rate of emergency hospital admissions has also increased over the past decade though it remains below the Scotland rate.
- The increase in rate of emergency admissions is accompanied by a greater proportion of over 65's being admitted, 39.5% in 2004/5 up to 44.0% in 2013/4.
- Emergency departments in their current form could struggle to meet the demands of the increasing elderly population, there has been a much greater rise in multiple admissions for over 65's (38.6% from 2004/5-2013/4) compared to just a 22.3% rise for all ages.
- 1,034 bed days were lost in July 2015 due to delayed discharges, over 75's accounted for 84% of those bed days.
- Over 65's received 13,595 hours of home care in 2014 (75.8% of the total home care hours), by 2037 the 65+ population is expected to have risen by over 72% (compared to 2012) – if home care provision was to remain at a similar level, almost 10,000 extra hours would be required.
- Expenditure on Direct Payments has risen considerably from £0.1 million in 2004/5 to £0.8 million in 2013/14, yet this not reflected in the number of people receiving direct payments, down by over 50% in the past two years.

7. Carers

7.1 Overview

A carer is a person who provides unpaid help or support to a family member, friend or neighbour who suffers from a disability, a long-term physical or mental illness or problems related to old age. There is no distinction made about whether that person provides that care within their own household or out with the household.

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.

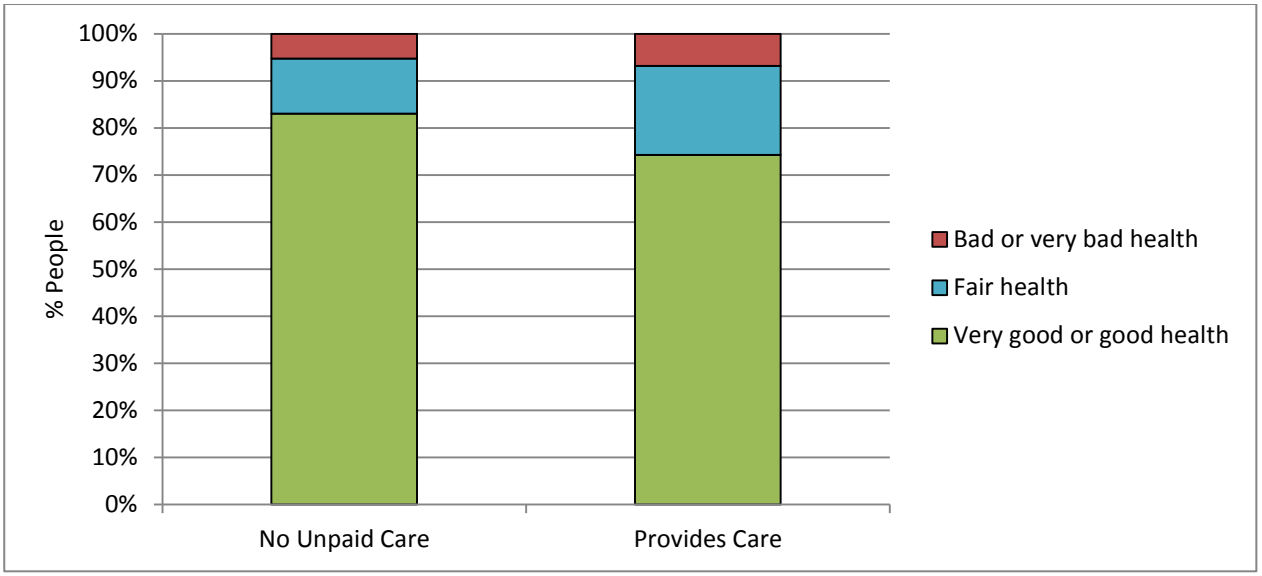
7.2 Characteristics of Carers

Utilizing data from the 2011 Scotland Census, an overview of carers in the Falkirk area is presented below:

- A total of 15,056 people were found to be providing unpaid care in Falkirk, 9.7% of the local population. The carer population was 59.5% female and 40.5% male.

- Approximately two thirds (65.4%) of those providing unpaid care are in the age band 35-64 years with those 65 years and over accounting for nearly a fifth (18.2%) of the carer population.
- Over a third (35.7%) of carers in Falkirk provide in excess of 35 hours unpaid care per week with 27.2% (of that 35.7%) providing over 50 hours unpaid care.
- 29% of those providing in excess of 35 hours care are aged 65 and over.

Figure 7.2a: Provision of unpaid care and general health in Falkirk, Scotland's Census 2011

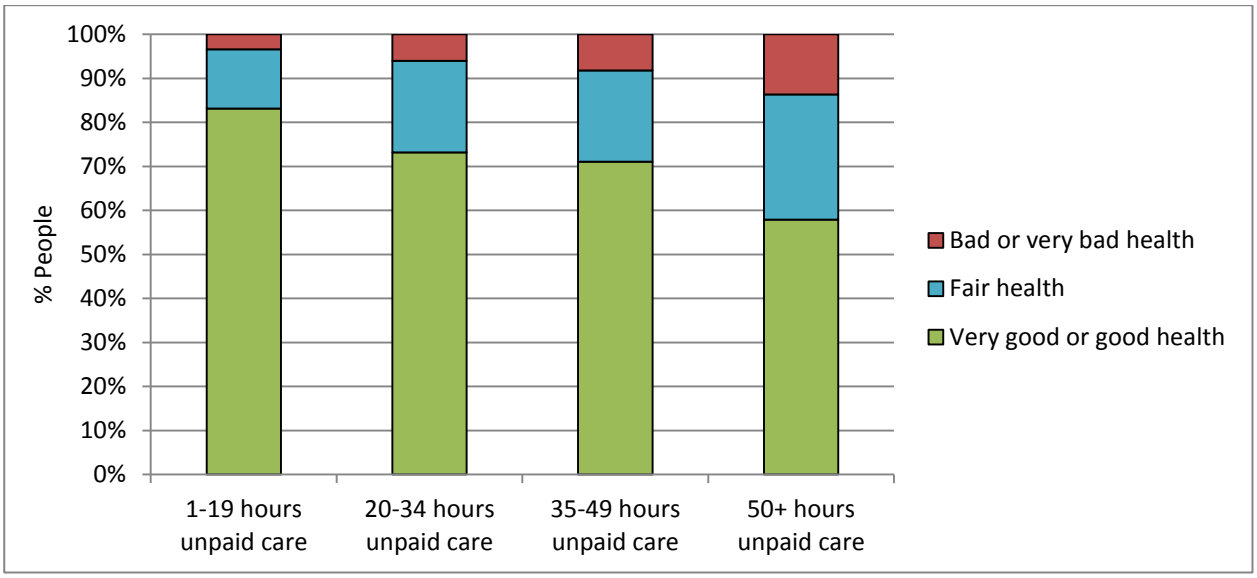


Source: Scotland Census 2011

Figure 7.2a shows that the proportion of those who class themselves as being of fair or bad/very bad health is greater for those providing unpaid care. Of the 18.2% of over 65s who provide care, only half (49.7%) would class themselves in good or very good health.

The chart below (Figure 7.2b) 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 7.2b: General health by level of unpaid care provision - Falkirk, Scotland's Census 2011

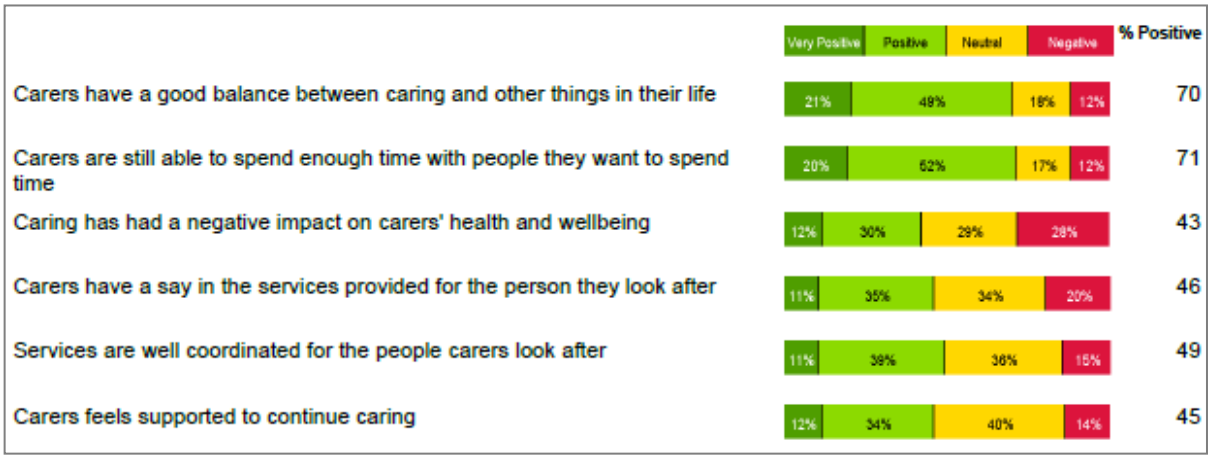


Source: Scotland Census 2011

7.3 Experience of Carers

The Health and Care Experience Survey not only looks at the experience of the care recipients but also the experience of those who provide unpaid care. Figure 7.3 provides a summary of responses from carers in Falkirk. Despite the majority of carers (70%) being positive about their caring/life balance, over 50% of people are neutral/negative about the impact caring has on their health and wellbeing. Less than 50% of carers responded positively when surveyed about the coordination of local care services and only 45% feel supported to continue caring.

Figure 7.3 – Summary of Carer Experiences in Falkirk 2013/14



Source: Health and Care Experience Survey 2013/14

7.4 Carers Implications/Considerations

- Over a third of carers in Falkirk (35.7%) provide greater than 35 hours care and nearly a third of those are over 65's. With over 50% of carers reporting that caring has a negative effect on their health and wellbeing, it is entirely possible that the over 65's carers of today will become those in need of care in years to come.

- The carer data from the 2011 Census showed a clear relationship between poor health and a greater number of hours care provided.
- The Health and Care Experience Survey 2013/14 highlighted that carers in Falkirk feel there is room for improvement in the services and support they receive.

8. Summary & Conclusion

8.1 Summary

This needs assessment has provided information describing current health and social care needs in Falkirk, and has forecast a significant increase in these needs.

Underpinning these needs are the concepts of engagement and redesign which are fundamental to making a real difference through integration.

Engagement with all stakeholders will also be required in identifying how to progress. This document has provided the basis for discussion on strategic planning and highlights the key areas of focus for the integrated services.

The following key issues have emerged from the needs assessment:

- Falkirk has an ageing population. Population projections forecast significant change in the age-profile of the local population over the next 25 years with the overall population expected to increase by over 10% while the 75+ population is projected to increase by 98% from the 2012 population. This has significant implications for service provision as over 75's are generally intensive users of health and social care. To coincide with the surge in the older population, the working age population is expected to decrease – crucially affecting the ability to provide services. The current models of health and social care will not be able to sustain this swing in population structure so there is a necessity for service redesign. It should be noted that although the projected increase in older people will have an impact on services older people make a valuable contribution to our society, both economically and socially, through, amongst other contributions, taxes, spending power, provision of social care and the value of their volunteering.
- There is a need to rebuild services in such a way to better meet the requirements of people with complex needs. Patients with several complex long term conditions are currently making multiple trips to hospital clinics to see a range of uncoordinated specialist services. A proposed way forward could be to look at developing new pathways and guidelines away from the current disease specific models to generic approaches focused on the holistic needs of patients (Lunt, 2013, p. 17).
- 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 elderly population is likely to mean there will be an increasing need for un-paid carers. In turn, these un-paid will need to be supported.
- If current disease trends continue then there are likely to be increasing numbers of individuals requiring support for their disease or condition. However, these trends

could be influenced positively through a continued focus on early intervention and prevention.

8.2 Conclusion

The traditional public service model – is to identify and 'assess' need and aim to meet it (on both an individual and population basis)

The public sector as we know it was established in the immediate post-war period where the population experienced poverty, overcrowding and slum housing. At this time the UK Welfare State was being established to ensure at least a minimum standard of living, through the National Assistance Act and a range of other legislation.

Since that time there has been great change:

- Demographic change (in part a result of the success of the welfare state)
- People living longer and healthier
- (This despite an increase in the prevalence of Long Term Conditions (LTCs) - due to a combination of new conditions and better/ earlier-diagnosis)
- So, the population of Falkirk is growing in size, ageing and increasing in complexity and multiplicity of health and social problems such that demand is exceeding supply in the present model
- There are rising costs and debt (national and personal)

However it may be argued that the traditional model for public services has often required individuals to abdicate responsibility, leading to ‘learned helplessness’ on the part of individuals, and risk aversion on the part of services / staff/ clinicians.

So there are positive consequences and negative consequences of current service provision. The changes experienced since 1945 are so great that the traditional model is no longer fit for purpose

The new paradigm needs to:

- put the individual person at the centre
- encourage individual responsibility and motivation for change to maximise wellbeing
- encourage ambition on the part of individuals, staff and all stakeholders
- encourage critical realism - the empathetic approach - based on intention, attention, mutual understanding, exploring options etc.

This is not to say that the individual is to be abandoned by public services, or that help will be with-held. Rather it is to recognise that intervention can be unintentionally disabling longer term, and that to maximise wellbeing longer term, we should provide support that is the minimum required to be effective, empathetic and enabling.

'Engagement' is key

- to recognise value as a key concept 'values-based value management'
- to consider how to maximise value generated by limited resources

The service implications, therefore are:

- real engagement ++
- workforce development in person-centredness
- wholesale, continuous redesign of public / third sector
- realistic access - e.g. consider signposting rather than referral (the onus is then on the individual to make the arrangements), but also a realistic increase in opportunities for access / addressing barriers (by working with carers and other stakeholders)
- realistic risk management - e.g. falls prevention (some risk of a fall needs to be accepted for the re-enablement process to occur)

The recommendations for the future therefore come under the following headings:

Engagement:

- Of the workforce in these issues, to generate understanding and a positive attitude to the future. And to build on workforce development in person-centred care (see appendix for examples)
- Of individuals – in their own health and wellbeing, facilitated by staff and other contributors and based on understanding, empathy, to improve connectedness, beliefs and values, knowledge and skills etc. (coming under the general heading of ‘resilience’). And thence to health improving behaviours – physical activity, diet and nutrition, no substance use; and also recognising adherence to medication and advice, for example, as a health behaviour.

Redesign:

- Wholesale public sector/ third sector redesign, outcomes-focussed yes, but recognising that process is key.
- Linking with engagement work – MCDM (Multi-criteria Decision Making), PSP (Public Social Partnerships) to reach a common understanding of goals and how these may be met
- Person-centred redesign – based on the above and work on person-centred care developed locally
- Working with CPPs (Community Planning Partnerships) on the ‘determinants of health’ with the aim of improving structural approaches and reducing the tendency for ‘lifestyle drift’. And emphasising work as key to health (not just paid employment, but caring and volunteering) which is often the basis for meaning and purpose in people’s lives.
- ‘Integrated anticipatory care’ – whereby the value of each of: prevention, early identification, treatment, management etc. is recognised in a spectrum of help/

intervention from a range of contributors – not least the person themselves (self-care).

If we make these changes....then we can expect

- better motivation in individuals - decreased risk factors, increased adherence to (minimal) intervention
- longer term, reduced disease (could be up to 40% or so)
- more efficient processes / less waste
- increased wellbeing, increased employability, increased work/ productivity of the population

Appendix A

Framework and Methods

A general philosophical framework considers ontology (what exists), epistemology (how knowledge is created) and logic (reasoning, causality and if...then relationships). The methods used attempts to work to the principles of applying these disciplines.

The following is a discussion of current and potential methods, in two groups – use of data items (usually singularly), and creation and development of models (using multiple data sources).

Data

- In using data it is important to consider their validity, which depends on the source, what the original intention was when they were generated, general reliability and validity etc.
- Population projections are based on modelling, using data from the census, modified to take into account various factors.
- Population projections tend to be inappropriately precise – down to single figures for single year of age – and are forecasts rather than predictions.
- Prevalence data often comes from a sample (e.g. through a survey) with the assumption that it is sufficiently representative, e.g. Scottish Health Survey
- Activity data relate to activity and any extrapolation to disease needs to be carried out with caution, e.g. data from ISD.
- Benchmarking is comparison with different areas' healthcare arrangements and again requires caution that the areas being compared are sufficiently alike.
- 'Synthesis' is applying data from one source to another to give an estimate – e.g. applying prevalence data to population projections (also known as spreadsheet modelling). It is important to be aware of the assumptions and caveats etc. with this kind of forecasting.

Models

- As discussed above models may be of different types – static or dynamic
- The findings section includes a large number of models, some of which are class models, others the beginnings of dynamic models (produced in a qualitative way but may be developed to using data)
- There is potential to use more sophisticated modelling techniques:
- Data envelopment analysis is used for assessing efficiency. Rather than simply benchmarking, it allows various data items to be combined as 'inputs', and others as 'outputs'. Plotting inputs against outputs for a range of 'decision making units' gives an 'efficiency frontier'. The advantage of this is that it gives a better idea of the scope for improvement for individual units, should inputs be increased.

- The origins and development of benchmarking have recognised the need to consider values, and processes in addition to a simple comparison of outcomes or outputs
- Discrete event simulation is used to forecast the results of changes in process or capacity at an operational level (see paper on modelling stroke beds)
- Systems dynamic modelling is higher level, considering ‘stocks and flows’ and might be used for modelling at the population level.

Needs assessment methods

What is need? One definition is the gap between ‘what is’ and ‘what should be’ – which is inherently a value judgement. Hence we need to be clear on the value base of this work.

NHS Forth Valley has specified 6 core values. These are:

- Respect
- Ambition
- Team work
- Supportiveness
- Integrity
- Person-centredness

It seems likely that in the process of integration these can be adopted by the whole of the public sector for Falkirk. A further value of ‘fairness’ could also be added, as our objectives include addressing inequalities.

The process of needs assessment could include expanding the agreed objectives, based on our values, to consider in more detail ‘what is’ and ‘what should be’. For example, to be ambitious (a core value) about what ‘should be’ in regards to living longer and healthier lives we could say everyone should live a perfectly healthy life and die on or after their 100th birthday.

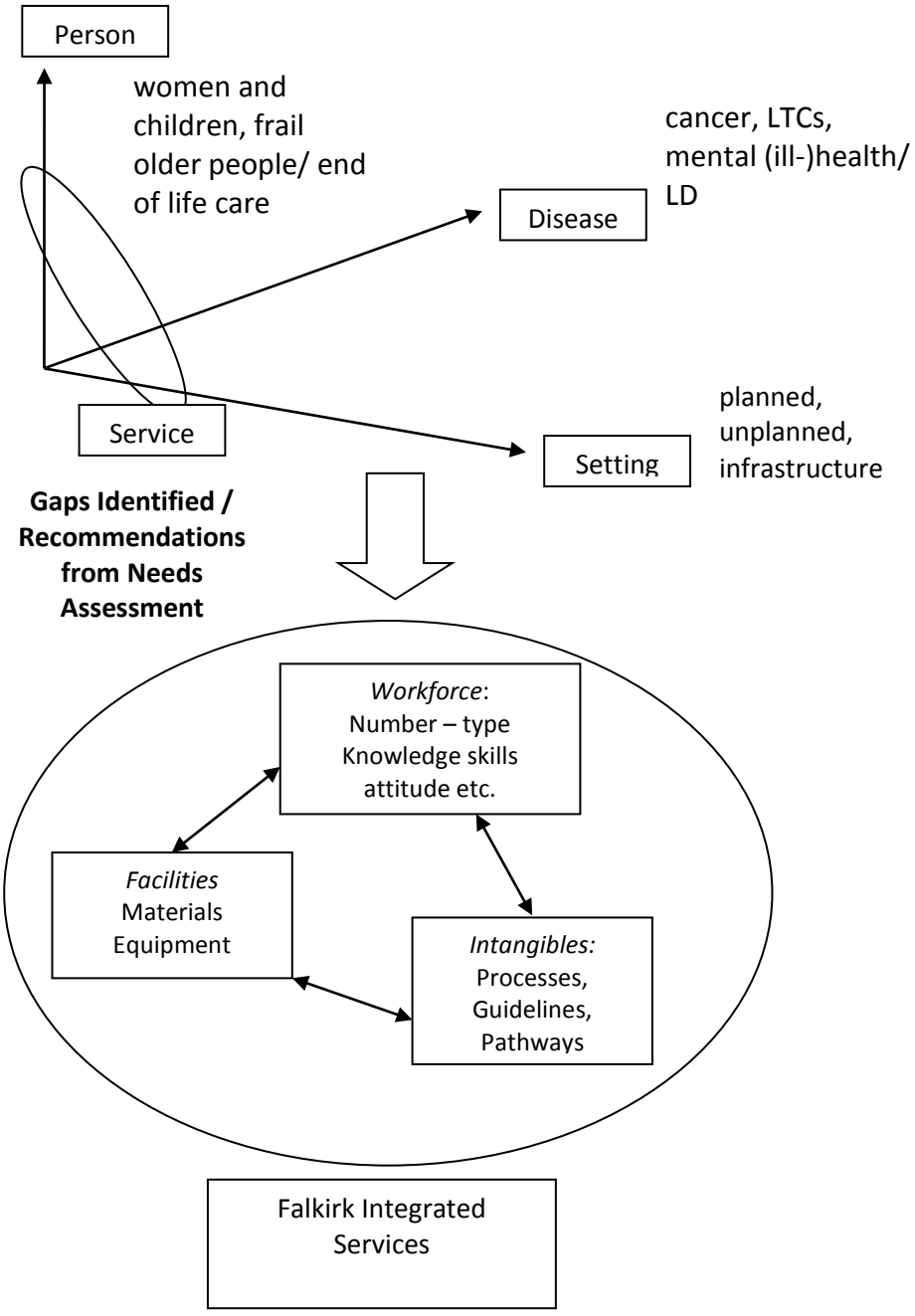
Types of need

The ontological basis of our needs assessment helps in defining types of need. Within this report we have described

- the people in our communities – demographics, but also their attributes in terms of life circumstances, risk factors, disease and long term conditions.
- The services and their attributes – including capacity

So need can be described at each level – population health and social care needs, which can be met by service activity; and service needs which require to be met in order to optimise service activity.

These elements come together as illustrated in the diagram below:

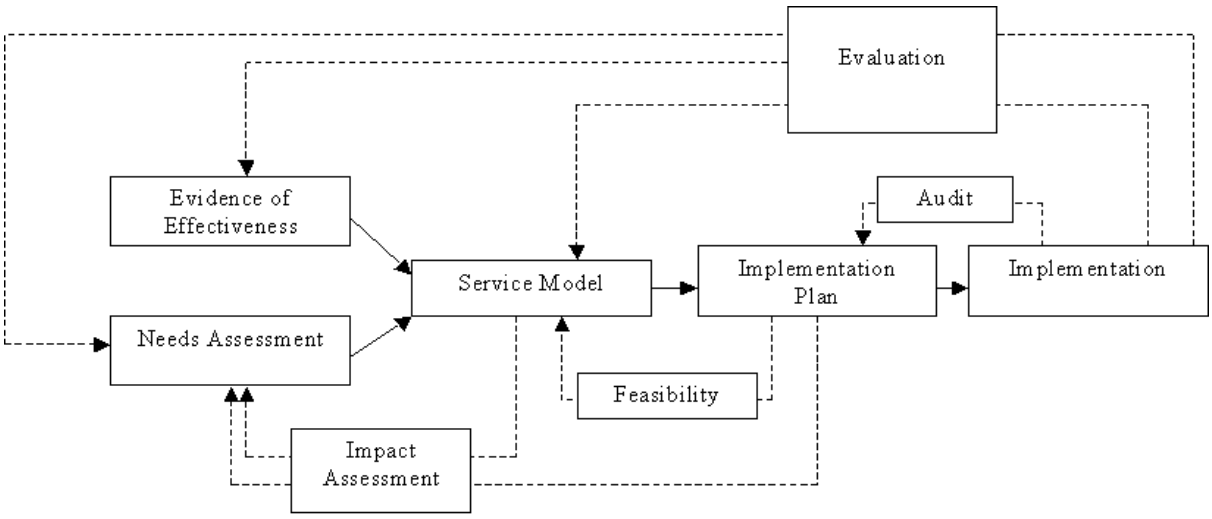


Beyond these needs, other types of need can be described, e.g. the ‘engagement’ needs of individuals – i.e. improvement in attitude and motivation in regard to the individual’s own health, and for services organisational needs and redesign needs. In many ways a needs assessment is not required for us to know that there is significant room for improvement in each.

Further Description of needs assessment

Population based needs assessment tends to be one-size-fits-all whereas working from a person-centred holistic approach we want everyone to be treated as individuals – implies 150,000 or so needs assessments/ personal health plans

The process of needs assessment is iterative (encompassing impact assessment, evaluation etc.) – not just a one-off exercise



Interpretation of data can depend on perspective – is the glass half full or half empty? And identified need in terms of a gap does not imply that resources should be allocated to it necessarily – effectiveness, feasibility, fairness etc. must also be considered.

Curve Model

This needs assessment will feed in to a strategic planning process, for which there are a number of important factors to consider prior to implementation, summarised as the CURVE model for strategic improvement

CURVE is

- **C**ulture
- **U**nderstanding
- **R**esponsibility
- **V**alues, value, valuing
- **E**nterprise

Culture

Culture is defined as “what is learned, shared, and transmitted in a group – reflected in that group’s beliefs, norms, behaviours, communication and social roles” (Kreuter and Haughton, 2006)

Further it can be defined using the ‘model for a person’ and extending this to collective attributes of a group or community etc. – i.e.

Collective:

- Physical and social environment
- Behaviour and sensation / perception within this environment
- Memory, imagination, and emotion
- Knowledge, skills and creativity
- Beliefs, values and attitudes
- Identity
- Spirituality / sense of connectedness

Culture change

Culture changes over time. The extent to which this can be guided or facilitated is debatable. It has been suggested that certain factors can facilitate culture change at the ‘edge of chaos’. These are:

- Diversity
- Information flow
- Connectivity
- Reducing barriers or inhibitors
- Enhancing or increasing catalysts
- Watchful waiting
- Positive intent

Understanding

Knowledge is a personal attribute and collective knowledge is a community or cultural attribute. But to be really useful it needs to go deeper to form understanding. There are several senses to the term understanding:

- Awareness of a situation in context, its meaning – based on evidence. Being able to see how things relate to each other, often in complex ways.
- Having and demonstrating common understanding between individuals, which relates to empathy and positive intent.

Responsibility

Within the context of family support, for example, improvement ultimately relies on individuals taking responsibility. Such individuals may be children, parents, other family members, peers, public sector or third sector staff. A process of engagement and involvement may be required to facilitate this, as may the meeting of some basic needs. Within the public sector there is increasing recognition that individuals' rights need to be balanced with responsibilities (as described in the recent Patient Charter for the NHS in Scotland, which is derived from legislation)

Values, value, valuing

Fundamental to improvement work is the underlying set of core values to which we are working. NHS Forth Valley has defined its core values as:

- Respect
- Integrity
- Person-centredness
- Supportiveness
- Ambition
- Teamwork

Value is also an important concept, as improvement work / redesign is often aimed at increasing the value gained from the use of resources. Value can be subjective however and this needs to be considered.

Valuing can also be important in terms of appreciating resources or actions. For example if the services offered are not valued by people, uptake will decline as will value.

Enterprise

Organisations and partnerships are engaged in some form of enterprise – establishing a vision and working towards it. Entrepreneurship encompasses core skills that are relevant for improvement work in general:

- Establishing and developing networks, teamwork and collaboration
- Understanding value and value chains
- Identifying and developing personal skills
- Identifying and developing innovative practice
- Understanding motivation

The emergence of the concept of a 'Social Enterprise' is particularly important for the public and third sectors. In the field of social enterprise a "triple bottom line" is described consisting of the 3 'P's

- Profit (monetary value) – or value for money in public spending
- People (social value) – quality and effectiveness in making a real difference to people's lives

- Planet (ecological value) – long-term sustainability of public services

Implementation

Each element needs to be considered in some depth. The CURVE model sets out ‘what?’ but for implementation there needs to be a consideration of ‘how?’

This strategic needs assessment document forms only the first part of a longer process which will involve:

- Further explication of needs from the information, in particular that produced down to locality level.
- Application of impact assessment processes, including Equality and Diversity Impact Assessment

Appendix 4

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

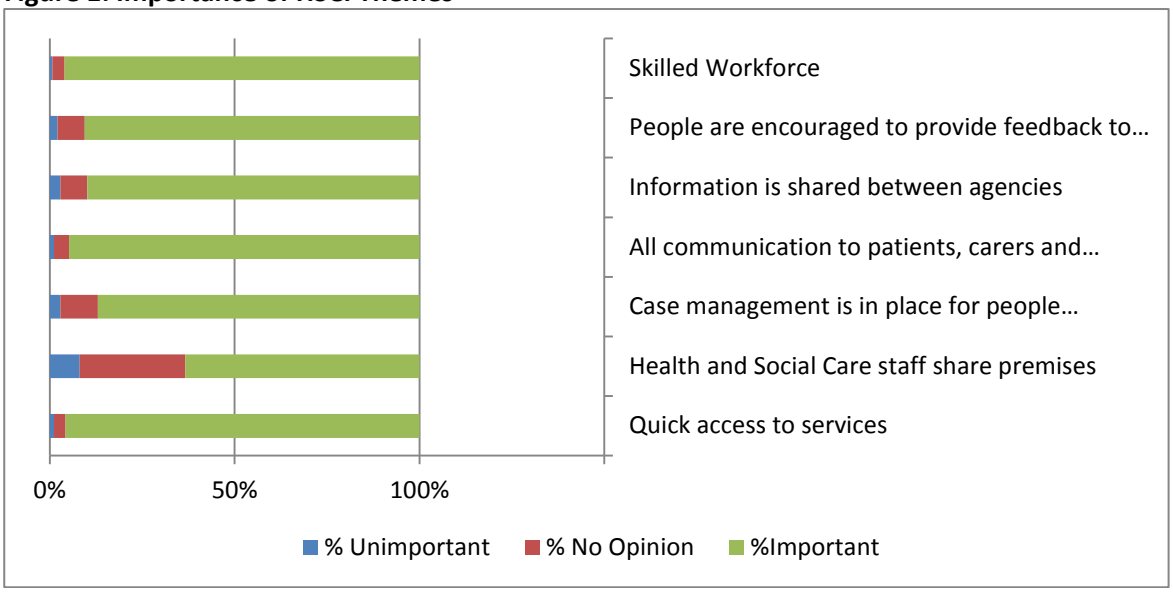
The Citizens Panel is made up of around 1,500 residents from across the Council area, with questionnaires distributed electronically or by post three times a year. The questionnaires have covered a variety of topics, with questions on quality of life, housing, community safety and public health. This 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

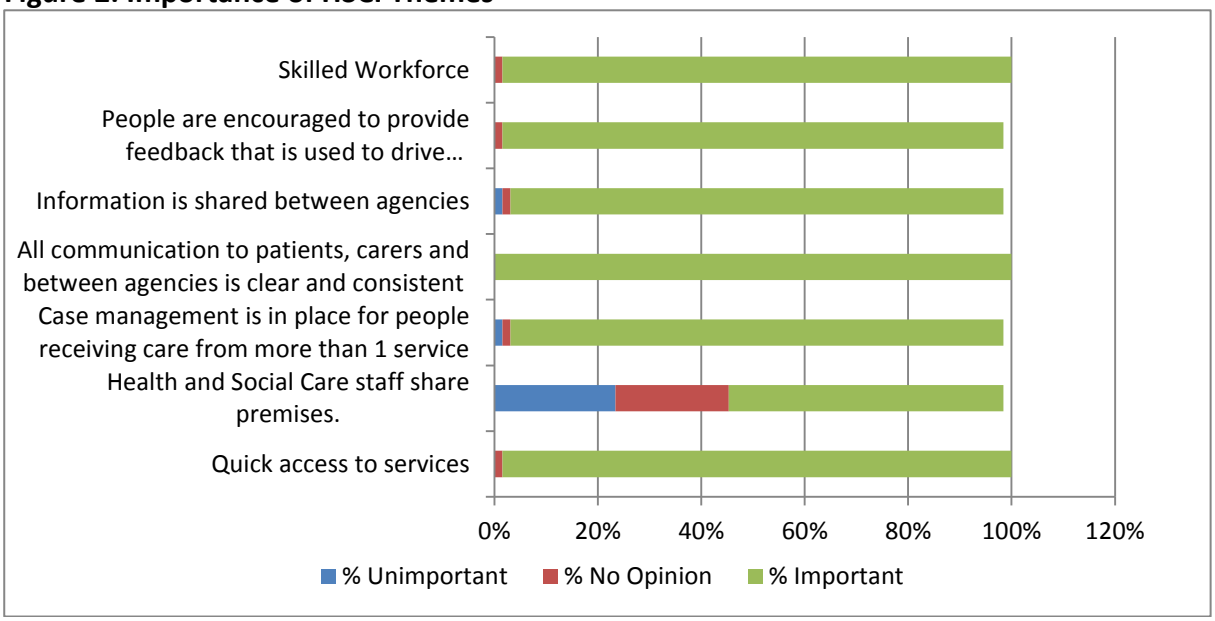
Theme	Responses	What People Said
Partnership Working	**17**	*'Reference to more explicit commitment to community planning (at strategic , tactical and operational levels) would strengthen the Plan and demonstrate a willingness to work in partnership with CPP partners to achieve improved outcomes.'* *'The 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'*

Communication	**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.

Appendix 5

Equality & Poverty Impact Assessment (EPIA

Information

Name of EPIA: Falkirk Health and Social Care Partnership Strategic Plan	**EPIA Reference No. (if applicable):**
Division / Department / Service / Team Lead: Falkirk Integration Joint Board	**Contact details:** Patricia Cassidy, Chief Officer

1.0 Identify the main aims and projected outcomes of the proposal / policy / project outline:

The Falkirk Health and Social Care Partnership Strategic Plan describes why, what and how health and social care services will be delivered for all adults aged over 18 years. This plan presents a framework to deliver the agreed strategic vision over the following three years and will be reviewed each year. A number of key outcomes and priorities have been identified. These outcomes are:

- **Self-Management** - Individuals, carers and families are enabled to manage their own health, care and wellbeing
- **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
- **Safe** - Health and social care support systems are in place, to help keep people safe and live well for longer
- **Service user experience** - People have a fair and positive experience of health and social care
- **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.

This Strategic Plan is the first plan to be developed by the HSCI Partnership. The outcomes and priorities will provide a direction and focus for service change and improvement that will enable service users, carers and the community to promote and maintain their health and well-being and independence.

The local outcomes and priorities are aligned to the national health and well-being outcomes and local plans for example the Falkirk Community Planning Partnership Strategic Outcomes and Local Delivery (SOLD) Plan.

The 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 Plan is supported by key documents as follows:

- Joint Strategic Needs Assessment
- Financial Plan
- Participation and Engagement Strategy

- Integrated Workforce Plan
- Clinical and Care Governance Framework
- Risk Management Strategy
- Performance Management Framework
- Housing Contribution Statement
- Market Facilitation Plan.

2. 0 For budget changes ONLY please include information below:		**Total**	**Benchmark e.g. Scottish Average**
Current spend on this service – (£,000's)	Total		
Reduction / increases to this service budget (£,000's)	Per annum		
Is this a change e.g. to introduce a new Charge or Concession	Expected annual income total		
	Current cost per person		
When will the saving be achieved	Start date for savings		
	End date – if any		

Equality Protected Characteristics:

3.0 Which individuals / staff are likely to be affected by the proposal / policy / project? (please score)									
Equality protected characteristics	**(A) Age**	**(D) Disability**	**(G) Gender**	**(E) Ethnicity**	**(R) Religion**	**(SO) Sexual orientation**	**(TG) Transgender**	**(P&M) Pregnancy & Maternity**	**(M&CP) Marriage & Civil Partnership**
Insert X where appropriate	X	X	X	X	X	X	X	X	X

Please summarise the POSITIVE impact for each affected protected characteristic using	**Please summarise the NEGATIVE impact for each affected protected characteristic using**	**Please summarise the NEUTRAL impact for each affected protected characteristic using**

appropriate initial:	appropriate Initial	appropriate Initial
Age, Disability The Strategic Plan is for all adults aged 18+ years, with the aim to deliver better outcomes for all of these protected characteristics. It is acknowledged there is strong links with relevant strategic and operational planning arrangements and partnership working, for example with children and young people, community justice. In response to the national and legislative drivers for health and social care integration, this will ensure that health and social care provision is more joined-up and seamless, especially for people with long term conditions and disabilities. The Joint Strategic Needs Assessment and consultation and engagement activities have identified that these would be the partnership priority categories for significant change and improvement.	**none**	**Gender, Ethnicity, Religion Sexual Orientation, Transgender, Pregnancy &Maternity, Marriage &Civil Partnership** There is not a specific focus in the plan on these groups, however it is intended that all people can access the health and social care services they need, and that a holistic approach to assessment and provision of services will be taken. This is in line with ensuring individual's needs, circumstances and views are taken into consideration and meet their identified outcomes.

Wider inequality issues / cross cutting themes

3.1 Are there any cross cutting themes or poverty indicators which when combined with equality protected characteristics could increase the level of inequality for individuals / groups with protected characteristics.	
Poverty / Inequality indicator **This list is not exclusive. Please add in categories or delete as necessary**	**Description of impact -** *will the proposal / policy / project have an impact on e.g. standard of living covering a person's ability to be independent, to feel safe, to be able to stay well fed, to have a house, to keep warm, to gain skills; to have a job and have access to other basic services to enhance well-being and reduce inequality.*

Wealth, income, poverty and welfare reform	The Integration Joint Board is a member of the Community Planning Partnership and therefore has a shared responsibility to deliver the Strategic Outcomes and Local Delivery (SOLD) Plan priorities and outcomes. These are: Priorities ▪ Improving mental health and wellbeing ▪ Maximising job creation and employability ▪ Minimising the impact of substance misuse on communities, families and individuals ▪ Tackling the impact of poverty on children Outcomes ▪ Our Area Will Be a Fairer and More Equal Place to Live ▪ We Will Grow Our Local Economy to Secure Successful Businesses, Investment & Employment ▪ Children Will Become Adults Who Are Successful And Confident ▪ Our Population Will Be Healthier ▪ People live full, independent and positive lives within supportive communities ▪ Our area will be a safer place to live.
Health inequalities; physical / emotional / behavioural	The Strategic Plan has 5 key outcomes and aligning priorities (see section 1). These aim to address the combined impact of equality protected characteristics, including the issues that impact on individuals beyond their health and social care needs.
Physical security; homelessness; criminal justice;	The Integration Joint Board is a member of the Community Planning Partnership and this will therefore ensure links with a number of relevant plans, including: ▪ Community Safety Plan ▪ Community Justice Transition Plan ▪ Local Housing Strategy – through the Housing Contribution Statement ▪ Integrated Children's Services Plan ▪ Falkirk Alcohol and Drugs Partnership Development Plan

Social responsibility / caring	The Strategic Plan addresses these issues in a number of ways. For example, supporting carers is a cross cutting priority identified within the Strategic Plan. The outcome relating to C*ommunity based supports* recognises the importance of supporting individuals and communities and that community engagement and empowerment is key. The Integration Joint Board, through the Council and NHS will act in accordance with respective policies and procedures in relation to environmental impacts and sustainability.
Influencing ability and participation; literacy / numeracy / language / rural	The Strategic Plan and associated documents - the Participation and Engagement Strategy and the Communications Framework – will ensure a focus on enabling participation, access to information and services across all groups, particularly those noted as hard to reach. The partnership will ensure that information will be available in suitable formats to meet the needs of a range of audiences. The Integration Joint Board, as a member of the Community Planning Partnership, will work with Community Learning and Development services.

Partners / other Stakeholders

3.2 Which sectors are likely to have an interest in or be affected by the proposal / policy / project?							
Partners / Stakeholders	**Business**	**Councils**	**Education Sector**	**FIRE**	**NHS**	**Police**	**Third Sector**
Insert X where appropriate:	X	X	x	x	x	x	x
Describe the interest / affect:							

Business (including the Independent sector and others eg supported employment) - 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.

Council and NHS Forth Valley – the Integration Joint Board through the Integration Scheme and the Strategic Plan will direct those health and social care functions delegated from the parties. In the Forth Valley area, there has been the development of shared services across NHS FV and the 3 Local Authorities, which will be considered through the Integration Joint Board and the Strategic Plan. In relation to specialist health services there will be engagement for regional services where required.

Education – there are a number of areas where the education sector will have an interest and where the IJB will actively engage with partners. These include:

- Children and young people at points of transition from children's to adult services
- Community based learning opportunities
- Workforce and availability of appropriate further and higher education courses and training
- Routes into employment for service users

Fire and Rescue and Police services – the IJB as a community planning partner will work with these services in relation to Outcome 3 (Safe) around areas of adult support and protections issues and wider community safety work.

Third sector – the sector is integral to the delivery of the Strategic Plan and has a role in contributing to the partnership's five local Outcomes. The Third sector is represented on the Integration Joint Board and the Strategic Planning Group, and will be involved as locality planning develops over the period of the plan.

Other interested parties (please list):	**Describe the nature of the relationship / impact:**
	Other – includes organisations directly contributing to health and social care for example the Scottish Ambulance Service, NHS 24 and organisations indirectly contributing to health and social care for example Falkirk Community Trust. There will be an interest in our regulators, for example Care Inspectorate, Health Improvement Scotland, Audit Scotland.

Quantitative and / or qualitative evidence

3.3 Please include any evidence or relevant information that has influenced the decisions contained in this EPIA (this could include demographic profiles; audits; research; health needs assessments; national guidance or legislative requirements)	
Quantitative evidence:	**Describe type; where accessible and key findings if not covered elsewhere in this assessment**

Social data: Service and workforce equality profile; Census information, Customer / staff survey etc.	The Joint Strategic Needs Assessment has been prepared and provides a comprehensive description of health and social care data relevant to the partnership. This brings together demographic data about the local population, including information about deprivation, housing and lifestyle factors and data about the needs of the local population describing the current pattern and level of services, and where possible identifies the extent of the gap between need and supply.
Environmental data: Research; Geographic / location information; crime rates; crime types;	The Integration Joint Board, as a member of the Community Planning Partnership, will work with partners to contribute, where required, to Strategic Environmental Assessments and as a partner to strategic plans, for example the Falkirk Open Space Strategy and Parks Development Plan. The NHS Forth Valley Clinical Services Review plan and HMYOI Polmont Health Services Plan provide relevant information.
Financial data: Procurement / budget; welfare benefits; welfare reform	As noted at 3.2 Business the Market Facilitation Plan will give the partnership a good understanding of the current levels of need and demand for health and social care services. The IJB will work within the commissioning and procurement arrangements of NHS FV and Falkirk Council to ensure consistency in commissioning services in line with the Strategic Plan priorities. The Strategic Plan has a financial statement prepared by the Chief Finance Officer. Within Falkirk Council a Welfare Reform Governance Group has been established, which has a remit to oversee the Council's response to the impact that welfare reform has on our services, employees and importantly, our communities. The group is responsible for gathering and reviewing data and then developing mitigating actions to ensure the significant risks to those in poverty are identified and that the necessary appropriate and integrated response is put in place. A welfare reform scorecard is used to track the impact of any changes on the Council's communities and services.
Health data: ageing; well-being;	The Joint Strategic Needs Assessment is the underpinning document supporting the Strategic Plan and provides evidence in support of the outcomes and priorities. The NHS FV Case for Change is the underpinning document supporting the NHS Forth Valley Clinical Services Review and provides evidence in support of the NHS Local Delivery Plan.
Qualitative evidence:	**Describe type; where accessible and key findings**
Social - case studies; personal /group feedback / other:	The Consultation and Engagement report provides information on the consultation process to develop the Strategic Plan and the feedback received. There were also a number of staff engagement sessions held and a report on this was considered.

Best judgement over hard evidence

3.4 (a) Has 'best judgement' been used in place of data/research/ evidence? **YES / NO**	**3.3(b) Who provided the 'best judgement'**	**3.3cWhat gaps in data/information were identified?**
Both – There has been a range of information available from different sources and informed judgement to assess and analyse this.	▪ Integration Joint Board ▪ Strategic Planning Group ▪ Strategic Planning Co-ordinating Group ▪ Staff engagement groups ▪ Consultees	
3.4(d) Is further research necessary? YES / NO		
If NO – please say why:		

Consultation

4.0 Has the proposal / policy / project been subject to involvement/consultation? If YES - state which individuals and organisations were involved / consulted; what form the involvement / consultation took and outcome.	
Who was involved/consulted: **Please indicate if it was active involvement or consultation**	**List:** 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 list of prescribed stakeholders for the Strategic Plan is set out in the Public Bodies (Joint Working)(Scotland) Act 2014: ▪ Users of health care ▪ Users of social care ▪ Carers of users of social care ▪ Carers of users of health care ▪ Commercial providers of social care ▪ Non-commercial providers of social care ▪ Commercial providers of health care ▪ Non-commercial providers of health care ▪ Non-commercial providers of social housing

	▪ Health professionals ▪ Social care professionals ▪ Staff of the Health Board and local authority who are not health professionals or social care professionals ▪ Third sector bodies carrying out activities related to health or social care other local authorities operating within the area of the Health Board preparing the integration scheme or the revised integration scheme. ▪ Residents of the locality An equalities monitoring proforma was distributed as part of the consultation document and the on-line survey. The return was low however the profile of respondents was considered in the Consultation and Engagement report.

How was the involvement/consultation carried out? **For other – describe:**	Focus group	Survey	Display / exhibitions	Users panels	Public event	Other
The communications to raise awareness of the consultation included: ▪ wide distribution of posters in public spaces, including GP surgeries, libraries, Council premises. ▪ active Twitter campaign co-ordinated through both HND FV and Falkirk Council comms team ▪ articles in the Falkirk Herald and Falkirk Council News.	x	x		x	x	x

What were the results from consultation?	**List:** Please see the attached Consultation and Engagement Report prepared on the consultation carried out in the development of the Strategic Plan. 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 a 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.
4.1 Has the proposal / policy / project been reviewed / changed as a result of consultation?	**YES** / NO
4.2 Have the results of the consultation been fed back to the consultees?	**YES** / NO
4.3 Is further consultation recommended	**YES** / NO
4.4 If no consultation has taken place. Please say why:	

Assessment outcome

5.0 Which of the following outcomes best matches your assessment of this proposal / policy / project?			
No major change required	**Adjust the proposal**	**Continue with the proposal**	**Stop and remove the proposal**
The EPIA demonstrates that the proposal is robust; there is no potential for discrimination and opportunities to promote equality have been taken.	The EPIA identifies some potential impact or missed opportunities. Adjustments can be made to remove barriers / promote opportunities.	The EPIA identifies adverse impact / missed opportunities. Adjustments cannot be identified. **You must set out reasons for continuing with this proposal:**	The proposal demonstrates actual / potential unlawful discrimination. Stop; remove and / or make changes.
No major change required – the EQIA has identified either positive or neutral impact on the equality protected characteristic groups, including poverty. The Plan will be subject to annual review and will continue to be informed with relevant data. The Partnership will encourage all staff and partners to have a human rights approach and complete all required fields on client based records, to ensure there is robust monitoring of all protected characteristics over the period of the plan. The IJB will consider any emerging impacts as required. Equalities consideration is a standing requirement in all reports to the IJB.			

Mitigating actions to minimise any negative impact

5.1 Have mitigating actions been identified? YES / NO. If YES outline below:				
Issue	**Action**	**Lead officer**	**Evaluation and Review date:**	**Strategic reference to Corporate Plan / Service Plan / Equality Outcomes**

No mitigating actions

5.2 Where a negative impact on diverse communities has been identified and no mitigation actions have been put forward; what is the justification for continuing with the proposal / policy / project?
Please outline:

EPIA Equality commentary

5.3 Equality commentary		
Comments:	Signature:	
	Date:	

Sign off

5.4 Sign off by Division / Department / Service / Team EPIA assessment officer

COMMITTEE / BOARD REPORT IMPLICATIONS SUMMARY

5.5 Sign off by Head of Service / Service Director			
Date of sign off:		Signature:	
Date of sign off:		Signature:	

Information from the EPIA must inform any Board / Executive report.

Equality and Poverty Impact Assessment
To be completed by Equality Task Group - Internal Equality Check

Name of EPIA:	**EPIA Reference No. (if applicable):**		
Date - EPIA received by Corporate Policy:			
Division and Service Contact details:			
Date - EPIA returned to Division and Service:			

Proposal / Policy / Project outline:	
Service- Project Manager:	**Contact details:**
Corporate Policy – Equality Check:	**Contact details:**

EPIA INFORMATION

Is the EPIA complete?	Is there a review date for the proposal / EPIA?	Have mitigating actions been identified where adverse impact known?	Have the actions been added to the relevant service plan?
YES / NO	YES / NO	YES / NO	YES / NO

OVERALL ASSESSMENT OF EPIA	ASSESSMENT FINDINGS – (use this box to highlight evidence in support of the assessment of the EPIA)
The EPIA has used data; appropriate consultation; identified mitigating actions as well as ownership and review of actions to demonstrate compliance with the general and public sector quality duties.	
OVERALL ASSESSMENT OF EPIA:	**ASSESSMENT RECOMMENDATIONS – (use this box to highlight actions needed to improve the EPIA)**
The EPIA has not demonstrated use of data; appropriate consultation; identification of mitigating actions to confidently demonstrate compliance with the general and public sector equality duties.	

Where adverse impact on diverse communities has been identified and it is intended to continue with the proposal / policy / project; has justification for continuing without making changes been made. **YES / NO**
If YES – describe:

EPIA - Publication checklist Corporate Policy Team	Passed to Web Team	Estimated date of publication
EPIA publication summary produced		
EPIA published on the website		
Signature on behalf of EPIA equality task group:		
Date:		

Appendix 6

PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

DIRECTION TO FALKIRK COUNCIL

1. The Integration Joint Board directs Falkirk Council ("the Council") in terms of section 26 of the Public Bodies (Joint Working) (Scotland) Act 2014 to carry out each of the functions listed in Annex 2 of the Integration Scheme ("the functions"), subject to the following conditions:-

   (a) the functions will be carried out consistent with the existing policies of the Council and any relevant decisions of the Council in relation to its revenue budget;

   (b) the functions will be carried out in a manner consistent with the strategic plan; and

   (c) no material change will be made to policies or service provision within the functions (with the exception of the function under section 24 of the Local Government and Planning (Scotland) Act 1982) unless agreed by the IJB.

2. The IJB will make a payment to the Council of £61,466m. to carry out the functions.

3. This direction will remain in force until revoked in full or part by the IJB.

Integration Joint Board
24th March 2016