Falkirk Integrated Strategic Plan 2016-2019

“To enable people in the Falkirk area to live full and positive lives within supportive communities.”
### Content

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting the scene</td>
<td>4</td>
</tr>
<tr>
<td>A Plan for Falkirk area</td>
<td>6</td>
</tr>
<tr>
<td>Why change?</td>
<td>13</td>
</tr>
<tr>
<td>People’s view</td>
<td>20</td>
</tr>
<tr>
<td>How will this plan be delivered?</td>
<td>22</td>
</tr>
</tbody>
</table>
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, Chair, Falkirk Integration Joint Board
Patricia Cassidy, 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:

1. **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.

2. **Grangemouth, Bo’ness and Braes**

   This is the largest of the three Health 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 petrochemical 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 of 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.

3. **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 to 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.

   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.

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**Figure 1: Falkirk Health and Social Care Locality Areas**
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 HSCI 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.

<table>
<thead>
<tr>
<th>Current Model of Care</th>
<th>Future Model of Care</th>
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<tbody>
<tr>
<td><strong>Disjointed care</strong></td>
<td>Integrated, seamless care with a single point of contact</td>
</tr>
<tr>
<td><strong>Reactive care</strong></td>
<td>Preventative and anticipatory care</td>
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<tr>
<td><strong>Acute centred</strong></td>
<td>Embedded in communities</td>
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<tr>
<td><strong>Services are given to people</strong></td>
<td>Services empower people to self-manage</td>
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<tr>
<td><strong>Service user as passive recipient</strong></td>
<td>Service user as partner</td>
</tr>
<tr>
<td><strong>Support for carers is variable</strong></td>
<td>Equitable support for carers</td>
</tr>
<tr>
<td><strong>Under use of technology</strong></td>
<td>Improved use of technology</td>
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<tr>
<td><strong>Acute condition focus</strong></td>
<td>Long-term condition focus</td>
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</tbody>
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Table 2: Illustration of old and new care model. Adjusted from Falkirk Joint Commissioning Plan for Older People 2014 - 2107
## 2.4 Local Outcome One

**Self-Management:** Individuals, carers and families are enabled to manage their own health, care and wellbeing.

<table>
<thead>
<tr>
<th>What does this mean for people?</th>
<th>What are we going to do?</th>
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</table>
| People, their carers and families are 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. | • 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 through 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 |

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<tr>
<th>What does this mean for our communities?</th>
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<tbody>
<tr>
<td>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 have available to provide and have confidence in them.</td>
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<tr>
<th>What does this mean for the HSCI Partnership?</th>
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<tr>
<td>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.</td>
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## 2.5 Local Outcome Two

**Autonomy And Decision Making:** Where formal support is needed people are able to exercise as much control and choice as possible over what is provided.

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<thead>
<tr>
<th>What does this mean for people?</th>
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| 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 well-being. 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 |

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<tr>
<th>What does this mean for our communities?</th>
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<tr>
<td>Communities are enabled to continue to develop and manage a variety of good quality local services to meet community need.</td>
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<tr>
<th>What does this mean for the HSCI Partnership?</th>
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<tr>
<td>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.</td>
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2.6 Local Outcome Three

**Safe:** Health and social care support systems are in place, to help keep people safe and live well for longer.

**What does this mean for people?**
People will be supported to live safely in their homes and communities. People will be involved and consulted on decisions about their care, treatment and support. People will have timely access to services, based on assessed need. Services will improve qualities of lives and be joined up to make best use of available resources.

**What does this mean for our communities?**
Communities are confident that systems are in place for the identification, reporting, and prevention of harm.

**What does this mean for the HSCI Partnership?**
The Partnership is able to identify, manage and tolerate risk, and staff are supported in being able to work in different ways, to support personal outcomes.

The Partnership recognise the critical link between health and social care provision and the contribution of wider partners, for example, the Community Planning Partnership, Criminal Justice and Housing.

The Partnership will continue to 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 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 Care Governance framework
- We will continue to invest in Technology Enabled Care as an effective and appropriate way to support care
### 2.7 Local Outcome Four

**Service User Experience:** People have a fair and positive experience of health and social care.

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<th>What does this mean for people?</th>
<th>What are we going to do?</th>
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| 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 |

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<tr>
<td>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.</td>
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<td>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.</td>
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### 2.8 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.

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<tr>
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| 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  
• 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 |

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<tr>
<td>Communities are informed, involved and supported to work cohesively to develop and manage community based supports.</td>
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<tr>
<td>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.</td>
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![Images of people]
### Local Outcomes: What They mean and what we’re going to do

<table>
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<tr>
<th>Local Outcomes</th>
<th>Evidence</th>
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| **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 35 hours care per week |
| **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 |
| **Safe:** Health and social care support systems are in place, to help keep people safe and live well for longer | - An average of 6,848 items of equipment are provided per annum to support people to live at home
- In 2014, 4,353 people received telecare services
- 990 adults with Learning Disabilities in Falkirk area, 51.1% live in mainstream accommodation
- 10,868 adults with physical disability, 53% aged 50-74. |
| **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
- Health & Care recipients survey 13/14 found – 94% respondents felt ‘treated with respect’ and 85% felt ‘health & social care services seem well coordinated’ |
| **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 which fall within the 15% most deprived in Scotland (SIMD) |
What People Said

‘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’

‘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 children’s 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.’

‘more emphasis placed on technology enabled care to help people self manage their conditions at home.’
‘Not all people needing help or re-homing are elderly […] More communication between staff might make a difference’
‘Use of technology to support people to articulate their needs, provide feedback and influence services and plans and improve care’

‘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 are—not punished, but seen as learning opportunities for the individuals and the systems’

‘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!’

Priorities

• 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

• 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

• We will ensure there is a greater focus given to individual case management, enhanced by the provision of advocacy support, where required
• We will ensure risk is acknowledged and managed effectively and risk based support is in place
• We will continue to work across the partnership to ensure adults at risk of harm are supported and protected.
• We will implement our Clinical Care Governance framework
• We will continue to invest in Technology Enabled Care as an effective and appropriate way to support care.
• We will pursue co-location of staff and services where appropriate to support integration

• 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 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
Case Study

Linda presented to her GP in a state of crisis. Linda had experienced suicidal thoughts on and off since adolescence, however things had become worse since the birth of her first child 9 months ago. Linda was struggling to cope and could not see a future.

Linda’s GP urgently referred her to Falkirk Community Mental Health Team (CMHT) and this was screened within 4 hours by the CMHTs rota coordinator. Based on risk, Linda was visited by 2 mental health professionals (a nurse and an occupational therapist) within 48 hours.

Linda was given immediate emotional support for the distress she was experiencing. The mental health professionals devised a safety plan with Linda which detailed practical ways she could keep herself safe during times when her emotions were overwhelming.

Linda’s had access to treatment and support and felt she had learned the skills necessary to manage. When Linda had been able to achieve a period of stability it was appropriate and safe for her care to be transferred back to her GP.

As Linda was the sole carer of a baby, the team’s social worker linked with the Health Visitor to provide support to Linda bonding with her baby. The Psychiatrist explained her condition and gave her some written information and she was encouraged to use some self-help materials and taught strategies to help her manage distress. A review of her medication was completed with her involvement.

Throughout Linda’s journey she was seen by the same professionals as much as possible. This proved continuity and consistency of care. A holistic care plan was generated using the different professional skills within the Community Mental Health Team (Linda was provided with evidence based biological, psychological and social treatments). When new professionals became involved in her care there were face to face discussions (paper bureaucracy was kept to a minimum- this allowed professionals more time to care for her and prevented delays in getting Linda help she needed). Her case was discussed and reviewed regularly by senior staff from all professional disciplines at the weekly team meeting and this provided regular safety checks as Linda progressed through her treatment journey. Recovery and self-management was promoted. When she was safe and ready to be moved on from secondary care services this was done so that the service has enough capacity to help the next individual like Linda.

We already have good examples of how joined up working between health, social care, the independent and third sector can make a difference. We will continue to work with our staff, service users and carers to deliver more streamlined and coordinated care. This will lead to better outcomes for people who use our services.

The following case study gives an example of how this can be done.
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.

Figure 4: 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
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](image)

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](image)

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.
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.

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 specialists 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.

• 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 (JointWorking) (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 (CPP) and therefore has a shared responsibility for the delivery of the priorities and outcomes set out in the Strategic Outcomes and 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 and 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
- 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.
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                      | Staff engagement sessions (7 in total April & May 2015)      | Citizens Panel Survey (November 2015, with 493 responses)             |
| Local Media                           | Transitional Board priority setting workshop (18 June 2015)  | Online Survey (Nov & Dec 2015, with 73 responses)                     |
| Social Media                          | Stakeholder engagement event for staff across all sectors (30 June 2015) | Targeted presentation and feedback sessions (23 in total throughout Nov & Dec 2015) |
| Website Banner                        | Strategic Planning Group meetings (August and Nov 2015 & Jan 2016) |                                                                      |
| Posters in public venues/GP surgeries |                                                              |                                                                      |

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:

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Group/Forum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communities</td>
<td>Community Council Forum, Carers Forum, ALFY Public Education Events, Patient Participation Forum, Friends of Dundas</td>
</tr>
<tr>
<td>Staff</td>
<td>Occupational Health Forum, GP Sub Committee, NHS Forth Valley Corporate Management Team, Community Care Service Managers Meeting, Playing to your Strengths Event</td>
</tr>
<tr>
<td>Partners</td>
<td>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</td>
</tr>
</tbody>
</table>

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’s 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:

<table>
<thead>
<tr>
<th>Current Community Health Services</th>
<th>Current Local Authority Services</th>
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<tbody>
<tr>
<td><em>District Nursing</em></td>
<td><em>Social work services for adults and older people</em></td>
</tr>
<tr>
<td><em>Services related to substance addiction</em></td>
<td><em>Services and support for adults with physical disabilities and learning disabilities</em></td>
</tr>
<tr>
<td><em>Services provided by AHPs in outpatient clinics or out of hospital</em></td>
<td><em>Mental health services</em></td>
</tr>
<tr>
<td><em>Primary medical services/Public dental service/General dental, Ophthalmic and Pharmaceutical services</em></td>
<td><em>Drug and alcohol services</em></td>
</tr>
<tr>
<td><em>Community Mental Health and Learning Disability services</em></td>
<td><em>Adult protection and domestic abuse</em></td>
</tr>
<tr>
<td><strong>Current Hospital Services</strong></td>
<td><em>Carers support services</em></td>
</tr>
<tr>
<td><em>Emergency Department</em></td>
<td><em>Community care assessment teams</em></td>
</tr>
<tr>
<td><em>Inpatient hospital services (General Medicine/Geriatric Medicine/Rehab Medicine/Respiratory)</em></td>
<td><em>Support services</em></td>
</tr>
<tr>
<td><em>Hospital based Mental Health services</em></td>
<td><em>Care home services</em></td>
</tr>
<tr>
<td><em>Psychiatry of Learning Disability</em></td>
<td><em>Adult placement services</em></td>
</tr>
<tr>
<td><strong>Table 6</strong></td>
<td><em>Health improvement services</em></td>
</tr>
<tr>
<td></td>
<td><em>Aspects of housing support, including aids and adaptations</em></td>
</tr>
<tr>
<td></td>
<td><em>Day services</em></td>
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<tr>
<td></td>
<td><em>Local area co-ordination</em></td>
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<td></td>
<td><em>Respite provision</em></td>
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<td></td>
<td><em>Occupational therapy services</em></td>
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<td></td>
<td><em>Re-ablement services, equipment and Technology Enabled Care</em></td>
</tr>
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</table>
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 = £131 million
Falkirk Council = £61 million
Partnership Funding = £8 million

The Falkirk HSCI Partnership budget for 2016/17 totals £200 million.

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 Equalities 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 IJB 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.