

# Falkirk Health and Social Care Partnership

## Strategic Plan 2019 - 2022

Communities  
Supportive  
Positive Lives  
**Enable**  
Inclusive

## Foreword

---

### Welcome from the Chief Officer and IJB Chair

We are pleased to present the second Strategic Plan for the Falkirk Health and Social Care Partnership (HSCP). This has been developed by the Strategic Planning Group, in consultation with people of Falkirk, staff and partners.

The Strategic Plan 2016 - 2019 was our first integrated health and social care plan. It set out the direction of travel the Falkirk Integration Joint Board wanted to make over 3 years. The plan recognised the scale of transformational change that was required and the context for services and partners about what could be achieved.

Over the past 3 years, there have been a number of service improvements. For example we have worked with adults who have used our day services to transform what type of support is available to them. We have done this with support from partners, such as Falkirk Community Trust and In Control Scotland. This collaboration has resulted in more young adults accessing a different range of leisure and community activities. Many positively describe the difference this has made to them.

We will continue this work to enable further positive changes to the way we deliver services. This Plan outlines our priorities and our commitment to improving outcomes for people living in the Falkirk HSCP area.

We anticipate we will be able to increase the pace of transformational change with the transfer of NHS operational services planned from 2019. We will develop integrated locality teams that will have a focus on enabling people to live at home, or in a homely setting, with services that empower them.

To do this, we will continue to work with communities, Third and Independent Sector partners and Community Planning Partners to ensure our combined efforts achieve the results for people that this plan aims to deliver.

We hope you find this plan ambitious and interesting as we work towards achieving our strategic vision and local priorities.

**Chief Officer**

**IJB Chair**

# Contents

<b>Foreword</b> .....	2
Welcome from the Chief Officer and IJB Chair .....	2
<b>Introduction</b> .....	5
About the Strategic Plan 2019 - 2022.....	5
About the Integration Joint Board (IJB) .....	6
About the Falkirk Health and Social Care Partnership .....	6
Partnership Working.....	7
Locality Plans.....	7
Why change is required .....	9
Our Challenges.....	10
Our Opportunities .....	10
<b>Vision, Outcomes and Priorities 2019 - 2022</b> .....	11
Our Vision is:.....	11
Our Strategic Outcomes .....	11
Our Principles.....	12
Our Priorities.....	13
Priority 1. Deliver local health and social care services including Primary Care, through enabled communities and workforce .....	14
Priority 2. Ensure carers are supported in their caring role.....	17
Priority 3. Focus on early intervention, prevention and harm reduction .....	19
Priority 4. Make better use of technology to support the delivery of health and social care services.....	23
Action Plans 2019 - 2022.....	25
Priority 1: .....	26
Priority 2: .....	28
Priority 3: .....	29
Priority 4: .....	31
<b>Review of Strategic Plan 2016 - 2019</b> .....	34
<b>Strategic Context</b> .....	37
Legislation.....	37
Planning.....	38

<b>Strategic Commissioning .....</b>	<b>41</b>
Strategic Needs Assessment (SNA) .....	41
Market Facilitation Plan.....	41
 <b>Participation and Engagement .....</b>	 <b>42</b>
 <b>Monitoring Performance .....</b>	 <b>43</b>
Falkirk Performance Summary .....	43
 <b>Finance and Risk.....</b>	 <b>45</b>
Partnership Budget .....	45
Medium Term Financial Plan (MTFP) .....	45
Partnership Funding .....	45
Risk Management.....	46
 <b>Glossary of Terms .....</b>	 <b>47</b>

# Introduction

---

## About the Strategic Plan 2019 - 2022

The Strategic Plan outlines how we will deliver adult health and social care services in Falkirk over the next 3 years, 2019 - 2022. It aims to set out the improvements we will make.

The Strategic Plan sets out how the Integration Joint Board (IJB) will plan and deliver services for the Falkirk area, using the integrated budgets under our control. The Plan will set out how we will deliver the national outcomes for health and wellbeing, and achieve the core aims of integration to:

- improve the quality and consistency of services for patients, carers, service users and their families
- provide seamless, integrated, quality health and social care services that care for people in their homes, or a homely setting, where it is safe to do so
- ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

Much has changed since the first plan was published in 2016. There has been the implementation of the Carers (Scotland) Act 2016; introduction of national integration priorities; a range of new policy and planning requirements and continued impact of demographic changes and budget pressures on services.

In the main we have been able to respond to these changes as they have fitted well with our vision and priorities. The new plan has been developed with an understanding of local needs, what people have told us about services and new policy and legislation. The plan provides an opportunity to better reflect these new requirements in our work. The 'Strategic Context' section provides more information.

NHS Forth Valley and Falkirk Council provide a range of health and social care services that are reflected in their respective strategic and operational plans.

The IJB and the Strategic Planning Group will oversee the Plan's progress. The HSCP will prepare an Annual Performance Report that will set out our progress in delivering the Plan. This report is published in July each year. The first report relevant to this plan will be in July 2020.

## About the Integration Joint Board (IJB)

NHS Forth Valley and Falkirk Council adopted the “body corporate” model of integration. This means we have established the Falkirk Integration Joint Board. The Board is a distinct legal and decision-making body. It plans and decides how health and social care services are delivered in line with the Strategic Plan. It then directs NHS Forth Valley and Falkirk Council to work together in partnership to deliver health and social care services based on their decisions, making best use of available resources. The [membership of the IJB](#) is prescribed in legislation, and includes:

- Council elected members
- NHS Board non-executive members
- Professional Advisors
- Service user, Carer, Third Sector and staff representation.

The arrangements for health and social care integration are outlined in [Falkirk's Integration Scheme](#).

The Board meetings are held in public and all our reports are published [online](#).

## About the Falkirk Health and Social Care Partnership

The Falkirk Health and Social Care Partnership (HSCP) has been set up in response to the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. This Act is often called the integration legislation.

*“At its heart, health and social care integration is about ensuring that those who use services get the right care and support whatever their needs, at any point in their care journey”.*

Health and social care services and functions are delegated by NHS Forth Valley and Falkirk Council to the Falkirk Health and Social Care Partnership. This is referred to as the ‘Partnership’ or ‘HSCP’.

The Partnership directly provides services like homecare, residential, day care services. There are also social care services which are contracted from the Third and Community Mental Health and Independent sectors, such as carers support, short breaks and nursing care homes.

Engagement with people is at the heart of everything we do. The IJB and Strategic Planning group has a wide representation and we will continue to make sure that as we develop our locality plans over the year we continue this approach.

## Partnership Working

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

- People live full and positive lives within supportive communities (outcome)
- Improving mental health and wellbeing (priority).

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

The IJB is a Community Justice partner, and the Chief Officer represents the IJB on the Falkirk Community Justice Partnership (CJP). People with lived experience of Community Justice Services often have a range of needs. These require partnership working between the IJB and CJP to ensure people access and make use of relevant services to address their range of needs.

Falkirk Alcohol and Drug Partnership (ADP) is a multi-agency partnership that aims to reduce the harm caused by the use and misuse of substances within our communities. The ADP oversees a broad range of activity to support individuals and communities. There are good links between the ADP and the HSCP, with alignment through the Strategic Plan priority for substance use.

The Partnership has established forums with the Third and Independent sectors, with sectors including communities represented on a range of service planning groups. This approach builds on positive working arrangements with the sector.

## Locality Plans

The Partnership has identified three locality areas for service planning and delivery purposes. This is required in the integration legislation and is reflected in the Community Empowerment Act. Our locality areas are aligned to the GP clusters:

- 1. West:** Denny, Bonnybridge, Larbert and Stenhousemuir
- 2. Central:** Falkirk town
- 3. East:** Grangemouth, Bo'ness and Braes

The Partnership has developed [Locality Profiles](#) for each of these areas. The profile presents a 'picture' of current need and demand in each of the areas. These will be used to inform locality discussions and further analysis will be done as required.

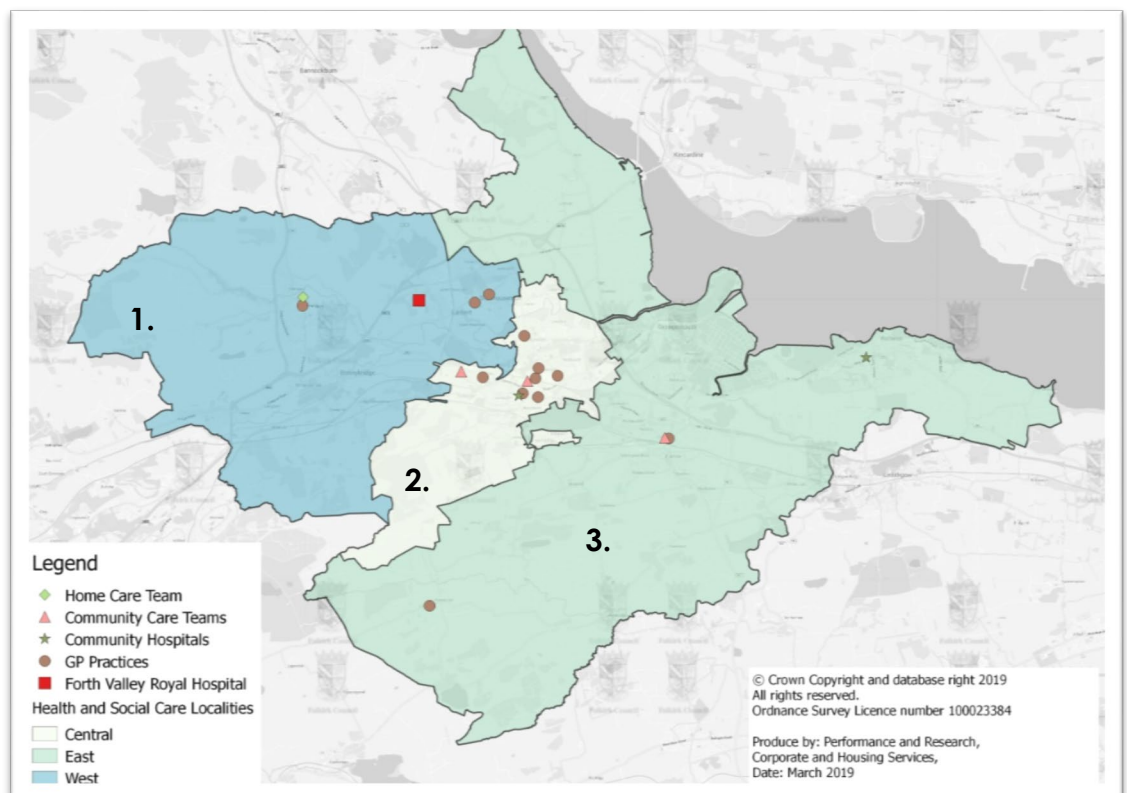
Locality working provides the opportunity for the Partnership to design integrated services and realign resources to deliver the Strategic Plan. This will also include working alongside our partners and their plans. This includes the Community Planning

Partnership (CPP) Strategic Outcomes and Local Delivery (SOLD) Plan. In developing our locality structures we will align with the work being led by the CPP to:

- co-produce locality plans
- design integrated and localised services, including health improvement and prevention support
- build community capacity to improve health and wellbeing outcomes, and address health inequalities.

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

1. West
2. Central
3. East





## Why change is required

We plan to change the way we will deliver health and social care services to improve people's health and wellbeing. Over the next 3 years we will focus on providing services that support recovery, reablement and rehabilitation and supports more people to remain independent in their own homes.

The Partnership will use our combined resources in a more effective, efficient and person-centred way. We need to do this to address the challenges we face. By working in an integrated way we will be better placed to respond to the increased demand on services within our available resources. We need to respond to what people tell us about their experiences of services, and what changes are needed.

The Partnership recognises that many of the changes we aim to deliver are transformational and will be achieved over a much longer term than the 3 years of the plan. The plan maintains a focus on prevention, early intervention and to enable people to be at the centre of decisions that affect them and supports them to self-management and have control.

By building on the work done over the period of our first plan, and keeping the same strategic direction, we will be better placed to have the right range of interventions available to help people in the best possible way. These will be high quality, responsive, promote independence, improve health and well-being and promote equality of access.

We will continue to work with people, communities, third and independent sectors, partners and academic bodies to deliver solutions to meet their needs. Our ambition is to design the right services, delivered in the right place, at the right time to meet their needs.



## Our Challenges

The Partnership faces some significant challenges over the 3 years of the plan. This is the same for many other Partnerships across Scotland. These include:

- increasing demand for health and social care services that is expected to continue
- people are increasingly living longer into old age, and therefore there is an increase in people living with multiple and complex conditions
- changes in the population mean we also have an ageing workforce - we also have challenges with recruitment and retention of posts across the workforce
- rising numbers of people with mental health and well-being concerns
- health and social inequalities in our communities
- numbers of adults and older people going into care home where alternative solutions might have been better options
- reducing numbers of people who use services and their carers saying they feel supported
- pressures managing the Partnership budget with growing demands on it
- fluctuating performance in supporting peoples timely discharge home from hospital

## Our Opportunities

- the Partnership has long-established positive relationships with the Third, Independent and Community Planning Partners
- grow and sustain our community assets
- dedicated and experienced staff who are committed to working together with people who use services, carers and families and communities. Through integration there will be opportunities to review the skill mix of staff and make best use of resources by avoiding duplication
- Partnership Funding is available to support innovation and transformation through a range of pilots and tests of change
- strengthened links with the acute services at Forth Valley Royal Hospital to support the Unscheduled Care Programme across the whole health and social care system
- use our buildings differently

## Vision, Outcomes and Priorities 2019 - 2022

This section summarises the Strategic Plan vision and outcomes we aspire to deliver. The priorities in the plan, alongside the delivery of health and social care services, will deliver the vision. They will also enable the transformational change that will be needed to deliver integrated services.

The Partnership has refined the 5 outcomes from the first plan. This was based on feedback from people about what matters to them:

- people are able to quickly access high quality support when they need it
- people have access to information, support and services locally available
- people are at the centre of their care and their personal outcomes are met
- people and communities are involved, enabled and empowered
- workforce are supported and valued and have access to learning and development opportunities to meet expectations on them.

### Our Vision is:

*“to enable people in Falkirk HSCP area to live full and positive lives within supportive and inclusive communities”*

### Our Strategic Outcomes

1

#### Self-Management

Individuals, their carers and families can plan and manage their own health, care and well-being. Where supports are required, people have control and choice over what and how care is provided

2

#### Safe

High quality health and social care services are delivered that promote keeping people safe and well for longer

3

#### Experience

People have a fair and positive experience of health and social care, delivered by a supported workforce that are skilled, committed, motivated and valued

4

#### Strong sustainable communities

Individuals and communities are resilient and empowered with a range of supports in place that are accessible and reduce health and social inequalities

## Our Principles

To complement our outcomes, under-pinning principles for the Falkirk Health and Social Care Partnership were also agreed and are set out in the Integration Scheme:

- putting individuals, their carers and families at the centre of their own care by prioritising the provision of support which meets the personal outcomes they have identified as most important to them
- recognising the importance of encouraging independence by focusing on reablement, rehabilitation and recovery
- providing timely access to services, based on assessed need and best use of available resources
- providing joined up services to improve quality of lives
- reducing avoidable admissions to hospital by ensuring that priority is given to strengthening community based supports
- sharing information appropriately to ensure a safe transition between all services
- encouraging continuous improvement by supporting and developing our workforce
- identifying and addressing inequalities
- building on the strengths of our communities
- planning and delivering health and social care in partnership with community planning partners
- working in partnership with organisations across all sectors e.g. Third sector and Independent sector
- communicating in a way which is clear, accessible and understandable and ensures a two way conversation.

## Our Priorities

The HSCP will continue much of the work already started through the first plan. Our new plan for 2019 - 2022 identifies priorities that will be of specific focus to the Partnership.

These are areas in which we need to make significant changes, progress or investment during the period of the plan. Focussing on these priorities will collectively contribute to our strategic outcomes. These priorities are:

**1** Deliver local health and social care services, including Primary Care, through enabled communities and workforce

**2** Ensure carers are supported in their caring role

Early intervention, prevention and harm reduction that:

**3**

- improve people's mental health and wellbeing
- improve support for people with substance use issues, their families and communities
- reduce the impact of health and social inequalities on individuals and communities

**4** Make better use of technology to support the delivery of health and social care services





## Our Priorities in More Detail

### 1 Deliver local health and social care services including Primary Care, through enabled communities and workforce



#### What we are already doing

Within the Partnership we have continued to develop new relationships with people, communities, our workforce and other stakeholders to put people at the centre of decisions about their care and support.

We intend to build on the success to date by working with people who use our services to redesign them. People are living longer and we need to find new ways to support people to remain active citizens.

There are 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, and improve health and wellbeing. Equality is at the heart of everything that we do.

### Primary Care Transformation Programme

There are three key strands of the Transformation Programme:

- Urgent care GP out of hours
- Primary care
- Mental health in primary care.

The Primary Care Improvement Plan for Forth Valley 2018 - 2021 identifies how additional funds will be used in line with the Contract Framework and outlines how services will be introduced to establish an effective multi-disciplinary team model at GP Practice and Cluster level.

### Locality Planning

We are organising our health and social care services within 3 locality areas (see page 8). There are three established locality groups, which have had an initial focus for professionals to network and improve joint working across statutory, private and Third sectors.

As Locality Managers take up their posts, these locality groups will develop their membership to include people and communities from different backgrounds. They will work together to develop locality plans for their area.

### Community Development

The Partnership has started work on a Community Led Support (CLS) initiative with the National Development Team for Inclusion (NDTI). They work with communities and health and social care professionals to support innovation and change in health and social care. By working together the intention is to design a health and social care service that works for everyone.

The principles the Partnership will adopt through this work are:

- coproduction brings people and organisations together around a shared vision
- there has to be a culture based on trust and empowerment
- there is a focus on communities and each will be different
- people are treated as equals, their strengths and gifts built on
- bureaucracy is the absolute minimum it has to be
- people get good advice and information that helps avoid crises
- the system is responsive, proportionate and delivers good outcomes.

Through this 18 month programme, CLS in Falkirk will give us the opportunity to introduce innovation to how we deliver services – designed and driven by practitioners along with local partners and members of the community. CLS will help us build on what is already working, joining up good practice and strengthening common sense, empowerment and trust.

## How do we know that this is a priority?

The integration legislation requires the Partnership to establish localities. There are three localities in the Falkirk HSCP. The Scottish Government published [Localities Guidance](#) reinforcing the importance of localities.

The Community Empowerment (Scotland) Act 2015 provides a legal framework for community planning. It also creates new rights for community bodies and places new duties on public bodies. The Act aims to improve outcomes achieved as a result of public services and has a significant emphasis on addressing disadvantage and inequality. The HSCP will continue to build on the existing strong links with the CPP. The Partnership leads on one strategic outcome and one priority for the CPP SOLD Plan.

Participation with communities lies at the heart of community planning. CPPs must support community bodies to participate in all parts of the process, in the development, design and delivery of plans and in review, revision and reporting progress.

### Support Primary Care Transformation

The move towards a new General Medical Services (GMS) Contract is set against a background of ongoing sustainability issues recognising that less doctors are choosing to become GPs and over 50% of our current GPs in Forth Valley are over 50, with 23-25% aiming to retire or significantly reduce their clinical commitment in the next 3-5 years.

### Palliative and End of Life Care

The Scottish Government's Strategic Framework for Action on Palliative and End of Life Care (SFA) states that by 2021 everyone in Scotland who requires palliative care will have access to it. Within Falkirk we aim to provide palliative and end of life care within a homely setting respecting individuals' choice. We aim for the majority of people with palliative and end of life care needs to be given the choice of completing an Anticipatory Care Plan, ReSPECT or similar document. These will facilitate sensitive and important conversations with individuals and their families.

### Outcome Focussed Rehabilitation and Reablement

It is recognised that multi-disciplinary and multi-agency rehabilitation and reablement improves outcomes, self-management and meets the demands of the Scottish Government 20:20 vision ensuring people stay at home or in a homely setting for as long as possible. Within Falkirk we will embed the reablement approach across all services.



## 2 Ensure carers are supported in their caring role

---



### What we are already doing

There is a productive partnership with the Carers Centre, Carers, Social Work Adult Services, Children's Services, NHS Forth Valley and the Third Sector. This group has overseen the programme of work to implement the Carers Act legislation, and deliver a range of services to support carers. This work includes:

- [Local Eligibility Criteria for Unpaid Carers](#) implemented in April 2018
- A [Falkirk Short Breaks Services Statement](#) published in January 2019
- Adult Carer Support Plans (ACSP) and Young Carers Statement (YCS) involve carers in the planning and design of their support
- Provision provided by partners includes:
  - short breaks/respite
  - advice and information
  - practical support
  - emotional support
  - training and learning
  - benefits assistance
  - future planning
  - emergency planning
- Carers Strategy published in April 2019.

## How do we know that this is a priority?

The Carers (Scotland) Act 2016 came into effect on 1 April 2018. The Act extends and enhances the rights of carers. The new legislation helps to ensure better and more consistent support for both adult carers and young carers so that they can continue to care, if they so wish, in better health and to have a life alongside caring.

The Falkirk HSCP [Unpaid Carers Needs Assessment](#) looked at what was currently known about carers in Falkirk, as well as service provision. It considered the factors that will impact on demand for support and informed the development of the Carers Strategy.

- Applying prevalence rates from the Scotland's Carers 2015 report, in Falkirk there may be over 22,000 (22,274) adult (16+) and 864 young carers (aged 4-15). This would mean there could be over 8,000 'hidden' carers
- Carers are more likely to have health conditions and perceive their health as poorer than non-carers
- Less than half of carers felt supported to continue caring and that the services for the person they cared for were well coordinated
- There is a growing aging population, many living with long term conditions. The potential for the number of people providing unpaid care in turn is likely to increase.
- The 2011 Census showed there is a greater proportion of carers in the most deprived areas
- In Falkirk, the highest number of carers and proportion of the population providing unpaid care was in the East locality.



### 3 Focus on early intervention, prevention and harm reduction



#### What we are already doing

##### Health and Social Inequalities

Health and social inequalities are the unfair and avoidable differences in people's health and social care between different population groups. Some of the groups that are most at risk of experiencing inequality are people with long term health conditions, mental health issues, people affected by substance use and people living in deprived areas.

Falkirk Council and the Community Planning Partnership have recently refreshed Falkirk's Strategy to address the impact of poverty Towards a Fairer Falkirk 2019 - 2024.

NHS Forth Valley's Health Improvement Strategy A Thriving Forth Valley 2017-2021 also identifies priorities, which are relevant to health inequalities. The action plans and programmes of delivery are being progressed by community planning partners, including the HSCP. The imminent review of the Falkirk SOLD will provide an opportunity to review and enhance existing programmes to ensure the health improvement strategy outcomes can be achieved

Specific programmes and projects currently in place or being developed in Falkirk include:

- Keep Well Forth Valley – supporting people experiencing deprivation
- Social Inclusion Programme (SIP) – focussed work with people with very chaotic lifestyles
- Rapid Rehousing Transition Plan – including Housing First.



## Mental Health and Wellbeing

The implementation of the mental health priorities within the previous Falkirk Strategic Plan continue to be taken forward. The HSCP is lead for the mental health and wellbeing priority in the CPP SOLD Plan. The group leading on this priority is reviewing the Delivery Plan to ensure this is consistent with the national Mental Health Strategy and local initiatives. The Partnership oversees the use of Scottish Government funding that is made available to implement the national strategy. There are specific projects in place that are supported by these funds.

The Partnership has undertaken significant work to ensure that the wide range of mental health and wellbeing services across Falkirk are effectively commissioned in line with local need. This work recognises the close links and overlap in mental health provision and other areas e.g. substance use and children and young people.

## Substance Use

Falkirk Alcohol and Drug Partnership (ADP) supports local delivery of the national Drug And Alcohol Treatment Strategy [Rights, Respect And Recovery](#).

The strategy supports the aims and outcomes identified in the CPP SOLD Plan in relation to reducing the harms related to substance misuse.

There are a wide range of opportunities across Falkirk which offer individuals and their families options for treatment and recovery. This includes:

- a dedicated family support service
- an early intervention service for young people
- recovery cafes - attendances at recovery meetings are increasing across the area and Forth Valley Recovery Community is flourishing
- a specialist Alcohol Related Brain Injury Service.

The Falkirk ADP, with the Partnership, has given a commitment to review services for people with a substance misuse problem. This will look at how services are provided in Falkirk across a range of partners including Adult Social Care, Children Services and NHS. It will pick up on work that has recently been undertaken through a strategic needs assessment and look at how issues identified might be addressed. This allows us to identify where improvements need to be made with those services as well as where we have gaps. Additionally it will inform how we allocate resources to service provision across the Falkirk area.

The ADP will ensure a review of governance is undertaken in preparation for a new Memorandum of Understanding (MoU) between the Scottish Government and Council of Scottish Local Authorities (COSLA). It is anticipated that this new MoU will reaffirm the role of local ADPs but without being specific about local arrangements for governance. This will recognise different functions of IJBs across the country and the different community planning arrangements.

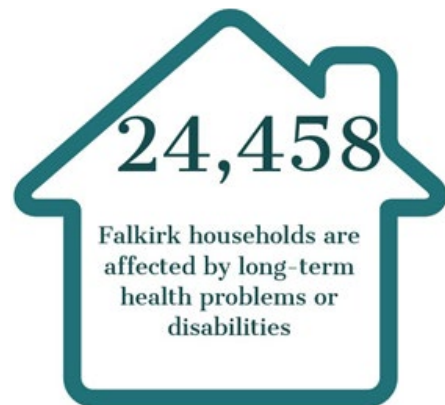
## How do we know that this is a priority?

### Health Inequalities

The Scottish Government's National Health and Wellbeing Outcomes state that health and social care services will contribute to reducing health inequalities. In Falkirk, all cause mortality has been increasing for the most deprived areas and declining for the least deprived areas. This shows that health inequalities in Falkirk, not only exist, they are widening.



**The difference of life expectancy at birth between Falkirk's most deprived and least deprived areas is 2.3 years for females and 6.4 years for men**



There are 3 national requirements relevant to improving health and tackling health inequalities. NHS Forth Valley is required to report on these by the Scottish Government and is currently developing action plans with partners to take forward:

- NHS Forth Valley Socio-economic Duty
- NHS Forth Valley – Mitigating the effects of Welfare Reform
- NHS Forth Valley – Local Children's Poverty Action Report

### Mental Health and Wellbeing

Mental Health is an umbrella term used to encompass both mental health problems/illness and mental wellbeing. The Scottish Government estimate that approximately 1 in 4 people will experience some form of mental health issue in their lifetime.

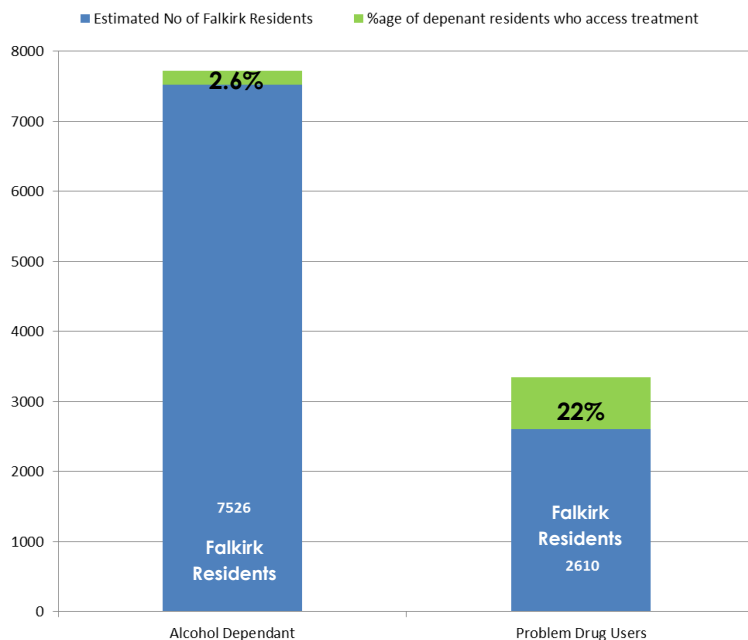
There is a high likelihood that many people who are experiencing mental health issues will not interact with any services in their time of crisis. Therefore a substantial proportion of the population may be dealing with mild to severe mental health issues at any one time with no professional or informal supports.

The Scottish Government has made mental health one of its public health priorities and recently published a 10-year vision for Mental Health in Scotland (2017-2027).

## Substance Use

Forth Valley Alcohol and Drug Partnership (ADP) completed a detailed [Needs Assessment in 2018](#).

**Estimated number of Falkirk Residents who access treatment for alcohol and drug use**



## 4 Make better use of technology to support the delivery of health and social care services



### What we are already doing

The national Digital Health and Care Strategy identifies service transformation and the contribution of digital technology to reshape and improve services, support person-centred care and improve outcomes. The strategy also identifies the need to use data effectively. This can be used to maximise the benefits of information to drive service improvements.

Technology Enabled Care (TEC) and Telehealth are important areas of development. These incorporate the range of equipment and devices used to enhance provision and directly support people and also the infrastructure required to support the use of advancing technology.

A range of TEC and Telehealth is currently used across health and social care services. This includes the use of mobile devices to enable people to access clinical support remotely and also a range of specialist devices and equipment such as GPS trackers, movement sensors and alarms. These can help people to remain at home safely.

Digital technology is also being used to enable a mobile and flexible workforce. This provides more opportunities to deliver services in different ways.

Partners across Forth Valley have worked together to produce a Technology Enabled Care Strategic Map. This provides a high level statement of intent and overview of organisational ambitions and priorities. The document highlights two key areas of development:

- providing care closer to home
- preventing ill-health and minimising delays.

We have recently established a Falkirk Digital Health and Social Care strategic group. This group is made up of key stakeholders from the Partnership, NHS Forth Valley and Falkirk Council. Over the short term the group will develop a Falkirk digital strategy that will dovetail with the overarching strategies of NHS Forth Valley and Falkirk Council.

### How do we know that this is a priority?

[Scotland's Digital Health and Care Strategy](#) sets out how we will work collaboratively to maximise the potential of technology to reshape and improve services, support person-centred care and improve outcomes.

***'Digital technology has the potential to change the face of health and social care delivery.'***

Scottish Parliament Health and Sport Committee report on Technology and innovation in health and social care

Digital technology is key to transforming health and social care services so that care can become more person-centred, empowering people to self-manage and live more independently.





## Action Plans 2019 - 2022

The following section presents 3 year action plans for each of the Strategic Plan priorities.

The Strategic Planning Group will support the IJB to monitor the implementation of the Plan. In addition they will provide their views and advice to the IJB on any emerging plans, programmes of work and service redesign related to the Plan.

The IJB will receive regular reports on key areas of the Strategic Plan and other relevant plans. The Annual Performance report will set out the progress of the Health and Social Care Partnership in delivering these priorities.



## Priority 1: Deliver local health and social care services, including primary care services that are able to respond to people and communities

Priority Outcomes	Actions	Time
Integrated locality based teams and approaches are in place	<ul style="list-style-type: none"> <li>Ensure frailty assessment in community is the norm</li> <li>Enable the right short term support at home through agile community care and support</li> <li>Coordinate community support with less duplication and a more efficient support model</li> <li>Deliver effective community model of care including effective response services, recovery , reablement , &amp; community support</li> <li>Ensure timely access to specialist rehabilitation</li> <li>Develop an approach to formal supports that is 'realistic' and personal outcome focussed</li> </ul>	Year 1
Primary Care Transformation is delivered	<ul style="list-style-type: none"> <li>Implement Primary Care Transformation Improvement Plan</li> <li>Put in place different professional roles in general practice to meet peoples primary care needs</li> <li>Put in place a range of community self support services that appropriately redirect people from the GP</li> <li>Implement Transformation of Community Nursing Services and Reablement Services</li> </ul>	Year 1 – 3
Empower more people and communities to support themselves	<ul style="list-style-type: none"> <li>Develop and embed Community Led Support model</li> <li>Test and embed community hubs to enable early access to support and advice</li> <li>Involve unpaid carers where possible in the full service user journey</li> <li>Enable the public to access information and navigate the local systems of support when needed</li> <li>Ensure 'home first' approach is the norm at times of health and care transition</li> <li>Develop a partnership approach to volunteering</li> </ul>	Year 2
An Integrated Workforce Plan is developed and implemented	<ul style="list-style-type: none"> <li>Review Partnership Integrated Workforce Plan</li> <li>Finalise the profile of HSCP workforce to inform the integrated Workforce Plan</li> <li>Develop and implement an Integrated Workforce Plan</li> <li>Develop approaches to recruit and retain workforce</li> </ul>	Year 2
An Integrated Learning and Development Plan is developed and implemented	<ul style="list-style-type: none"> <li>Complete Partnership skills matrix and training needs assessment</li> <li>Develop and promote accessible programme of training</li> <li>Encourage and support workforce to progress personal and professional development</li> <li>Ensure the workforce have access to information about, and are involved in, service developments and improvements</li> </ul>	Year 1 – 3

Priority Outcomes	Actions	Time
Effective communications messages and arrangements are in place	<ul style="list-style-type: none"> <li>▪ Develop a communications plan for the Partnership</li> <li>▪ Ensure clear and well communicated access points to services and supports are available</li> <li>▪ Develop public messages and awareness raising programmes on a range of topics for people, communities and staff</li> <li>▪ Review and refresh Participation and Engagement Plan</li> <li>▪ Co-ordinate consultation and engagement and provide feedback about how input has been used</li> </ul>	Year 1
Effective systems are in place to facilitate communication between services and partners	<ul style="list-style-type: none"> <li>▪ Develop systems and process to enable effective communication and sharing of information</li> <li>▪ Ensure there is appropriate information governance in place across the Partnership</li> <li>▪ Improve use of technology to help people access information and services</li> <li>▪ Promote Living Well Falkirk</li> <li>▪ Ensure information on Living Well Falkirk is up-to-date</li> <li>▪ Explore how to make better use of social media across Partnership</li> </ul>	

## Priority 2: Ensure carers are supported in their caring role

Priority Outcomes	Actions	Time
Implement Carers Strategy	<ul style="list-style-type: none"> <li>▪ Embed adult carer support plans within standard practice</li> <li>▪ Improve coordination of the services that support carers</li> <li>▪ Support the development of informal networks within communities</li> <li>▪ Develop the use of technology and Technology Enabled Care to support carers</li> <li>▪ Ensure Partnership workforce is carer aware and able to respond to carers' needs</li> <li>▪ Embed effective data collection across the Partnership</li> </ul>	Year 1 – 3
Carers are engaged and informed	<ul style="list-style-type: none"> <li>▪ Review and improve the ways that carers are involved in service design and develop how we gather feedback, for example through engagement with the Carers Forum</li> <li>▪ Explore and develop how we reach hidden carers, for example engaging with organisations that will help us reach black and ethnic minority carers</li> <li>▪ Ensure Partnership systems and processes are understood and accessible for carers</li> <li>▪ Improve the visibility and accessibility of support for older carers</li> </ul>	Year 1 – 3
Services for carers are commissioned based on evidenced need	<ul style="list-style-type: none"> <li>▪ Understand service landscape for carer support</li> <li>▪ Align local services and support with Carers Strategy</li> <li>▪ Ensure accessibility to a range of carer support service</li> </ul>	Year 1

### Priority 3: Focus on early intervention, prevention and harm reduction

Priority Outcomes	Actions	Time
National Mental Health Strategy is implemented	<p><b>Commissioning</b></p> <ul style="list-style-type: none"> <li>Develop a Mental Health Commissioning Plan</li> <li>Embed whole systems method of commissioning services with appropriate governance and monitoring</li> </ul> <p><b>Service Provision</b></p> <ul style="list-style-type: none"> <li>Explore and establish better referral pathways and processes</li> <li>Increase the range of early intervention and prevention activity</li> <li>Identify deficits in provision for particular groups, including substance use</li> <li>Identify people who are not engaged in services and what support they require</li> <li>Develop the use of e-Health solutions to manage mental health services capacity and demand</li> <li>Develop a tiered approach to provision that diverts people from ED whose needs can be met elsewhere</li> <li>Reduce Police time spent accompanying vulnerable people to hospital</li> <li>Standardise the process for Care Programme Approach (CPA) across the system where clinically appropriate</li> </ul> <p><b>Dementia</b></p> <ul style="list-style-type: none"> <li>Implement an integrated dementia service</li> <li>Review and put in place a range of community based dementia support</li> </ul> <p><b>Suicide</b></p> <ul style="list-style-type: none"> <li>Implement the National Suicide Strategy</li> <li>Ensure strategic awareness of trends within the Falkirk area</li> <li>Review and develop crisis provision for vulnerable people and their families/friends</li> </ul> <p><b>Performance</b></p> <ul style="list-style-type: none"> <li>Develop a mental health performance framework</li> <li>Improve performance in achieving national targets for mental health services</li> </ul> <p><b>Workforce</b></p> <ul style="list-style-type: none"> <li>Develop the mental health workforce</li> <li>Plan and support the introduction of the Primary Care Development plan</li> <li>Undertake workforce planning for community and mental health services</li> </ul>	Year 1 - 2

Priority Outcomes	Actions	Time
<p>Alcohol and Drug Partnership will align with local evidenced need</p>	<p><b>Support people with Alcohol Related Brain Injury (ARBI)</b></p> <ul style="list-style-type: none"> <li>Ensure that current programmes are supporting people to maximise their potential within their own communities</li> <li>Develop treatment services specifically to support people at home, and their families</li> <li>Ensure we are diagnosing people with ARBI and then offering appropriate support to recover</li> <li>Raise awareness of the causes and effects of ARBI and that these are treatable</li> </ul> <p><b>Challenge harmful perceptions of norms within our communities</b></p> <ul style="list-style-type: none"> <li>Ensure the message of 'no alcohol no risk' during pregnancy is consistently communicated by all services as a way of preventing Foetal Alcohol Spectrum Disorder</li> <li>Be clear and consistent in our messages of minimising risk in terms of consumption of alcohol and drugs</li> <li>Support the extension of social norms to other key groups e.g. young people in YOI, women, older people etc.</li> <li>Review the impact of social norms programmes in a variety of settings and groups</li> </ul> <p><b>Address the stigma of seeking support</b></p> <p><b>Promote and Provide opportunities for recovery</b></p> <p><b>Seek to prevent Foetal Alcohol Spectrum Disorders (FASD) and to understand the needs of young people affected FASD</b></p>	<p>Year 1</p>
<p>Partners will work together to address the determinants of health and social inequalities</p>	<ul style="list-style-type: none"> <li>Enable the workforce to be skilled and confident in identifying and responding to health inequalities issues</li> <li>Embed health inequalities identification and provision of additional / targeted support services or signposting</li> <li>Develop collective thinking, planning and delivery between HSCP and CPP partners</li> <li>Work with partners to understand and effectively use data evidencing health and social inequalities</li> <li>Support specific targeted initiatives such as Housing First</li> <li>Develop awareness raising programmes about health inequalities for people, communities and staff</li> <li>Test and develop Community Link Work programme within locality areas, as part of the Primary Care Transformation Programme</li> <li>Develop resilience and capacity within locality areas</li> <li>Support the development of community and third sector organisations</li> <li>Improve knowledge about the impact of lifestyle choices and develop consistent approach to Health Improvement messages</li> </ul> <p><b>Reduce social isolation and loneliness</b></p> <ul style="list-style-type: none"> <li>Scope how resources are currently used within localities</li> <li>Develop the existing resource on key information for staff</li> <li>Support community networks and support people to access these</li> </ul>	

## Priority 4: Make better use of technology to support the delivery of health and care services

Priority outcomes	Actions	Time
A HSCP Technology Enabled (TEC) Care Strategy will be developed and implemented	<ul style="list-style-type: none"> <li>Establish a multi-agency TEC strategic group</li> <li>Understand current use of TEC across partnership</li> <li>Engage with people, carers and communities about the use of TEC</li> <li>Develop and implement Partnership strategy through a Partnership action plan</li> </ul>	Year 1
Access to TEC in localities will be widened	<ul style="list-style-type: none"> <li>Identify and build-on what already works well and develop options for tech solutions within localities</li> <li>Ensure wide partner engagement, including Forth Valley College &amp; Economic Development</li> <li>Establish locality based, multi-agency Hub model with access to a range of services without a consultation/appointment</li> <li>Support development of skills and confidence in use of TEC at home</li> <li>Develop and support volunteer roles to support TEC in communities, including intergenerational education opportunities with young people</li> </ul>	Year 2
TEC enabled infrastructure will be developed	<ul style="list-style-type: none"> <li>Conclude options appraisal about a digital upgrade</li> <li>Upgrade central phone systems to provide additional functionality</li> <li>Improve staff use of technology and access to digital records across the Partnership</li> <li>Develop TEC solutions focussing on access to service, prevention and reassurance</li> </ul>	Year 2
TEC enabled workforce will be supported	<ul style="list-style-type: none"> <li>Identify workforce training requirements</li> <li>Develop and implement skills development programme as component of the Integrated Workforce Plan</li> </ul>	Year 1 - 3

The table below aligns the Strategic Plan priorities to the nine national health and wellbeing outcomes and integration priorities.

HSCP Priorities	National Health and Wellbeing Outcomes									Integration Priorities
										
	1	2	3	4	5	6	7	8	9	
Deliver local health and social care services, including Primary Care services that are able to respond to people and communities	✓	✓	✓	✓	✓	✓	✓	✓	✓	Reduce occupied hospital bed days associated with avoidable admissions and delayed discharge
Ensure carers are supported in their carer role	✓	✓	✓	✓	✓	✓	✓	✓	✓	Increase provision of good quality, appropriate palliative and end of life care
Early intervention, prevention and harm reduction that: <ul style="list-style-type: none"> <li>Improve people's mental health and wellbeing</li> <li>Improve support for people with substance use issues, their families and communities</li> <li>Minimise the impact of health inequalities on individual and communities</li> </ul>	✓	✓	✓	✓	✓	✓	✓	✓	✓	Enhance Primary Care
										Reflect delivery of the new Mental Health Strategy
										Support delivery of agreed service levels of alcohol and drugs partnership work
										Ensure provision of the living wage to adult care workers and plan for sustainability of social care provision
Make better use of technology to support the delivery of health and social care services	✓	✓		✓		✓		✓	✓	Continue implementation of Self Directed Support
										Prepare for commencement of the Carers (Scotland) Act on 1 April 2018



# Falkirk Health and Social Care Partnership

## National Health and Wellbeing

### Outcomes

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

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

## Integration Priorities

The Scottish Government has set out national priorities for the Falkirk HSCP are:

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

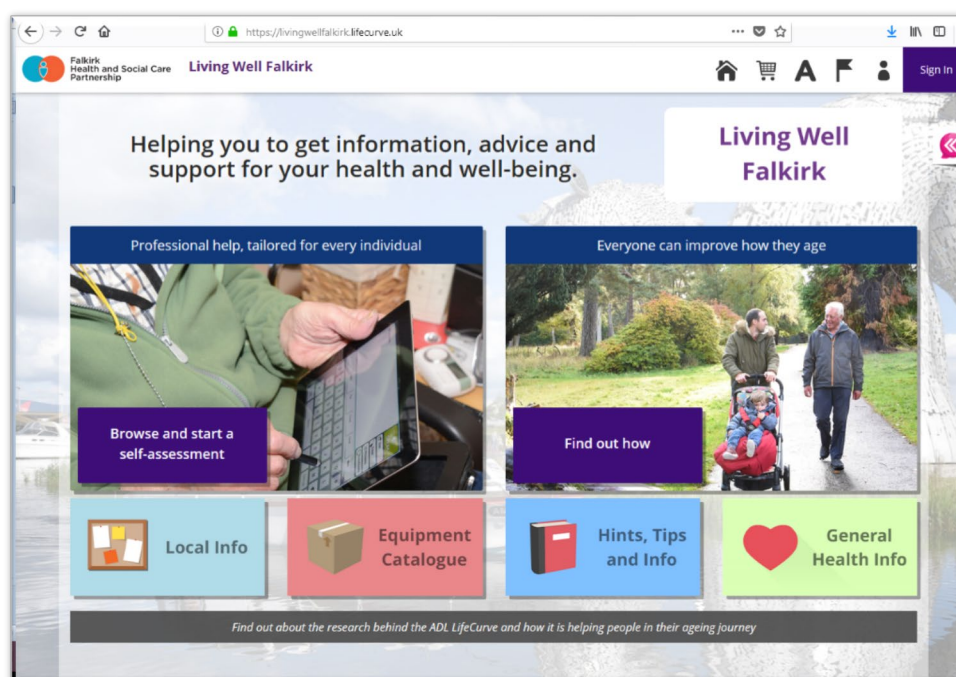


## Review of Strategic Plan 2016 - 2019

The HSCP has made good progress across a number of priorities set out in our first Strategic Plan. Progress is set out in more detail in our [Annual Performance reports](#) and progress is reported aligned to the outcomes of the Plan:

### Self-Management

- **Support for Carers** across a range of services is in place, including the implementation of the Carer's Act
- Development and co-ordination of **Reablement Services** to support people to regain their independence including:
  - Developed a Reablement Pathway
  - Successful Discharge to Assess (D2A) pilot
  - Establishment of the Reablement Project Team, building on the D2A pilot
  - Increased bed capacity for intermediate care
- **Living Well Falkirk** is a guided self management web based service offering people in Falkirk area an opportunity to find support, advice and solutions about their health and wellbeing
- **Enhanced Dementia Team** is a multi-agency team incorporating Alzheimer's Scotland Post Diagnostic Support Workers, nursing staff from the Dementia Outreach Team (DOT) and Social Work, with supervision from a Consultant Psychiatrist



### Autonomy and Decision-Making

- Improved access to **Palliative and End of Life Care** to ensure that timely, appropriate and accessible services are available at end of life
- **Enhanced Community Team and GP Fellows** support people to remain at home by delivering enhanced care in the community when people are unwell. This involves coordinated health care to meet individual needs, and can prevent hospital admission or support discharge home. The team operates 24 hours a day over 7 days a week.
- **Moving Assistance Project** and **Adapting for Change** projects have assisted older people and people with a disability to access information about moving homes. They also reviewed processes for the provision of housing adaptations to enable people to stay in their own homes.
- **Public Awareness of Adults with Incapacity campaign** has been in place to increase the numbers of people with Power of Attorney. There has also been good progress to address the issue of high numbers of people delayed in their discharge from hospital as a result of the Guardianship process. Both of these areas of work have involved working with Solicitors for Older People.
- **Anticipatory Care Plans** are in place and have a focus on prevention, anticipation and supported self-management with the person at the centre of all decisions regarding their care.

### Safe

- Modernised equipment used by the **Mobile Emergency Care Service**
- **Social Inclusion Project** supports individuals to navigate and consolidate a recovery plan
- **Falkirk Alcohol and Drugs Partnership** undertook a self-evaluation process with the Care Inspectorate to assess compliance with National Quality Principles for Substance Misuse Services
- **Uninjured faller pathway** with the **Scottish Ambulance Services (SAS)** improves the experience and outcomes of people that the SAS respond to following a fall. This avoids unnecessary transportation to hospital for people who are uninjured or uninjured and medically unwell. People are instead referred to community based services.
- **Advocacy Services** support people to have a say in decisions affecting them

## Service User Experience

- **Redesign of day services for younger adults** reflects Self-Directed Support principles to empower and enable people to have choice and control over the design of their own support. This has seen the development of a range of alternative community based services.
- **Frailty at the Front Door Collaborative** has resulted in a successful service redesign that improves outcomes for people and their carers living with frailty and presenting to acute services
- Implementation of the **National Health and Social Care Standards** to drive improvement, promote flexibility and encourage innovation in how people are supported and cared for
- **Equalities and Mainstreaming Report** has been produced that sets out how the HSCP will work to:
  - eliminate unlawful discrimination, harassment and victimisation
  - advance equality of opportunity between different groups
  - foster good relations between different groups.

## Community Based Support

- **Hope House Low Secure Unit** we identified the need for a local unit to support people with mental health needs nearer their home. The unit has established links with local community services and teams.
- **Redesigning services at Lochview** to support more people with a learning disability to move to alternative accommodation and support in the community. This has shifted care from a hospital setting.
- **Primary Care Transformation Programme** focuses on modernisation of primary care to deliver a safe, effective and person-centred healthcare service and deliver the General Medical Services (GMS) contract
- **Home Care Review** to deliver responsive, efficient and high quality home care services
- Falkirk HSCP **Community Grants Scheme** supports the Third sector to delivery projects that make a positive difference to communities
- Introduced three **Changing Places toilet and changing facilities** within Falkirk to enable people with a disability to access appropriate changing facilities that meet their needs. A further two facilities are planned.

# Strategic Context

---

Since the first Strategic Plan was published, the Scottish Government has passed key legislation and published a number of strategies. These have set out the strategic direction for health and social care. They have a common theme - to put people at the centre of their care with a focus on better outcomes for them. This will be achieved through a whole system approach to health and social care service planning and delivery.

The Strategic Plan 2019 - 2022 takes into account the relevant legislation, policy and planning directives and provides an opportunity to better reflect these changes and requirements in our work. Some key legislation and strategies have been incorporated within the priority section of this plan. Relevant documents are listed below.

## Legislation

- **The Carers (Scotland) Act 2016** came into effect in April 2018. The Act places a range of duties to support unpaid carers, including developing a Carers Strategy.
- **Community Empowerment (Scotland) Act (2015)** provides a new legal framework for community planning and creates new rights for community bodies and places new duties on public bodies. This will help to empower community bodies through the ownership or control of land and buildings, and by strengthening their voices in decisions about public services. Falkirk Council, NHS Forth Valley, Police Scotland, National Fire and Rescue service, and CVS Falkirk (the Third sector interface) form the Community Planning Partnership (CPP) for the local authority area.
- **Equalities (Scotland) Act 2010** requires public sector organisations to plan and report on equalities outcomes. IJBs were made subject to the Act during 2015 and were required to publish Equality Mainstreaming and Outcomes plans. Addressing inequalities is a key priority for the Strategic Plan.
- **Fairer Scotland Duty** was introduced in 2017 and places a duty on public authorities to do more to tackle the inequalities of outcome. Authorities must make sure that strategic decisions about the most important issues are carefully thought through. This is so that they are as effective as they can be in tackling poverty and reducing inequalities.



## Planning

- Scottish Government and Convention of Scottish Local Authorities (COSLA) have agreed **public health priorities for Scotland:**
  - healthy and safe places and communities
  - flourish in early years
  - good mental wellbeing
  - reduce the use of and harm from alcohol, tobacco and other drugs
  - sustainable, inclusive economy with equality of outcomes for all
  - eat well, healthy weight and physical activity

These will be a focus for work to improve the health of the population, and the Partnership will work with services including health improvement, the CPP and Third and Independent sectors to make progress.

- **National Health and Social Care Standards** were launched in 2018. The objectives of the new Standards are to drive improvement, promote flexibility and encourage innovation in how people are supported and cared for.
- **Realising Realistic Medicine** 2017 sets out the NHS vision for introducing the realistic medicine concept. It also sets out how it will make sure that by 2025 anyone providing healthcare in Scotland will take a realistic medicine approach. It puts the person receiving health and social care at the centre of decisions made about their care.
- **National Clinical Strategy for Scotland** 2016 makes proposals for how clinical services need to change in order to provide sustainable health and social care services fit for the future
- **Regional planning** - the Scottish Government has commissioned Regional Delivery Plans to be developed. These take a whole-system approach to the delivery of health and social care for each of 3 distinct regions (North, East and West). This work aims to deliver the National Clinical Strategy (2015) and the Health and Social Care Delivery Plan (2016), ensuring better health, better care and better value. Falkirk is part of the West of Scotland Region, which is covered by 5 NHS Boards (including NHS Greater Glasgow and Clyde), 16 Local Authorities and 15 Health and Social Care Partnerships as well as the Golden Jubilee Foundation.
- **Age, Home and Community:** next phase was published in 2018 and builds on the 2011 strategy. It sets out the approach to housing and older people that by providing the right advice, house and support, older people will be able to live the way they choose.

## Falkirk Health and Social Care Partnership

- Housing - including the requirement to produce a **Housing Contribution Statement** and **Rapid Rehousing Transition Plan**. The Housing Contribution Statement is a bridge between housing strategic planning through the Local Housing Strategy and health and social care through the Strategic Plan. The priorities for the new Housing Contribution Statement (HCS) will be informed by the Local Housing Strategy 2017-2022. There will be continued priority in the new HCS on the housing needs of those with mobility issues and older people to assist them to remain in a homely setting. This will involve people and practitioners discussing current and future housing issues as early as possible in someone's health and social care journey. This will inform the need for accessible housing through adaptations to current housing stock, provision of new build housing and support to sustain someone in a homely setting. Nationally the Scottish Government have renewed their commitment to ending homelessness and have highlighted that this requires partners across services including health, education, social work, community support, justice and the Third sector to recognise and act when people are at risk of homelessness and ensure homelessness is only ever rare, brief and not recurrent.
- **A Connected Scotland: our strategy for tackling isolation and loneliness and building stronger social connections** the Scottish Government [strategy](#) was published in December 2018 and sets out a clear vision which is underpinned by core values of kindness, dignity and compassion. This is complemented by clear links to the most relevant of Scotland's National Outcomes and associated National Indicators.
- **Scotland's Digital Health and Care Strategy** 2018 sets out how the Scottish Government will work with partners to use technology to reshape and improve services, support person-centred care and improve outcomes. The strategy is about how care for people can be enhanced and transformed through the use of digital technology. The Partnership will realise the opportunities for health and social care services and the wider public to utilise digital technology as an enabler to improve health and wellbeing.
- **Mental Health Strategy** 2017 – 2027 sets out to improve access to services and support earlier intervention. Poor mental health is an important public health challenge and improving the mental health of the population is recognised as having a positive effect on many different aspects of society.
- **Suicide Prevention Action Plan: every life matters** 2018 has been designed to continue the work from the 2013-2016 suicide prevention strategy.
- **Primary Care Transformation Programme** (2018) – the purpose of the programme is to test and evaluate what primary care models work in individual communities in line with the new General Medical Services contract model.
- A priority within the national "**The keys to life**" strategy is that all adults with learning disabilities, including those with complex needs, experience

meaningful and fulfilled lives. This includes where individuals live, as well as the services they receive. Some people with learning disabilities and complex needs are living out with the Falkirk area, or within a hospital setting. A new integration framework for Keys to Life is expected to be published in 2019. The Partnership will respond to this, and the finding of the Scottish Government commissioned report on Delayed Discharge and Out Of Area Placements for people with a Learning Disability.

- **Strategic Framework for Action on Palliative and End of Life Care**, sets out the aim that by 2021 everyone in Scotland who needs palliative care will have access to it
- **Palliative and End-of-Life Care** by Integration Authorities: advice note (2018) supports the strategic commissioning of Palliative and End of Life Care services
- **National Health and Social Care Workforce Plan** (2018) is to enable better local and national workforce planning to support improvements in service delivery and redesign. This will involve a whole system, complementary approach to workforce planning recognising the new integrated landscape.
- **Towards a Fairer Falkirk 2019 – 2024**: Falkirk's Strategy– the purpose of the strategy is to understand and address the impact of poverty on individuals, families and communities in our area and to reduce inequalities between the wealthiest and poorest in our communities in order that everyone can have a better life.
- **Review of Progress with Integration of Health and Social care** in February 2019, the Ministerial Strategic Group (MSG) for Health and Community Care, published a [report on the review of progress with integration](#). The purpose of the review is to help ensure there is an increase in pace in delivering all of the integrations principles and national health and well-being outcomes. There are a number of proposals for ensuring progress and these will be taken forward.





## Strategic Commissioning

Strategic commissioning is the term used for:

- the activities involved in assessing and forecasting needs
- linking investment to agreed desired outcomes
- considering options
- planning the nature, range and quality of future services
- working in partnership to put these in place.

Strategic commissioning relates to services that are delivered within health and social care and also to services that are purchased from Independent and Third sectors.

During the period 2017–2019, work has been undertaken to establish a consistent framework for commissioning. During the course of 2019–2022, we will finalise the commissioning principles and implement a framework, which will:

- ensure that service users and their carers are involved
- provide stability for providers
- improve the way that performance information is gathered and used for service evaluation and improvement
- make sure that Equality and Poverty Impact Assessments are embedded within commissioning
- provide the IJB with a transparent and robust process to ensure accountability for resources.

### Strategic Needs Assessment (SNA)

This is produced to support the development of the Strategic Plan. The [SNA](#) is one component part of the strategic commissioning process. This underpins the content of the Strategic Plan and priorities for the Partnership.

### Market Facilitation Plan

The Strategic Plan is underpinned by a [Market Facilitation Plan](#). This plan will give the Partnership a good understanding of the current levels of need and demand for health and social care services. Which will help 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 and report to the IJB.

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. The plan will ensure that we are responsive to the changing needs and aspirations of Falkirk's residents.

## Participation and Engagement

Falkirk's HSCP Participation and Engagement Strategy is intended to set 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.

The Strategy recognises legislative requirements established within the Public Bodies (Scotland) Act 2016 and the Community Empowerment (Scotland) Act. It aligns with the National Standards for Community Engagement and draws on existing good practice established within NHS Forth Valley's Person Centred Health and Care Strategy and Falkirk Council's Strategy for Community Engagement. The format of the strategy includes information about participation rights and signposting about how people can get involved.

The HSCP has developed an embedded approach to supporting engagement whereby a multi-agency group of engagement specialists has been formed to provide support for activities across the HSCP.

Some of the key priorities for participation and engagement during the period 2019 - 2022, will be to:

- provide more opportunities for communities to be involved in service design and improvement
- make communities more aware of all opportunities they have to get involved
- show communities how their contributions make a difference to decision making
- equip our staff with skills and knowledge to be able to involve people
- reduce any barriers to participation and carefully plan how people can be involved

## Monitoring Performance

### Falkirk Performance Summary

The IJB receives regular performance reports. These reports ensure the Board fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services. These reports note where improvements and achievements are being made. They also highlight where performance may be below target or is an area of concern, with agreed actions to make improvements.

The reports also provide information on performance against local and national performance indicators. A Strategy Map ensures there is a direct link between the national health and well-being outcomes, the Strategic Plan outcomes and performance indicators. This enables the IJB to ensure that performance management activity is focussed on both the national and local outcomes.

The following tables report performance against the national outcomes for the Falkirk Partnership. With the exception of indicator 18, the data reported is 2017/18 against the baseline year 2015/16 - before the Partnership was established. A comparison to the Scotland position and to our peers has also been included. The HSCP peer group has been compiled by taking an average outcome for each of the national indicators for seven Local Authority areas.

	Indicator Title	Falkirk 2015/16	Falkirk 2017/18	Direction of Travel	Average of Comparat ors 2017/18	Average of Comparat ors 2017/18	Scotland 2015/16	Scotland 2017/18
Outcome indicators	NI - 1 Percentage of adults able to look after their health very well or quite well	93%	92%	v	94%	93%	95%	93%
	NI - 2 Percentage of adults supported at home who agreed that they are supported to live as independently as possible	85%	83%	v	83%	81%	83%	81%
	NI - 3 Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	80%	76%	v	80%	75%	79%	76%
	NI - 4 Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	79%	72%	v	76%	77%	75%	74%
	NI - 5 Total % of adults receiving any care or support who rated it as excellent or good	81%	81%	< >	81%	81%	81%	80%
	NI - 6 Percentage of people with positive experience of the care provided by their GP practice	84%	81%	v	86%	83%	84%	83%
	NI - 7 Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	84%	78%	v	82%	82%	83%	80%
	NI - 8 Total combined % carers who feel supported to continue in their caring role	43%	37%	v	39%	37%	40%	37%
	NI - 9 Percentage of adults supported at home who agreed they felt safe	85%	84%	v	83%	84%	83%	83%
	NI - 10 Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	NA	NA	NA	NA

	Indicator	Title	Falkirk 2015/16	Falkirk 2017/18	Direction of Travel	Average of Comparat ors 2017/18	Average of Comparat ors 2017/18	Scotland 2015/16	Scotland 2017/18
Data Indicators	NI - 11	Premature mortality rate per 100,000 persons	440	427	^	429	416	441	425
	NI - 12	Emergency admission rate (per 100,000 population)	11,528	12,335	v	13,047	13,482	12,276	12,176
	NI - 13	Emergency bed day rate (per 100,000 population)	137,626	139,171	v	133,062	131,284	128,503	122,595
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	112	120	v	100	105	97	102
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%	^	87%	88%	87%	88%
	NI - 16	Falls rate per 1,000 population aged 65+	20	22	v	21	21	21	22
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	84%	88%	^	84%	88%	83%	85%
	NI - 18	Percentage of adults 18+ receiving personal care as a % of those requiring care - <b>data available up to 2016/17</b>	64%	63%	v	64%	63%	62%	61%
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	864	910	v	726	709	915	762
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	25%	25%	<>	25%	25%	24%	24%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	NA	NA	NA
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	NA	NA	NA
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	NA	NA	NA

Key	
^	Improvement
<>	Position maintained
v	Deterioration

The national data lists twenty-three indicators within the report, but data is provided for only 19 of these. Of the published indicators during the same period:

Indicator performance		Local	National
Deteriorated	v	14	12
Improved	^	3	6
Stayed the same	<>	2	1

The IJB produces an Annual Performance Report for the end of each reporting year (1 April - 31 March). This reports progress over the year and the HSCP's performance against agreed national and local performance indicators and commitments set out in the Strategic Plan.

## Finance and Risk

---

### Partnership Budget

The Partnership Budget is made up of contributions from:

NHS Forth Valley	£151.345m
Falkirk Council	£69.926m
Partnership Funding	£3.744m

In addition, there will be further allocations of ring-fenced funding, for example the Primary Care Transformation work and Mental Health Outcomes Framework but these funding streams have not been confirmed yet for 2019-20 and the sums are therefore not included in the figures above.

These figures include additional funding received from the Scottish Government for extension of free personal and nursing care for under 65s, continued implementation of the Carers (Scotland) Act 2016 and support to pay the living wage to social care staff.

### Medium Term Financial Plan (MTFP)

The MTFP will set out the overall resources available to the Partnership to support delivery of the Strategic Plan. The plan will help to ensure that resources are directed to the delivery of IJB outcomes.

The aim of the plan is to ensure a more robust approach to financial planning, allowing co-ordination between service redesign and transformation and annual budgets. Such an approach is considered essential to facilitate delivery of the Strategic Plan and maximise the use of resources across the medium term.

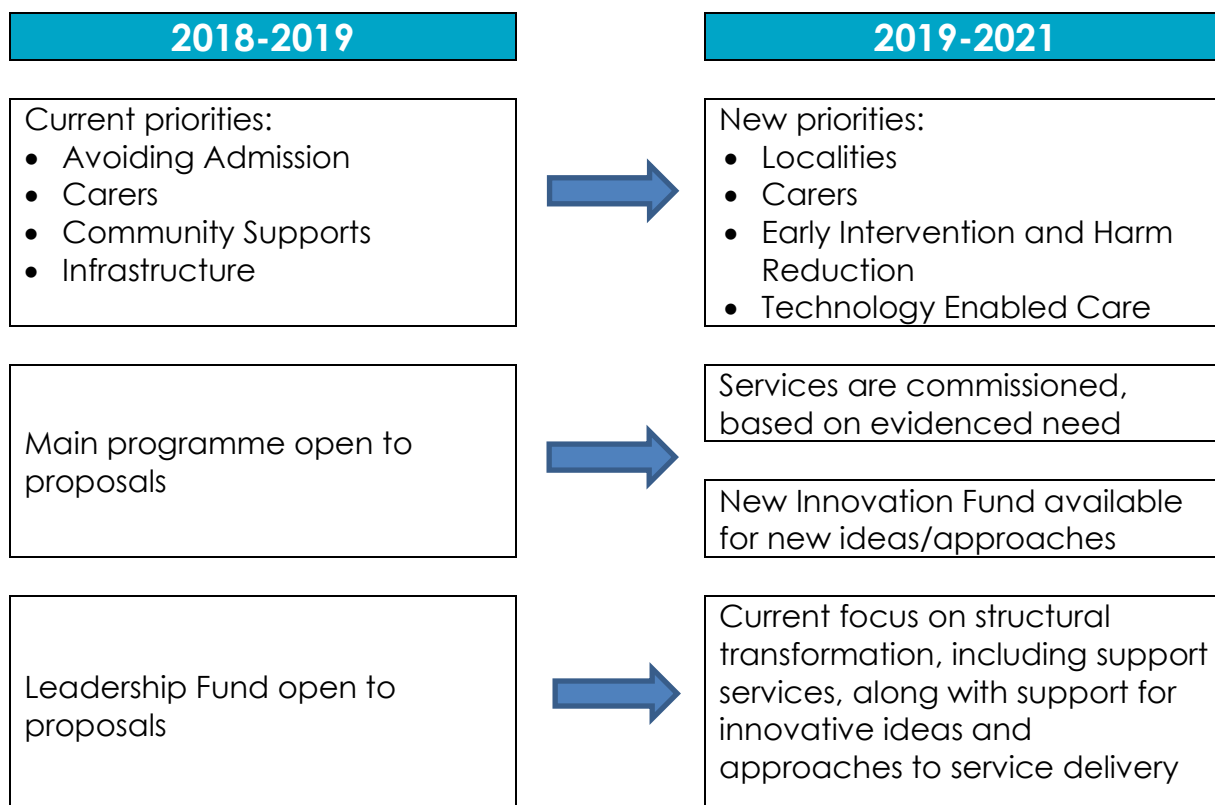
### Partnership Funding

Falkirk HSCP operate a Partnership Funding programme, which brings together previously ring-fenced funds; Integrated Care Fund, Delayed Discharge Fund and Carers Funding. The period of the current programme is 2018 – 2021.

The purpose of the Partnership Funding programme, is to enable the Partnership to invest in service re-design and transformation and also to test new ideas and approaches. The programme is open to statutory, Third and Independent sector partners. During 2018/19, we have invested in 41 projects, with a total value of £5.133m.

Partnership Funding includes 2 strands. The main programme is overseen by the Partnership Funding Group, which is a sub-group of the Strategic Planning Group and the Leadership Fund which is available to Falkirk's Leadership Team. Both these have robust governance and monitoring frameworks and report to the IJB.

In 2018-2019, the Partnership Funding Group reviewed the governance and operational priorities of Partnership Funding. In order to ensure that resources are targeted to improve outcomes, the programme will change as follows:



Some of the services currently supported by Partnership Funds have now become core components of health and social care service delivery. During 2019-2020, the Partnership Funding Group will continue to review initiatives to determine if and how the service should be continued.

## Risk Management

The IJB has a Strategic Risk Management Strategy and Risk Register in place to provide the necessary structure to assess and manage risk. The Partnership approach is to identify, manage and tolerate risk, to enable staff to work in different and innovative ways to meet service user and carer personal outcomes and deliver the national and local integration priorities.



## Glossary of Terms

<b>Acute Care</b>	Acute Care is a branch of health care where people receive active but short-term treatment for a severe injury or episode or illness, an urgent medical condition, or during recovery from surgery. Acute care services are generally provided in a formal hospital setting.
<b>Advocacy and Advocate</b>	Advocacy means getting support from another person to help someone express their views and wishes, and to help make sure their voice is heard. Someone who helps in this way is called an advocate. In the Standards, we are referring to formal advocacy provided by an organisation to someone using care.
<b>Adaptations</b>	Adaptations can help older people and people with disability to live independently in their own homes. They can reduce the risk of falls and other accidents in the home and also reduce the need for home care or long term admission to a care home. A wide variety of aids and equipment is available to help with daily living tasks. This ranges from simple adapted cutlery, to telecare alarms, specialist seating and beds. Common examples of adaptations include replacing a bath with a level access shower, or making it easier to get in and out of the home by widening doors or installing a ramp.
<b>Anticipatory Care /Plans</b>	Anticipatory care / plans can take many forms. However it is expected to help reduce avoidable and unscheduled acute admissions for people with pre-existing conditions. The purpose of Anticipatory Care Planning is to support the individual to have greater choice and control of care preferences through communication across the support team, across agencies and across care settings.
<b>Assessment</b>	A health and/or social care assessment will find out what help and support a person needs, such as healthcare, medication, advocacy, equipment, care at home, housing support or a care home.
<b>Avoidable Admissions</b>	An admission to a bed that may be regarded as unnecessary had other more appropriate services been available
<b>Body Corporate Model</b>	The body corporate model is a model of integration where a Health Board and Local Authority both delegate the responsibility for planning and resourcing service provision for health and social care services to an Integration Joint Board. This is established as a separate legal entity.
<b>Capacity</b>	Capacity refers to an individual's ability to make decisions about their wellbeing. This may change over time and may refer to different aspects of their life. For people who have been medically assessed as lacking capacity there is legislation to protect their wellbeing.
<b>Care home</b>	A care service providing 24 hour care and support with premises, usually as someone's permanent home.

<b>Care Journey / Plan</b>	A Care Plan is the plan of treatment or actions agreed with a service user, their carer and family, following an assessment of need by a health or care agency.
<b>Carer</b>	A carer is someone of any age who looks after or supports a family member, partner, friend or neighbour in need of help because they are ill, frail, have a disability or are vulnerable in some way. A carer does not have to live with the person being cared for and will commonly be unpaid.
<b>Chief Officer</b>	Where the body corporate model is adopted, a Chief Officer of the Integration Joint Board will be appointed to provide a single point of management for the integrated budget and integrated service delivery. They are accountable to the Integration Joint Board and to the Chief Executives of their Health Board and Local Authority for the delivery of the integrated services.
<b>Choice and Control</b>	Choice and control is about shaping services to meet people's needs, rather than allocating people to fit around services.
<b>Community Based Support</b>	Services that are delivered within community settings, sometimes within a person's home. Community based support is provided by NHS Forth Valley, Falkirk Council and also by voluntary and community organisations.
<b>Community Care Assessment</b>	A community care assessment is a review of someone's personal circumstances and needs, carried out by Adult Social Care Services, and will look at how the person copes with day-to-day living, and recommend help or equipment that might make day-to-day life easier.
<b>Day Care</b>	Day care offers personal care during the day for those who are assessed as needing it. It is usually provided in a day care centre run by trained staff or volunteers for those with complex physical and social care needs. Attending day care allows people to get out of their home to meet and socialise with others, receive personal care, take part in activities and in some cases receive meals.
<b>Delayed Discharge</b>	Delayed discharges occur when a patient who is ready to be discharged cannot leave the hospital, because the necessary care, support or accommodation is not available.
<b>Early intervention and prevention</b>	Early intervention and prevention include an action or set of actions that are planned and put in place to prevent a situation happening or escalating. In the context of health and social care, examples are education and information that will help people make positive lifestyle choices to help them stay healthy, or supporting a person to remain in their own home by providing specialist equipment and support.
<b>Emergency or unexpected event</b>	This is an incident or emergency that could require immediate action, such as the premises being evacuated.

## Falkirk Health and Social Care Partnership

<b>Engagement</b>	Developing and sustaining a working relationship between one or more public bodies and one or more community groups to help them both understand and act on the needs or issues that the community experiences. It is now accepted that public services, that involve their users, are likely to be of higher quality and more relevant to the communities they serve. Within the context of health and social care integration, involving staff is also critical.
<b>Health and Social Care Integration</b>	In the UK, Health and Social Care (often abbreviated to HSC or H&SC) is a term that relates to services that are available from health and social care providers. This is a generic term used to refer to integrating/brining together the whole of the health and social care provision infrastructure, public and private sector, including the Third sector.
<b>Health Inequalities</b>	Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. Health Inequalities do not occur randomly or by chance, but are socially determined by circumstances largely beyond an individual's control. These circumstances disadvantage people and limit their chance to live a longer, healthier life.
<b>Healthy Life Expectancy (HLE)</b>	HLE is an estimate of how long the average person might be expected to live in a 'healthy' state. Like Life Expectancy (LE), it is most often expressed for an entire lifetime from the time of birth. HLE at birth is the number of years that a newborn baby would live in 'healthy' health if they experienced the death rates and levels of general health of the local population at the time of their birth, throughout their life. HLE is calculated by combining LE and a measure of 'healthy' health: in these HLE analyses the measure used is self-assessed general health.
<b>Home Care</b>	Home care is an umbrella term used for a range of care services provided by care workers in a person's home. Home care can involve personal care (such as help with dressing or washing), non-personal care (such as cleaning or shopping services), provision of meals or nursing and health care. Home care services are flexible and delivered when required, either on a long or short-term basis. In Falkirk those are called Care at Home Services
<b>Housing Contribution Statement (HCS)</b>	The HCS sets out the arrangements for carrying out the housing functions delegated to the Integration Authority under the Public Bodies (Joint Working) (Scotland) Act 2014.
<b>Integrated Care</b>	Integrated Care focuses on improving services in relation to access, quality, user satisfaction and efficiency. The aim is to enable better coordinated, joined-up and more continuous care, resulting in improved patient experience whilst achieving greater efficiency and value from health and social care delivery systems.

<b>Integration Joint Board</b>	Where the body corporate model is adopted, the NHS Board and Local Authority will create an Integration Joint Board. This Board consists of representatives from the Health Board, the Local Authority, the Third and Independent Sectors and people who use health and social care services and carers. The Integration Joint Board, through its Chief Officer, will have the responsibility for the planning, resourcing and the operational oversight of integrated services within the strategic plan.
<b>Integration Scheme</b>	The Integration Scheme is a legally binding agreement between Councils and Health Board who are known as 'the parties' in the Integration Scheme. The scheme describes what the parties will do to enable the Integration Joint Board (IJB) to meet its responsibilities (or 'delegated functions'). It does not describe what the IJB will do in detail. The IJB will become responsible for adult and older peoples services in April 2016. The scheme contains high level statements of commitment to ensure flexibility and accommodate future changes. Integration Schemes must be reviewed by the Health Board and Local Authority at least every five years.
<b>Intermediate Care</b>	Intermediate Care services support people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community and residential settings. The term has been defined as a "range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living"(NSF for Older People, DOH, June 02).
<b>Life Expectancy (LE)</b>	LE is an estimate of how long the average person might be expected to live. LE is most often quoted for an entire lifetime; LE at birth is the number of years that a newborn baby would live if they experienced the death rates of the local population at the time of their birth, throughout their life. It is a theoretical measure rather than a true prediction of life expectancy, since death rates may increase or decrease during a person's lifetime, and people may move to areas with different mortality risks.
<b>Long-term conditions</b>	Long-term conditions are conditions that last a year or longer, impact on many aspects of a person's life, and may require ongoing care and support. The definition does not relate to any one condition, care group or age category. It covers adults and older people as well as children and those with physical and mental health issues. Common long-term conditions include epilepsy, diabetes, some mental health problems, heart disease, chronic pain, arthritis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease.
<b>Market Facilitation</b>	Market Facilitation is a key aspect of the strategic commissioning cycle. Integration Authorities will undertake a range of activities to promote the successful development of services to meet the needs of the local population effectively. These activities should include the development of an accurate picture of local need and markets, published as a Market Facilitation Plan.

## Falkirk Health and Social Care Partnership

<b>National Health and Wellbeing Outcomes</b>	<p>The nine national health and wellbeing outcomes provide a national framework for measuring the effect of integrated health and social care services on the health and wellbeing of individuals.</p> <p><a href="http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes">http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes</a></p>
<b>Partnership</b>	<p>A partnership refers to two or more individuals or organisations working together to achieve a shared aim. Within the context of health and social care integration, the Partnership consists of Falkirk Council, NHS Forth Valley, Third and Independent sectors working together to provide effective, joined up services.</p>
<b>Planning and Delivery Principles</b>	<p>The principles that underpin the making of arrangements for integration, and the strategic planning of integrated services, will inform how services are planned and delivered. They explain what people using services and their carers can expect from integrated services and the behaviours and priorities expected of organisations and people planning and delivering care and support.</p>
<b>Public Bodies</b>	<p>NHS Forth Valley and Falkirk Council are both public bodies. A public body is democratically accountable at either national or local level. They have specific functions and requirements generally driven by legislation, which they must undertake. The Public Bodies (Joint Working) (Scotland) Act requires the integration of health and social care, and is an example of legislation.</p>
<b>Reablement</b>	<p>Reablement is about giving people the opportunity and the confidence to relearn/regain some of the skills they may have lost as a result of poor health, disability/impairment or entry into hospital or residential care. As well as regaining skill, reablement supports service-users to gain new skills to help them maintain their independence.</p>
<b>Redesign</b>	<p>Redesign within the context of health and social care integration, relates to services may be changed and improved. Redesign is based on evaluation and review of existing services and will often include listening to service users, their carers and families about what services are important to them.</p>
<b>Rehabilitation</b>	<p>Rehabilitation entails restoring someone to health or normal life through guidance and therapy after addiction, or illness.</p>
<b>Self-management</b>	<p>Self-management encourages people with health and social care needs to stay well, learn about their condition and their care and support needs, and remain in control of their own health.</p>
<b>Service users</b>	<p>Service users are people who receive health and/or social care services. They may be individuals who live in their own home, are staying in care or are being cared for in hospital.</p>
<b>Stakeholders</b>	<p>Stakeholders include any person or group with a vested interest in the outcome of a project or plan.</p>

<b>Strategic Commissioning</b>	<p>Strategic Commissioning is a way to describe all the activities involved in:</p> <ul style="list-style-type: none"> <li>• assessing and forecasting needs</li> <li>• links investment to agreed desired outcomes</li> <li>• planning the nature, range and quality of future services; and</li> <li>• working in partnership to put these in place</li> </ul> <p>This is the process that informs the Integration Authorities Strategic Plan</p>
<b>Strategic Needs Assessment (SNA)</b>	<p>The SNA is an analysis of the current and future health and social care needs of the local community to inform and guide service planning. The aim is to accurately assess the health and care needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities. The intention is to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities.</p>
<b>Technology and other specialist devices</b>	<p>Specialised devices that helps people in their day to day life, such as telecare, telehealth or telemedicine, alarm call system, remote support and advice or mobility aids.</p>
<b>Third Sector</b>	<p>Third Sector Organisations is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives. It also includes local intermediary organisations (Third Sector 61 Interfaces), and Third sector strategic intermediaries, for example Voluntary Action Scotland (who represent Scotland's 32 Third Sector Interfaces) and the Health and Social Care Alliance Scotland.</p>
<b>Transition</b>	<p>Used to describe a significant change for someone, such as starting to use a new care service or a change in life stage (eg becoming an adult).</p>
<b>Whole system approach</b>	<p>Whole systems approaches involve identifying the various components of a system and assessing the nature of the links and relationships between each of them.</p>