Strategic Plan 2023-2026

Creating a healthier Falkirk

Falkirk
Health and Social Care
Partnership

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INTRODUCTION

The Strategic Plan outlines how we will deliver adult health and social care services in Falkirk over the next 3 years, 2023 – 2026.

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

OUR STRATEGIC PLAN: ON A PAGE

OUR PRIORITIES FOR THE NEXT 3 YEARS ARE:

Community-based services
Services will be enhanced to improve the 'flow' of patients through hospital settings, prevent admission, and promote independent living.

Accessible care
Improve the way people access services – enabling everyone to access the right care, at the right time, in the right place.

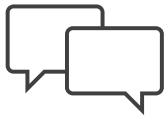
Early intervention & prevention
Minimise the harm of long-term health conditions, ill-mental health, substance use, or neglect through early action.

Carer support
Assist, inform, and empower unpaid carers to manage their caring role and have a fulfilled life outside of caring

THESE PRIORITIES ARE DRIVEN BY 3 WORKSTREAMS:

Workforce
Recruitment, retention, and celebration of staff across all services.

Technology
Explore new ways of helping people and delivering services.



Communication
Improving engagement, feedback opportunities, and signposting info.

WE MEASURE PROGRESS BY REVIEWING OUTCOMES

There are 9 National Health and Wellbeing Outcomes that every health and social care partnership uses to measure performance. In addition, we have set 4 local outcomes. Falkirk publishes an annual report and regular performance data to show local people how we are doing.

THIS STRATEGY WILL HELP US ACHIEVE OUR VISION:

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

ABOUT HEALTH AND SOCIAL CARE INTEGRATION

Falkirk Health and Social Care Partnership is one of 31 integration bodies in Scotland, serving a population of over 160,000 across rural and urban communities.

The Partnership's workforce is employed by Falkirk Council, NHS Forth Valley, and its partners in the third and independent sectors. They work in local social work offices, health centres, GP Practices, community hospitals, care homes, intermediate care facilities, day centres, and communities across the Falkirk area.

Falkirk Health and Social Care Partnership delivers care and support for adults and older people with mental health problems, long term physical conditions, and substance misuse problems.

People who provide direct care for their loved ones, known as unpaid carers, are also supported by The Partnership through the Falkirk and Clackmannanshire Carers Centre.

The Partnership is run by its Integration Joint Board made up of representatives from Falkirk Council, NHS Forth Valley, the third sector, service users and carers.

The Board has responsibility for planning, resourcing and operating services, working to deliver the nine National Health and Wellbeing Outcomes.

The principles of integration set out that health and social care should:

- be integrated from the point of view of service users
- take account of the particular needs of different service users
- take account of the particular needs of service users in different parts of the area in which the service is being provided
- take account of the particular characteristics and circumstances of different service users
- respect the rights of service users
- take account of the dignity of service users
- take account of the participation by service users in the community in which service users live
- protect and improves the safety of service users
- improve the quality of the service
- be planned and led locally in a way which is engaged with the community
- best anticipate needs and prevents them arising
- make the best use of the available facilities, people and other resources

The Partnership aims to enable people in Falkirk to live full and positive lives within supportive and inclusive communities.

It achieves this by planning and delivering the services and functions delegated by NHS Forth Valley and Falkirk Council to the Falkirk Health and Social Care Partnership.

The Partnership directly provides services like care at home, residential care and day care services. There are also social care services which are contracted from the Third Sector and Independent providers, such as carers support, short breaks and nursing care homes.

Some services operate across the Forth Valley area and they are the responsibility of either Falkirk HSCP or Clackmannanshire & Stirling HSCP as lead authority:

- Specialist mental health and learning disability services – Clackmannanshire & Stirling HSCP (C&S HSCP)
- Primary care services – Falkirk HSCP
- Health Improvement strategic planning – Falkirk HSCP
- Keep Well Service – Falkirk HSCP
- Strategic planning for elements of health improvement – Falkirk HSCP (although C&S HSCP will retain responsibility for local planning)
- Strategic planning and service delivery of services for stroke rehabilitation - C&S HSCP
- Strategic planning and service delivery of services for neurology rehabilitation – Falkirk HSCP
- Mental health services (set aside) strategic planning and delivery – C&S HSCP

WHAT NEEDS TO CHANGE TO DELIVER INTEGRATED HEALTH AND SOCIAL CARE SERVICES?

The Framework for Community Health and Social Care Integrated Services[i] describes health and social care integration as having the high-level aim of shifting care from the status quo to a future state, as shown in Table 1, below.

STATUS QUO	FUTURE STATE
Focus on pathways into hospital for specialist assessment and care planning	*Focus on specialist assessment, treatment, care and support at home and in community settings*
Focus on the roles, skills, competencies and professional boundaries of practitioners	*Focus on supporting and caring for a person as far as skills and competencies allow, while looking to develop these further over time*
Focus on reactive interventions and episodic treatments	*Focus on early engagement to support prevention and early intervention with well-established anticipatory care planning*
Focus on treatment, support and care based on a professional assessment of need	*Focus on having conversations to understand a person's strengths and resources, needs and preferences while adopting an ethos of co-production in jointly exploring options to meet these*
Focus on traditional model of service commissioning	*Focus on an outcomes-based model of strategic and service commissioning*

Table 1 Framework for Community Health and Social Care Integrated Services

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.

PARTNERSHIP WORKING

The HSCP is a strategic partner within the Falkirk Community Planning Partnership and makes a significant contribution to the Community Planning Partnership's Falkirk Plan (or Local Outcomes Improvement Plan).

The IJB is a Community Justice partner, and the Chief Officer represents the IJB on the Falkirk Community Justice Partnership. People with lived experience of Community Justice Services often have a range of needs. These require partnership working between the IJB and Community Justice Partnership 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 Falkirk Plan (Falkirk's Local Outcomes Improvement Plan).

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.

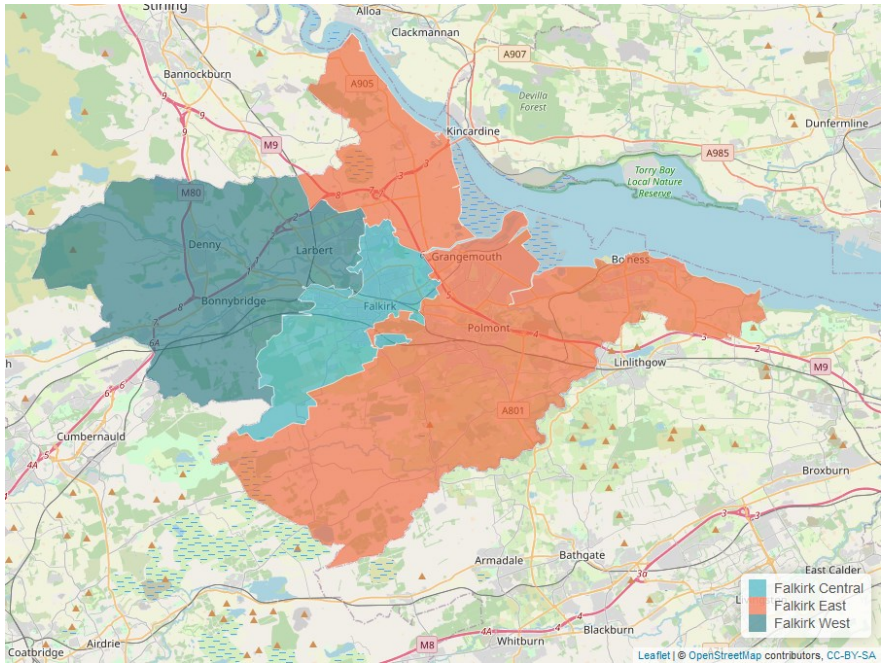


Figure 1: Locality map

In developing our locality structures we will align with the work being led by the Community Planning Partnership 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.

VISION, OUTCOMES, AND PRIORITIES

Our Strategic Plan 2023-26 outlines the outcomes and priorities that we aim to deliver to help improve health and social care in Falkirk. The Plan explains why we believe these outcomes and priorities will make a significant contribution to our vision:

OUR VISION:

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

Our vision and the key outcomes that we need to achieve in the long-term remains unchanged since our last Strategic Plan

We have identified four Strategic Priorities that we believe will make the biggest difference in helping us to achieve our outcomes over the next three years. These priorities are enabled by three Cross-cutting Priorities that support everything that we do.

OUR LOCAL OUTCOMES ARE:

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

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

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

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 PRIORITIES

We have identified **four strategic priorities** we believe will make the biggest difference in helping us to achieve our outcomes over the next three years. These priorities are backed by **three supporting workstreams** that drive everything that we do.

OUTCOMES

Our 4 local outcomes and the 9 National Health and Wellbeing Outcomes are supported by:

OUR STRATEGIC PRIORITIES

Support and strengthen community-based services	Ensure people can access the right care, at the right time, in the right place	Focus on prevention, early intervention, and minimising harm	Ensure carers are supported in their caring role

SUPPORTING WORKSTREAMS

Workforce	Technology	Communication and Engagement

CONTEXT

POPULATION

Falkirk has an estimated population of 160,560 as of 2020, with 78,645 (49%) males and 81,915 (51%) females. The National Records for Scotland estimate that this will increase to 169,962 by 2043 (a 6% increase based on 2018 mid-year population).

Population projections anticipate an 80% increase in the 75+ population between 2018-2043 (see Figure 2). The large rise in the older population relative to the increase in working age population is likely to increase demand for health and social care services without the required growth in workforce to deliver these services.

In order to enable people to live independently for as long as possible, a combination of appropriate housing and care services will be required to serve the increasing older population.

In Falkirk, more than a third (38.5%) of dwellings were occupied by a single person in 2020. Living alone can increase a person's social isolation and loneliness. Furthermore, there is evidence that older adults living alone are more likely to go to A&E and be admitted to hospital, and more likely to visit their GP.

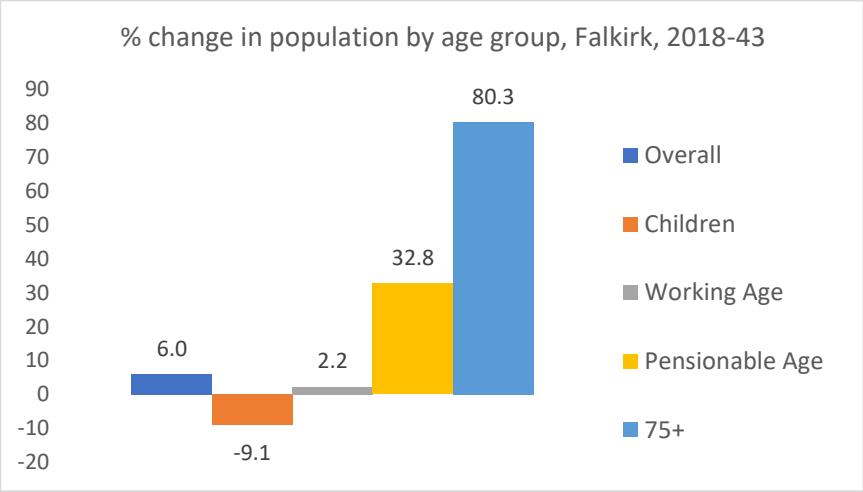


Figure 2: % change in population by age group, Falkirk, 2018-43

DEPRIVATION

Deprivation is associated with increased harm from alcohol and drug misuse, lower uptake of cancer screenings, increased likelihood of hospitalisation and death from various long-term health conditions, poorer mental health and a greater number of deaths by suicide.

The Scottish Index of Multiple Deprivation (SIMD) divides Scotland into 6,976 small areas, called data zones. The Index provides a relative ranking for each data zone according to its level of deprivation. One way we can use these is to divide all data zones into 5 equal deprivation quintiles. Quintile 1 is the most deprived and quintile 5 is the least deprived.

In Scotland as a whole, each of the five SIMD quintiles contains 20% of the population. Falkirk has a higher proportion of its population in SIMD three. It has below the national average in SIMD five (the least deprived areas) but it also has a lower proportion in the areas of highest deprivation (see Table 2).

Among Falkirk's three localities, Central has the highest proportion of its population living in the most deprived quintile (32% compared to 12% in Falkirk East and 7% in Falkirk West). The most deprived data zones within Falkirk are distributed across the main conurbations, with clusters in Bainsford and Langlees, Grangemouth and Camelon East.

SIMD Quintile	Population	% of population
1	25,930	16.1
2	36,055	22.4
3	39,920	24.8
4	28,003	17.4
5	30,982	19.3
Total	160,890	100

Table 2: Source: Public Health Scotland (PHS) Scottish Index of Multiple Deprivation (SIMD) data 2020

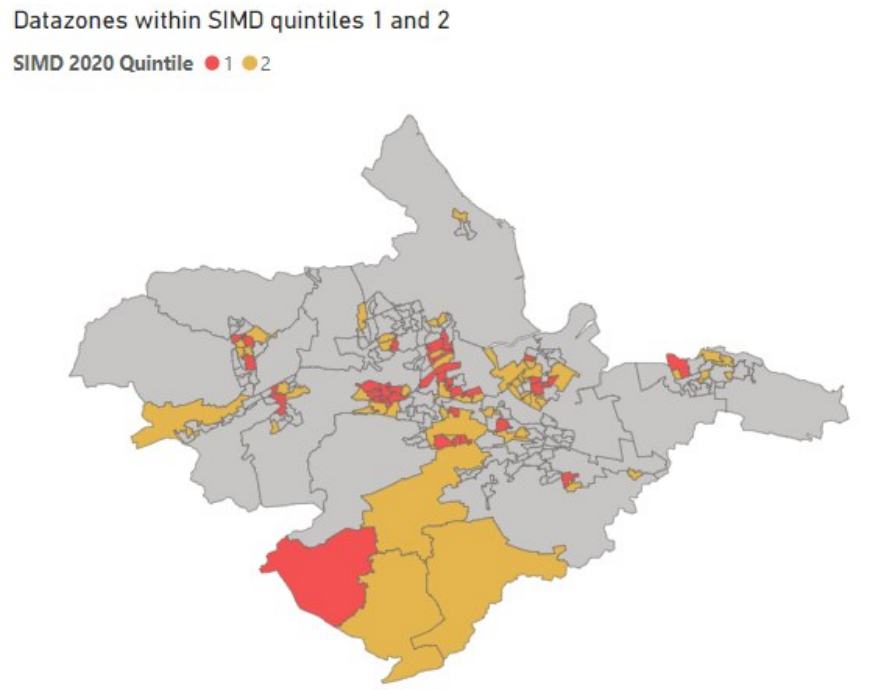


Figure 3: Map of Falkirk with SMID Data zones

Fuel poverty is defined by the Scottish Government as any household spending more than 10% of their income on energy - after housing costs have been deducted.

Living in cold, damp homes exacerbates certain respiratory conditions including colds, flu, bronchitis, and pneumonia. Hypothermia is also caused by long-term exposure to cold and those who are chronically sick, disabled or with limited mobility are at particular risk.

In December 2020 it was estimated that 22% of the Falkirk households were in Fuel Poverty (Scotland Average = 24%). Estimates from the Scottish Government after the energy price cap increase in April 2022 suggest that the number of people in fuel poverty would rise to 31%.

Living in deprivation with low income and little opportunities hugely impacts on life, from day to day living to the longer-term impact on physical and mental health. Within Falkirk there are pockets of higher deprivation where people have less income, are more reliant on benefits and more children are living in poverty.

For many people, the Covid-19 pandemic has meant living on reduced pay, being more reliant on benefits and being more socially isolated. The legacy of Covid-19, combined with the continuing increase in daily basic living costs, is likely to further increase the stress for many people living in deprived circumstances.

ECONOMY

In 2020, 63.5% of Falkirk's population was of working age with around 71,000 jobs. The table below (Table 3) illustrates that on several economic and employment measures Falkirk is similar to the national average. It has a similar working age population, employment rate, population on out of work benefits and population economically active and unemployed. Where it differs is on gender pay. While the gender pay gap in Falkirk was narrower than that nationally this is due to the male median gross weekly earnings for full time workers being less and the females being slightly more than the national average. It should be noted however that this relates to a period where many people would have been furloughed. In the UK the gender pay gap has been declining slowly over time and it is much higher for people aged 40 and over than under.

Measure	Year	Falkirk	Scotland
Employment Rate (%) [1]	2019/20	75.0	74.4
Enterprise Survival [1]	2019/20	54.8	56.5
Working Age population Employment Deprived (%) [2]	2017	9.01	9.29
Out of Work Benefits (%)[1]	May-20	15.5	15.7
Working age population (16-64)[3]	2020	63.5	63.9
Median Gross Weekly Earnings for Full Time Workers - Men[3]	2021	602.5	650.4
Median Gross Weekly Earnings for Full Time Workers - Female[3]	2021	584.7	577.3
Economically Active (%)[3]	Oct 20-Sept 21	77.0	76.1
Unemployed, model-based (%)[3]	Oct 20-Sept 21	3.9	4.2

Table 3: Overview of Economic and Employment Measures

Inflation has been rising during 2022 at a quicker rate than wages and benefits causing cost of living pressures, leaving people struggling to pay for essentials such as food and energy. The financial pressures on individuals could have a long-term impact on their health as when people become disadvantaged by their socioeconomic position their health outcomes worsen. The period of high inflation will also impact the HSCP with extra pressure and constraints placed on its budget.

HEALTH

One of the key objectives of the strategic planning process should be to make informed decisions which help to reduce health inequalities. Health inequalities shouldn't exist, but figures suggest that there are still significant health inequalities across all of Scotland dependant on where a person is born.

Both male and female life expectancy is less for those living in the most deprived areas compared to those living in the least deprived - over ten years for men and eight years for women. Over the past decade the death rate for 15-44 years olds has increased. However, while it has increased by 50% in the most deprived areas (quintile 1) it has actually decreased by 40% in the least deprived (quintile 5).

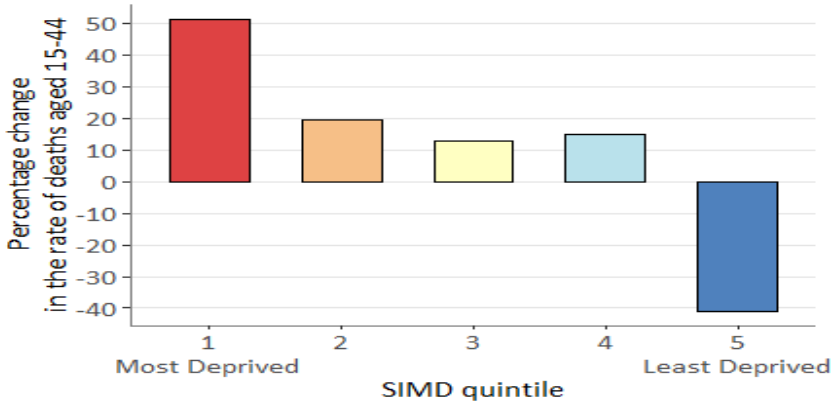


Figure 4: Percentage change in the rate of deaths aged 15 - 44

In short, poorer outcomes are experienced by people living in the most deprived areas and while it may not be within the gift of the Health and Social Care Partnership to influence all the underlying causes of inequalities, the HSCP is in a position where it can target support to those most in need and contribute to reducing inequalities.

	Falkirk HSCP	Falkirk Central	Falkirk East	Falkirk West	Scotland
Female	80.4	79.1	81.1	80.8	81.0
Male	76.6	75.5	77.4	77.4	76.8

Table 4: Life expectancy at birth in most recent estimate (2018-2020 for Falkirk HSCP and Scotland, 2016-2020 for localities)

Health inequalities within Falkirk are demonstrated by the life expectancy of males and females in each locality (see Table 4). Falkirk Central locality has the lowest life expectancy for both men and women of the three localities. Falkirk Central includes a higher proportion of people living in deprived areas.

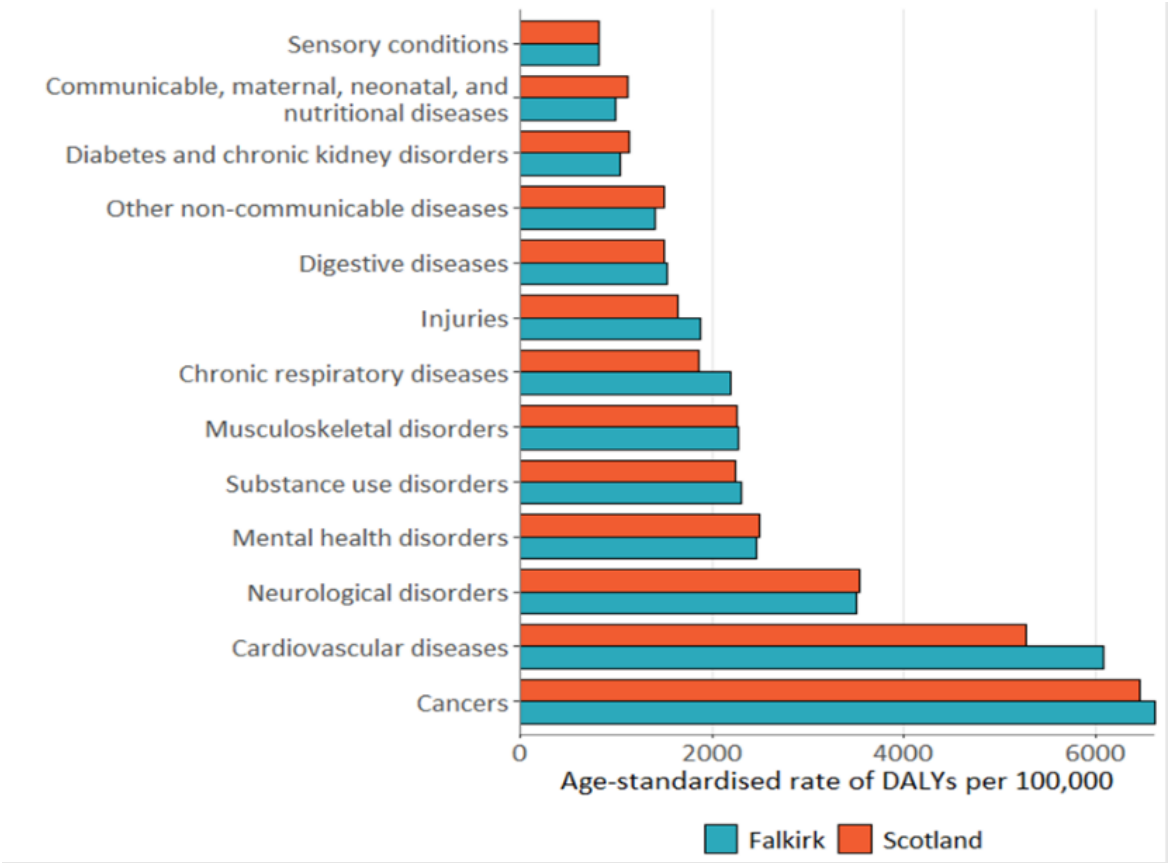


Figure 5: Disability Adjusted Life Years (DALYs) in Falkirk and Scotland 2019

Burden of disease is a measure of the health of the population. It aims to quantify the difference between living to old age in good health, and the situation in which healthy life is shortened by illness, injury, disability and early death.

The measure used to describe the overall burden of disease is called the Disability Adjusted Life Year (DALY) and was calculated by adding together 'years of life lost' and 'years lived with disability, illness or injury' for each condition (Figure 5).

Cancers and cardiovascular diseases are by far the conditions with the most important burden in Falkirk. Cardiovascular diseases appear to have a higher burden in Falkirk than Scotland. Mental health conditions are responsible for the most years lived with disorder or disease.

According to the Scottish Health Survey, in 2021 36% of people in Falkirk lived with a limiting long-term illness.

In Falkirk in 2021/22, General Practice data suggested that 1,198 people registered had dementia (0.8% of the population), but it is important to note that this figure is likely an undercount as it will only include those who have been registered with a diagnosis of Dementia. The estimated number of people with dementia in Falkirk is likely to increase by around 40% in the next 25 years as the population ages.

Diabetes is a long-term condition characterised by elevated blood sugar levels. In 2021/22, the General Practice disease prevalence report found that 6% of the Falkirk population had diabetes, compared to 5.3% in Scotland overall. Type 2 diabetes accounts for 90% of diabetes diagnoses within Falkirk, with excess weight being a risk factor. Although physical activity in adults have been improving since 2015, less than a quarter of the population meet the requirements for fruit and vegetable consumption.

Information on physical disabilities in Falkirk is limited. In 2011 only 7% of the total population recorded having a physical disability. The proportion of people with a disability increases as people age. Again, with an ageing population, it can be anticipated that this number has increased since 2011.

Unfortunately, data regarding people that are blind or partially sighted is also limited and was last recorded in 2010. For deafness and hearing impairment there is no national data at all. This lack of data means that there is a hidden population of people in Falkirk that are affected by these health conditions.

In 2019, 691 adults with learning difficulties were known to local authorities in Falkirk. 45% were under the age of 35, 40% lived with a family carer and 20% attended a day centre. These statistics highlight the importance of services provided by the HSCP and the role that our unpaid, family carers play in our community.

BEHAVIOURAL FACTORS

Alcohol and drugs remain a challenge in Falkirk. In the last five years alcohol-related hospital admissions have been rising, and while these were historically below the national average, in 2020/21 Falkirk rates were very similar to Scotland. It is worth noting that this trend seems to be driven by rates in Falkirk Central locality, which is the only locality with rates higher than Scotland. Similarly, it is also the only area with drug-related hospital admissions above the national average, although these have been consistently increasing across all areas over the past decade. In Falkirk, the number of drug-related deaths has more than tripled between 2010 and 2020.

Smoking remains a significant national public health issue, however smoking prevalence and smoking attributable deaths have steadily declined in Falkirk and Scotland.

There was slight rise in Falkirk's smoking prevalence between 2017 and 2019. This could be attributed to the 35-64 age group where 18.5% are classed as smokers, more than double the figure of older people aged over 65 which is 8.3% Falkirk's rates for smoking prevalence and smoking attributable deaths are below the national average.

The latest Scottish Health Survey (covering 2016-2019) found that 58% of females and 73% of males in Falkirk met the recommended guidelines for physical activity levels. It is possible that this difference in physical activity between sexes plays a role in obesity rates being higher among females than males.

It is also worth noting that the proportion of people meeting their recommended activity levels has increased from 53% for females and 68% for males since 2012-2015.

Although activity levels have risen, 35% of females and 25% of males are considered to be obese. Less than a quarter of Falkirk's population met the recommended guidelines for fruit and vegetable consumption with 1 in 10 not eating any fruit or vegetables at all.

MENTAL HEALTH

Mental health is an umbrella term used to encompass both mental health problems / illness and mental wellbeing. Mental Health problems or illnesses are clinically diagnosed symptoms which affect the way that a person thinks, feels or behaves. Mental wellbeing describes mood and how well a person can cope with day-to-day life.

Life events such as bereavement, loneliness, loss of employment and money worries can all lead to low mental wellbeing. People who are socially excluded, who have a long-term condition, are homeless or living in poor housing, or socially disadvantaged are more vulnerable in terms of mental wellbeing, and consequently poor mental health in the long-term.

There is considerable debate as to the true prevalence of mental health disorders in Scotland, but here are some key points to recognise how widespread mental health issues are:

- The Scottish Government estimate that approximately 1 in 4 people will experience some form of mental health issue in their lifetime.
- According to the 2019 Scottish Health Survey, in 2018/19 17% of adults in Scotland had scores indicative of psychiatric disorders.
- Conditions related to mental health had the highest non-fatal burden of any condition group in 2019 (see Figure 5 in the Health section)

Socio-economic deprivation is associated with increased risk of developing a mental health disorder. Individuals from disadvantaged backgrounds may have higher exposure to stressful experiences and weaker support systems over the course of their lives, both of which play a role in mental wellbeing.

Evidence also suggests that the pandemic has negatively affected the mental health of people living in Scotland, particularly among people already experiencing inequalities. Data relating specifically to Falkirk is more limited, however, there is some evidence to suggest that people living in Falkirk may not have received the help they needed for their mental wellbeing in recent years. Whilst nation-wide research suggests mental health worsened due to the pandemic, in Falkirk the weekly average number of patients starting a new treatment course for selected mental health medicines was 13.5% less in 2020 and 16.9% less in 2021 compared to the weekly average in 2018 and 2019.

Data from local services, including the Primary Care mental health service and FDAMH (Falkirk Mental Health Association) Immediate help service reveals the main reasons people have asked for help. Anxiety and depression are the most common presenting problems, with low mood, stress and low confidence also being prevalent.

Loneliness can be a contributing factor to a person's mental health. Social isolation and loneliness are often discussed together. However, they are not necessarily connected as people are socially isolated may not feel lonely, and people who have many social connections may feel lonely. Social isolation refers to the quality and quantity of the social relationships a person has at individual, group, community and societal levels. Loneliness is a subjective feeling experienced when there is a difference between an individual's felt and ideal levels of social relationships.

31% of people who reached out to Falkirk's Mental Health Association (FDAMH) in 2021 experienced loneliness.

Suicide is a significant public health issue in Scotland and there are inequalities in suicide risk, with those in lower socio-economic positions at a higher risk. According to the 2021 report from the Scottish Suicide Information Database (ScotSID), between 2011 and 2019, 6,798 individuals aged 5+ years died from suicide in Scotland, 229 of which were in Falkirk.

Rates of suicide are higher in males than females. In fact, 73.2% of the entire ScotSID cohort from 2011 to 2019 was male. This pattern is present in many other high-income countries across the world, and there are many plausible explanations for it, mostly related to social expectations and pressures on men.

UNPAID CARERS

During the Covid-19 pandemic, unpaid carers were heavily relied upon to provide necessary care when care packages or respite services were stopped. Some people became carers for family members for the first time, possibly without realising.

The Carers Centre Survey in June 2020 showed that 78% of respondents had not been able to have a break from their caring role throughout the whole of lockdown. It is essential that support systems are provided to unpaid carers to ensure they are fully supported and able to sustain their caring roles at a time when social care services are already experiencing high levels of demand.

Unpaid carers are the largest group of care providers in Scotland. Tables 6 & 7 (next page) show the estimated number of unpaid carers in Falkirk. Research from Carers UK suggests that three in five people will become carers at some point in their lives. Anybody can become a carer at any time, sometimes for more than one person and it can be at any age from young children to the elderly.

Unpaid carers can receive payment for part of their time caring through the Carers Allowance. Many carers though are 'hidden' and may not be accessing the support and services to which they are entitled. Estimates indicate that there could be thousands of 'hidden' carers in Falkirk that are not receiving support through services like the Carers Centre or the Department for Work and Pensions (DWP.)

Many carers do not recognise themselves as a carer, rather simply a family member or friend and others may experience fear or anxiety, particularly young carers, which prevents them from looking for the support they deserve.

The 2022 Health and Social Care Experience Survey revealed that only 29% of carers in Falkirk felt supported in their role. That is why one of the main priorities for the Strategic Plan is to ensure carers are supported in their caring roles and will aim to break down the barriers that prevent hidden carers receiving the support they deserve and are entitled to.

It will also take into consideration the measures implemented by the Falkirk Carer's Strategy 2019-2022 which outlines how the HSCP will support carers and meet statutory requirements.

HOW MANY UNPAID CARERS LIVE IN THE FALKIRK AREA?

For various reasons, we don't have an exact number of how many people provide care for their loved ones in Falkirk. We know that many people may not consider themselves as a carer, or be aware of the help they can access to carry out their caring role. These people are often referred to as 'hidden carers'

From the tables opposite, you can see that around 3,785 adult carers have engaged with the local Carers Centre, but a population estimate shows there could be over 25,000 people in the local area providing care.

Adult Carer Estimates	*Source*
14,752	2011 Census, Carers aged 16+
25,228	Estimate based on Scottish Health Survey, 2020 telephone survey (19% of people aged 16+)
32,365	Estimate based on 2020 YouGov Poll (25% of adult population)
3,785	Adult Carers known to the Carers Centre
3,889	DWP Carers Allowance, Entitlement cases, Aug 2021

Table 5: Various Adult Carer Estimates

Young Carer Estimates	*Source*
304	2011 Census, Carers aged under 16
921	Estimate based on Scottish Health Survey 2016-19 (young carers aged 4-17)
381	Young Carers known to the Carers Centre

Table 6: Various Young Carer Estimates

WORKFORCE

The Partnership has created a comprehensive Workforce Plan, also covering 2023 – 2026. The Plan addresses the make-up of the current workforce, the challenges facing the Partnership in terms of workforce and the objectives required to develop a sustainable future workforce.

Some of the key challenges and drivers highlighted in the Workforce Plan include:

- Ageing population and workforce
- Marked increase in substance use
- Mental wellbeing
- Reduced funding with increased demand
- Recruitment skills shortages
- Technological and system improvements required
- Ageing estates and lack of suitable premises

The pandemic has also had a long-lasting impact on staff working in the care at home and adult care home sectors, with significant and sustained pressured affecting staff health and wellbeing.

The latest Scottish Social Services Council workforce publication shows that while staffing levels in both services has decreased, they have decreased considerably for the Housing Support / care at home Service.

Recruiting and retaining staff in social care worker roles poses a particularly acute challenge. The main factors influencing recruitment and retention are:

- **Competition** – the minimum wage for care workers (December 2021) is £10.02 per hour, but job opportunities in sectors such as supermarkets in the area are often preferable due to nature of work and higher wages. Cost of living increases in 2021/2022 are only likely to exacerbate the impact on social care services.
- **Fuel costs** – unprecedented increases in the price of fuel combined with low wages means the job is not sustainable for some.
- **Change of circumstances** - People who were employed in the care sector before the pandemic may have had to shield during 2020 and perhaps changed to a non-front-line role that enabled home working. In these cases, people may have chosen not to return to the front line role.
- **Working demands** – with many services short staffed new staff will be subjected to considerable and perhaps stressful levels of demand which undoubtedly will impact on staff retention

SOCIAL CARE DEMAND

While there have been long standing challenges with social care provision including funding and staffing, the pandemic has had a profound effect on social care services. Since Covid-19, some services have struggled to manage demand due to unrelenting pressures. Exhausted staff have received little respite following the periods of Covid-19 restrictions, which, combined with recruitment challenges and considerable pent-up demand, has meant that key services such as care at home, Emergency Department and Hospital Discharge Teams have struggled to keep up with sustained high levels of demand.

Demand for social care in Falkirk is mainly with older adults although there is a large group of working age adults requiring support, predominately those with disabilities (physical, sensory and learning). There are around 8,035 people that receive social care support and services and the highest number of clients are in the services of community alarms and telecare. Evidence also shows that services and staff are dealing with more complexity of care. With the older adult population in Falkirk predicted to increase significantly demand for social care provision is anticipated to increase as well.

Care at home services have undoubtedly been one of the services most impacted by the pandemic. Pressures on care at home services have a knock-on effect elsewhere in the system specifically for hospital admission and hospital discharge and in 2020 Falkirk's delayed discharge was higher than Scotland's. Almost everyone supported by care at home required personal care which again adds more pressure to the system in terms of staff.

Services have had to adapt quickly and do more with less resources which has resulted in services dealing with long waiting lists and staff health and wellbeing being impacted, with many facing burnout.

HOUSING

Housing plays a pivotal role in the health and wellbeing of the population and it is imperative that the Strategic Plan reflects the need to provide sufficient quality housing provision to those who need it. The World Health Organisation considers “physical environment” to be one of the 3 determinants of health, alongside the social and economic environment, and the person’s individual characteristics and behaviours. It is argued that these factors have a greater impact on the health of the population than commonly considered factors such as access to health and care services.

The new Falkirk Council Housing Need and Demand Assessment (HNDA) was approved by the Scottish Government in December 2022, and this highlights that although the number of new households is increasing, the rate of the increase is slowing down. This is very much a feature of the economic climate. Fewer new households form when the country is in an economic slowdown as they cannot afford to set up a separate household.

Therefore, although there continues to be a need for more housing this is not as much as estimated in the Falkirk Council HNDA 2018. Despite this, the need for housing across all tenures continues to outstrip supply. The HNDA estimates need for an annual average of 466 additional properties over the next 5 years of which 131 are social rented and 91 below market rent. The remainder being private sale or private rented.

There is a need for adapted, accessible or wheelchair housing from all age groups and the need for such housing is rising fastest in younger age groups. The HNDA estimated that there were 2, 670 wheelchair users in 2022 with 527 who had an unmet housing need.

By 2027 there is projected to be 3, 433 wheelchair users with 677 in housing need. By 2032 there is projected to be 4, 188 wheelchair users with 872 in housing need. The HNDA 2022 highlighted currently there are 258 wheelchair properties (189 Falkirk Council 69 Housing Association). There are 510 amenity properties (401 Falkirk Council and 109 Housing Associations). There are 2000 ambulant disabled properties (1937 Falkirk Council and 63 Housing Associations).

Falkirk Council have an all-tenure wheelchair target of between 5-10% for new build housing as set out in the Affordable Housing Policy.

For people who experience functional difficulties due to health or mobility problems there are several options to support continued independence. Options include equipment to facilitate independence, minor or major adaptations, or even moving to a more suitable property. Basic adaptations could consist of things like internal/external grab rails, bannister rails, lever taps or relocation of difficult to reach plug sockets. For more complicated major adaptations it will be necessary to complete a formal assessment through social work. The HNDA estimates approximately 2,000 or 3% of all households in Falkirk need disabled adaptations which is an increase from 1, 380 or 2% in the last 2018 HNDA.

In relation to supported housing for older people, Falkirk Council housing service owns four developments where care and support is provided by the Health and Social Care Partnership by care staff based onsite early morning to late evening with the development switched to mobile emergency care overnight. The HNDA 2022 indicated that in 2021 care and support was given to 27 tenants in one very sheltered housing development and 205 tenants in 3 sheltered housing developments. There were 139 applicants in 2021 for this supported housing option.

Housing Associations have moved away from providing sheltered and very sheltered housing. This has been a national direction of travel relating to local authorities withdrawing from the provision of housing support funding and perceived complexities around care commission registration. As with local authorities, Housing Associations are experiencing low demand for some of their older peoples' housing developments. Housing Associations currently provide 440 retirement properties which were previously sheltered housing. An onsite staff presence is weekdays often part time with the focus being on housing management and repairs issues and not support. Care and support are only provided to individual tenants where they are assessed as requiring this by the Health and Social Care Partnership in a community care needs assessment.

The HNDA 2022 recognises the need for a core and cluster model of accommodation, care and support for around 100 people who are aged under 65 with community care needs and are housed out with Falkirk Council area due to a lack of options locally.

Evidence suggests that the health of people experiencing homelessness is significantly worse than that of the general population. The number of people presenting as homeless in Falkirk has remained relatively consistent over the last few years. In 2020-21, 1,072 applications were made for assistance (down 92 on the previous year). Falkirk Council considered that

823 (77%) of those who applied for support were found to be homeless or threatened with homelessness.

The quality of housing will also impact upon people's health. Certain respiratory conditions are exacerbated by the cold and people living in cold homes are more likely to suffer colds, flu, bronchitis, and pneumonia. Hypothermia is caused by long-term exposure to cold and those who are chronically sick, disabled or with limited mobility are at particular risk. Those who are fuel poor are more likely to be forced to turn their heating down below the level tolerable for their wellbeing, and potentially more likely to live in energy inefficient homes.

The Scottish Government released estimates in February 2022 (based on April price cap) suggesting that nearly 1 in 3 of households (31%) in Falkirk will be in fuel poverty.

The HNDA 2022 recognised that the Scottish Government have not released updated detailed information on households in fuel poverty at local authority level since before the covid pandemic. Data collected over the period 2017-2019 estimated 22% of households in Falkirk Council area were in fuel poverty. Due to the current economic climate, it is recognised that this is an underestimate with the likely figure closer to the figure quoted of 1 in 3.

The increasing numbers of people living in properties in disrepair, most often older people was also noted in the HNDA 2022.

It is recognised there is a need for services which maintain people in their current accommodation, reduce social isolation and prevent or delay use of formal health and care services (HNDA 2022). Such services include Small Repairs Handypersons Service, access to repairs grants, use of low level or digital options.

The HNDA 2022 recognised that care workers are becoming older, and some have left the sector due to the impact of the covid pandemic. It was also recognised that incentives for people to remain in or join the care sector will be continuing to be explored by partners.

From a housing perspective, care workers are now identified in the Affordable Housing Policy as a priority group and the strategic housing authority would welcome working with the Health and Social Care Partnership to highlight affordable options under the AHP as they are developed in future.

Also highlighted in the HNDA was consultation carried out on the Falkirk Council gypsy traveller site in 2021. This recognised that the site does not meet current requirements. Families onsite also highlighted those

older residents and those with disabilities want to stay on site in future and changes may be required to ensure this is feasible.

The Housing Contribution Statement provides an overarching strategic statement on how the housing sector will support the work of the Integration Joint Board to achieve national and local outcomes for health and social care.

The Housing Contribution Statement creates a bridge between the Local Housing Strategy and the Strategic Plan.

FALKIRK COUNCIL HOUSING NEED AND DEMAND ASSESSMENT: KEY ISSUES

1. Need for more affordable housing
2. Need for more disabled adaptations
3. Need for more adapted or accessible housing for all age groups
4. Need for more wheelchair housing for all age groups
5. Need for a core and cluster models of housing with support and care for people under 65 currently living out with the Falkirk Council area
6. Shortage of key workers specifically health and social care workers which support the priority given by the strategic housing authority to such workers under the Affordable Housing Policy
7. Need to make best the use of digital technology
8. Need for support for people specifically those who misuse alcohol and drugs, have mental health issues, are fleeing domestic violence
9. Need for work to improve the existing gypsy travellers' site. Including need to take account of older and disabled people on site.

LOCAL AND NATIONAL INFLUENCES

The Strategic Plan 2023-26 considers 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.

THEME	SUMMARY
Integration Public Bodies (Scotland) Act 2014 Independent Review of Adult Social Care National Care Service National Health and Wellbeing outcomes Health and Social Care Standards National Clinical Strategy	Collectively, these documents describe the ambitions for how health and social care services will change to meet the needs of the population. They share a number of common features, including the need to address health inequalities, strengthen primary and community care, and improve the co-ordination of health and social care services. Integration legislation and guidance requires health and social care services to work together to provide services that are integrated from the perspective of the service user. The legislation also aims to ensure that care is delivered consistently and resources are used efficiently. The Independent Review into Adult Social Care (IRASC) recommended the establishment of a National Care Service. The National Care Service will be responsible for social work and social care support, including support for carers. It will also be responsible for planning and commissioning primary care and community health services. To ensure services are joined up, from a community healthcare context GPs, Nurse Directors and other clinical and healthcare leaders will engage in the development of local plans. The National Care Service (Scotland) Bill was introduced to the Scottish Parliament in 2022, with the aim of establishing a functioning National Care Service by the end of this parliamentary term in 2026. The Falkirk HSCP Strategic Plan incorporates many of the principles of the Independent Review of Adult Social Care, which will ensure that

	services develop in similar direction to the proposed National Care Service. We will also contribute to consultation and engagement activities regarding the development of the National Care Service.
Wider determinants of health The Falkirk Plan 2021-30 Falkirk Council Plan 2022-27 A Resilient Forth Valley: A Health Improvement Strategy to Tackle Impacts of Covid-19 2021-2026 A Connected Scotland	Several plans and strategies have been prepared that address the wider determinants of health, i.e. the social, economic and environmental factors which influence people's mental and physical health. The HSCP works in partnership with organisations across Falkirk to mitigate some of these issues. The Health Improvement Strategy outlines a Public Health approach to tackling the three significant harms intensified by the pandemic, i.e. suicides and drug related deaths, mental health and alcohol related harm.
Housing Housing Contribution Statement Housing to 2040 Local Housing Strategy Rapid Re-Housing Transition Plan	Housing conditions can have a direct impact on physical health, for example damp, cold homes cause respiratory conditions. Providing accessible housing with elements of care and adaptations also plays a significant role in enabling people to live independently. The plans at local and national level outline how housing will be improved to help address some of the wider determinants of health. 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. Falkirk's Rapid Re-Housing Transition Plan is about rehousing those who have experienced homelessness as quickly as possible, reducing the time and trauma of being in temporary accommodation.
Digital Digital Health and Care Strategy Data Strategy for Health and Social Care in Scotland	Greater use of digital technology to deliver and improve services forms a core part of the Strategic Plan. Our local ambitions align with Scotland's Digital Health and Care Strategy, which aims to increase the availability of

	digital services, improve access to information and make better use of data to understand and improve services. The Scottish Government Data Strategy outlines how data will be used to aid the delivery of better services and greater innovation. The Strategy will also explain how people will have greater access to, and greater control over, their health and social care information.
Carers Carers (Scotland) Act 2016 Carers Strategy	The Carers Act (2016) establishes rights for carers to receive support from local authorities, including the preparation of a personalised plan. The Strategic Plan aligns with the Carers Act and the Falkirk Carers Strategy by prioritising support for carers and the development of person-centred services.
Equality and Poverty Towards a Fairer Falkirk Fairer Scotland Duty Public Sector Equality Duty The Equality Act 2010 & The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012	Equality legislation requires public bodies to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. The Scottish Specific Duties also require public bodies to consider a range of other Duties, including to mainstream equalities, publish equality outcomes and assess and review policies and practices. Similar legislation (The Fairer Scotland Duty) exists that requires public bodies to consider how to reduce inequalities of outcome caused by socio-economic disadvantage. Historically, health and social care services have been designed with equality of provision in mind (i.e. the service is provided in the same way to everybody), which can disadvantage some groups. One of the most effective methods of tackling poverty and advancing equality is to develop services using a person-centred approach.
Involvement Participation and Engagement Strategy Communication Strategy	Involving people in decisions and the co-production of local services is a priority for the Strategic Plan. The Community Empowerment Act obliges Scottish public authorities to involve people and communities in making decisions. Falkirk HSCP describes how it will involve people in its

Community Empowerment (Scotland) Act 2015	strategies regarding Participation & Engagement Strategy and Communication.
Mental Health National Mental Health Strategy Suicide Prevention Strategy	The National Mental Health Strategy sets out how Scotland's approach for creating a parity of esteem between the treatment of mental health and physical health problems. The Strategy focuses on prevention, access to treatment and the physical health of people with mental health problems. 'Creating Hope Together', the national Suicide Prevention Strategy, outlines a set of outcomes and priorities for suicide prevention. The priorities include addressing the social determinants that influence suicide; strengthening responsiveness and awareness of people that are suicidal; promoting effective and timely support; and creating a more co-ordinated approach.
Dementia National Dementia Strategy	Scotland's National Dementia Strategy 2017-2020 focussed on improving the quality of care for people living with dementia and their families through work on diagnosis, including post-diagnostic support; care co-ordination during the middle stage of dementia; end of life and palliative care; workforce development and capability; data. information and research. The Scottish Government are due to publish a new Dementia Strategy in 2023.
Learning Disability Keys to life Learning/Intellectual Disability and Autism Towards Transformation	Keys to Life is the national strategy to improve the quality of life for people with learning disabilities. It is accompanied by 'Towards Transformation', which aims to 'ensure that the human rights of autistic people and people with learning/intellectual disabilities are respected and protected and that they are empowered to live their lives, the same as everyone else.' The strategies are based on developing services that help people

	with a learning disability to live independently and participate as active citizens.
Drugs and Alcohol National Mission on Drug Deaths: Plan Rights, Respect & Recovery: alcohol and drug treatment strategy Alcohol Framework	These documents describe a number of outcomes and actions that aim to prevent and reduce problem drug and alcohol use. The Scottish Government's approach is to reduce the individual, family and societal factors which increase the likelihood of alcohol and drug use and related harm. In order to achieve this, services helping people with drug and alcohol problems will become more person centred and evidence informed.
Palliative and End of Life Care Strategic Framework for Action on Palliative and End of Life Care Palliative and End-of-Life Care by Integration Authorities: advice note	The Framework sets out how everyone in Scotland who needs palliative care will be able to access it. The advice note supports the strategic commissioning of Palliative and End of Life Care services.

Table 7

Our Strategic Plan reflects the Framework for Community Health and Social Care Integrated Services, which explains the key components of effective, sustainable integrated care. Further information about the framework can be found on the Health and Social Care Scotland website.

OUR PRIORITIES IN DETAIL: SUPPORT AND STRENGTHEN COMMUNITY-BASED SERVICES

Services will be enhanced to improve the 'flow' of patients through hospital settings, to prevent admission, and promote independent living within Falkirk's communities.

Community health and care services play a vital role in helping to reduce avoidable demand on acute services, improving quality of life and keeping people well for longer. Community health and care services are delivered by a range of providers including the NHS, Falkirk Council, GP Practices, the independent sector and third sector / community organisations. Together, these organisations provide a wide variety of functions, including (but not limited to):

- Community Nurses (e.g. District Nursing, General Practice Nurses, Care Home Nurses, Community Mental Health Nurses)
- Allied Health Professionals (such as Physiotherapists, Occupational Therapists, Podiatrists, Dietitians)
- Care and support services (e.g. home care, day care, respite care, befriending)
- services and support for adults with physical disabilities and learning disabilities
- re-ablement services, equipment, and telecare
- palliative care services (not within a hospital)
- mental health services (not within a hospital

Demand for community health and care services is growing due to the ageing population. Not only are people living longer, but they are often living longer with poorer health, frailty and multiple long-term conditions. The Covid-19 pandemic has also contributed to increased demand through 'deferred care' (i.e. additional demands arising from care could not be provided during the pandemic) placing great strain on the capacity of community health and care services.

When community health and care services do not have sufficient capacity, the impact can be seen across other aspects of the health and care system. Community-based services in this context are essential in enabling the 'flow' of patients / service users from one part of the system to the next without delay. Hospitals, for example, face a vicious cycle. When community-based support isn't available, people that could otherwise be cared for at home end up presenting instead at hospital. The hospital itself may be unable to discharge existing patients due to a lack of capacity to support the individual in the community. Demand ultimately ends up increasing as services

become unable to focus on prevention and early intervention.

Increasing the capacity of community-based services will make a significant contribution to all our outcomes.

HOW WILL WE GET THERE?

We will embed the characteristics of effective, sustainable integrated care outlined in the Framework for Community Health and Social Care Integrated Services. Specifically, we will:

- Develop integrated multi-disciplinary teams in communities so people can access a wider range of professionals and services in local GP Practices and localities, closer to their home, e.g. community nursing staff, link workers, physiotherapists, mental health practitioners, social workers and pharmacy services
- Create sustainable services for community-based urgent unscheduled care, aligned with wider community services and teams around General Practice and comprising advanced practitioners and care staff to respond rapidly to changing needs, offering people alternatives to acute hospital admission
- Continue working with the Scottish Government and local partners to implement the 2018 GP Contract that will enable GPs to provide a key role within the extended community based multi-disciplinary team
- Provide a range of short-term, targeted and specialist care and support services, offering alternatives to hospital admission and supporting timely hospital discharge to support people to live healthy, independent life at home or in a homely setting

We will also work towards achieving the vision of our Community Led Support Strategy:

- People have the opportunity and choice to access local services and supports, which will enable them to live well in the community. This will include a range of options, from informal community supports through to statutory services, designed and delivered through collaboration between health and social care professionals, third sector partners and communities. These services and supports will be person-centred, helping people to improve and maintain their health, wellbeing and quality of life.

WHAT WE ARE ALREADY DOING:

Making more community-based services available via GP Practices – capacity in GP Practices has been increased through the Primary Care Improvement Programme. The initiative has included the recruitment of the following roles to work within GP Practices:

- Primary Care Mental Health Nurses (specialist nurses who have in-depth training, experience and understanding of mental health issues)
- Advanced Practice Physiotherapist's (experienced physiotherapists that are able to work with a high degree of autonomy. They are often the first point of contact for patients with musculoskeletal problems)
- Advanced Nurse Practitioners (nurses who are qualified in clinical assessment, enabling them to make treatment decisions, prescribe some medicines, make referrals to secondary care and sign fit notes)
- Community Link Workers (support people to take greater control of their own wellbeing and access relevant non-medical resources or services in their community)

The Programme has also increased access to phlebotomy (blood tests) and pharmacotherapy (treatment using medication) services within the community.

Developing a partnership of third sector organisations to help people be discharged from hospital - the Home from Hospital Partnership is a collaboration between RVS, Strathcarron Hospice, Food Train, the Carers Centre, Dial-a-Journey Falkirk HSCP and Clackmannanshire & Stirling HSCPs. It began in December 2021 and has supported over 2,000 service users in its first year. The service supports those with health issues coming back home after an illness, accident or surgery. They provide the practical and emotional support required to help patients get back on their feet.

Building capacity in the community - the HSCP currently supports three Community Development Workers, one within each locality area. The key role of these workers is to work with people to identify local needs, particularly relating to health and wellbeing, and then support communities and third sector organisations to develop supports to address these needs. Community capacity building is a critical area of work in creating conditions for people to maintain and improve their health and wellbeing without requiring access to formal HSCP services.

Helping people with dementia stay at home and live within their communities for as long as possible – the Joint Dementia Initiative (JDI) aims to help people with Dementia to continue to live the life they want to live by supporting them to live at home in their own communities for as long as possible. The JDI team work with the service user and carer to find ways to reduce the risks surrounding remaining at home.

Dementia Innovation Fund - The Dementia Innovation Fund was developed in 2019. Work relating to the local Dementia Strategy and commissioning work has been on hold for a significant amount of time, due to the pandemic and changes in personnel across the Partnership. At this time, the only funding allocated is to Town Break, who provide day services for people affected by dementia and their carers. They currently operate groups throughout Falkirk area, over 5 days. The service was paused during Covid-19, however is now fully operational. Most referrals come from the Community Mental Health Team, Alzheimer Scotland, GPs and the Carers Centre. People are also able to self-refer.

Dementia Link Workers – help to provide post-diagnostic support, which is based on the following five pillars:

- Planning for future decision-making
- Supporting community connections
- Peer support
- Planning for future care
- Understanding the illness and managing symptoms

The Dementia Link Workers are employed by Alzheimer Scotland with funding from Falkirk HSCP.

Investing in community-based services and projects - Partnership Funding is the term used to describe ringfenced funds that are currently available to Falkirk HSCP. Each fund has a specific purpose, criteria and duration. In order to ensure that the IJB can maintain oversight of the allocation and impact of these funds across the whole system, a programme approach is taken. In practice, a programme approach means that all funds are cited within a single, high level investment strategy. The plan covers a three-year period 2021-2024.

The purpose and criteria of the funds vary, however the single investment strategy intends to provide linkage between ringfenced funds to accelerate the delivery of the Strategic Plan by adding value to core

provision, whilst also enabling service redesign and improvement. Partnership Funds include:

Main Programme: An annual investment programme of £1.4m. This fund currently supports twenty-eight projects or services. This includes an NHS based Alcohol Related Brain Injury Management Service, Peers Network Support Groups, community podiatry, and a post Covid-19 Re-start/Start Up Community Grants Programme.

Carers Fund: An annual investment programme of £2m, intended to provide direct support for unpaid carers. This includes investment in Falkirk & Clackmannanshire Carers Centre who help Falkirk HSCP fulfil statutory obligations to provide a range of support to carers. A Carers Challenge Fund worth 500k, is also in place to enable community based initiatives with funding to provide innovative support to carers.

Health Inequalities & Wellbeing Fund: A focussed programme of £780k investment in communities available until 31 March 2024. This fund currently supports twenty-seven projects across the Falkirk area, including sustainable food provision, physical and mental health, loneliness and isolation and older people.

A full overview of Partnership Funding during 2021/2023 is available from the Integration Joint Board, 2nd September 2022 meeting pages.

ENSURE PEOPLE CAN ACCESS THE RIGHT CARE, AT THE RIGHT TIME, IN THE RIGHT PLACE

Improve the way people access services – enabling everyone to access the right care, at the right time, in the right place.

Being able to access the right care, at the right time, in the right place is vital in helping to maintain or improve people's health and wellbeing. Currently, however, this is often not the experience that people have when they access the health and social care system.

The consequences of deferred care from the Covid-19 pandemic can be seen in long waiting lists for social work assessments, home care, mental health services and other aspects of the health and social care system. While people are waiting for care, the outcomes they are looking to achieve might change, their condition may deteriorate and their problems may become more complex to address.

Covid-19 served to exacerbate long-standing issues with access to care. Adult social care, for example, has traditionally been orientated towards delivering services based on assessed needs. Advice and support services have been comparatively limited, which often means that people do not access care until they become eligible as a result of their condition deteriorating[ii].

People are often unaware of appropriate alternative sources of help even where they do exist. Consequently, many people come to rely on the services that they know exist and have used before, for example GPs and hospitals. Effective communication is, therefore, essential to influence people to access care in the most suitable way.

People can also access services digitally and this was a huge benefit when services could not be accessed in-person due to Covid-19. Many people continue to find it more convenient to access services digitally as it eliminates the need to travel and causes less disruption to work or home life. However, despite the benefits of digital technology, it does not suit everybody, and physical access to services should not be overlooked.

We also need to provide care that supports people to achieve their personal outcomes. These are realistic goals that the person receiving care and support, and their care worker or carer can work towards. Not everyone will expect, or benefit from, a 'one size fits all' approach where services are provided in the same way, regardless of the individual's aspirations. Through developing a more person-centred approach, we will

work with people to identify their aims and strengths before agreeing solutions that take account of their wider social and cultural background. Our approach reflects the aims of Realistic Medicine.

Some people may not be able to live independently in their own home without support. In the past it was common for people that needed additional support to be housed in residential care or in hospital. The health outcomes for people living in residential care tend to deteriorate, however, more quickly than for people that are able to maintain a greater degree of independence.

Housing plays an important role in helping people that need additional support to live independently. Housing that is designed or adapted appropriately can help frail older people avoid falling, for example, and it can enable people with physical disabilities to care for themselves. Assistive technology and telecare can also be provided within the home to help people maintain their independence.

HOW WILL WE GET THERE?

We will embed the characteristics of effective, sustainable integrated care outlined in the Framework for Community Health and Social Care Integrated Services. Specifically, we will:

- Engage people in conversations about their goals, assets, safety, strengths and needs, with care and support centred around people's own health and wellbeing priorities and with a strong focus on early intervention and prevention
- Develop skills and practice to ensure the adoption of a human rights based approach to assessment, treatment, care and support
- Provide people with access to clear and simple information, advice and support reflecting specific communication needs and preferences, including any issues with literacy, health literacy or language, so they can care for themselves and their families at home and know how to access help, support and services when they need to
- Provide people who require assessment, treatment, care and support (and those involved in their care) with access to local services free from barriers, behaviours and discrimination that may impact negatively on them, ensuring a positive contribution to their safety, tackling inequalities and promoting equality of opportunity and outcome
- Establish clear pathways between primary care and locality teams, intermediate care, specialist services and acute care so that people benefit

from access to the right care, in the right place at the right time as their needs change

- Focus on supporting people in their home environment with a home first approach adopted at all times, supported by seamless transitions through rehabilitation and reablement to long-term support and care, as well as high quality palliative and end of life care

WHAT WE ARE ALREADY DOING

Establishing the 'good conversations' model - Work has been undertaken in Falkirk to establish pathways to increase access to support in the community, including the establishment of Community Link Workers at GP Practices in some of the more deprived areas.

Community Link Workers use a social prescribing model to support individuals with a variety of social, financial, mental wellbeing, and practical issues that are affecting their life, and in turn, their health. This provides a holistic person-centred approach to supporting individuals. The service expanded during 2021/2022 with additional link workers recruited, including a Community Link Worker focused on supporting young people. The partnership is looking to further expand its Community Link Work Service during 2022/2023.

Creating new pathways to help people avoid delay in their discharge from hospital - Home First is a local initiative focussing on supporting people to avoid delay in their discharge from hospital. Home first works with the person and their carer/relative to agree how they can support their loved ones to get home or to an appropriate interim or onward destination, without any delays. Home First consists of social work professionals, including social workers, social care practitioners, and occupational therapists, who carry out assessments and work in collaboration with health professionals to determine people's needs to return home.

Using technology to enable people to access services remotely - Near Me is a rapidly expanding option for individuals to access services via video consultations. It is typically offered in addition to face to face, telephone and email. In this way it can enable our service users to receive advice from home or access their health or care services remotely. This is an area that rapidly expanded during the COVID-19 pandemic. NHS Forth Valley and Strathcarron Hospice currently offer Near Me for video appointments and we are currently working on a project to embed the platform into Social Work and Living Well Falkirk.

Giving choice when it matters at the end of life – the Strathcarron Hospice@Home service successfully

reduces the amount of time that a patient spends in hospital in the last two weeks of life. The service is funded by Strathcarron Hospice. An evaluation of the service compared Hospice@Home patients with patients who did not use the Service but had the same diagnosis and it concludes that each patient, on average, uses six fewer hospital (or Hospice) bed days.

Providing choice, control and flexibility over support - Self-Directed Support (SDS) ensures that individuals with eligible support needs and their carers can exercise choice and control over the support they receive. SDS is based on four options:

- option 1 - payments being made directly to the individual / carer;
- option 2 - the individual / carer chooses the support they need, but the local authority pays the provider;
- option 3 – the local authority arranges the support, and
- option 4 – a mixture of the other options.

We have been working with SDS Forth Valley through their Support in the Right Direction funding from Scottish Government (SiRD). This consists of a pilot project with the Central Locality Social Work Team to try to identify people early when an assessment or review is requested. The aim is to provide advice and information about what to expect at assessment, potential to access community or personal resources/networks and information about SDS Options, should there be eligible support needs identified through social work assessment. The learning from the pilot will be used to help streamline processes and support people that are waiting for assessment.

The Falkirk Collaborative Team - is working to develop person centred models of support for people with learning disabilities. The Collaborative includes partners from Healthcare Improvement Scotland, Falkirk HSCP, Falkirk Council, NHS Forth Valley, and Neighbourhood Networks. The project aims to work with service users, carers, staff, communities, and key stakeholders to improve outcomes and opportunities for adults with learning disabilities in the key areas of living, learning, wellbeing, and working.

Engagement undertaken by the Collaborative has found that people would like:

- Person-centred support
- Choice of meaningful and safe activities and venues, including outdoor access
- More opportunities for college and work
- Better transport provision
- Improved building-based support
- More community-based support options

- Opportunities to develop social connections
- More staff and support
- Improved access to respite

The Team are working collaboratively to establish what people want for their lives and to work with them and key stakeholders in taking stock of what we already have and create what we don't have.

Providing advice, aids and adaptations to enable people to maintain their independence - the Living Well Falkirk services provide citizens with information and support at an earlier stage than formal health or social care services are needed. The Living Well approach is supported by an online tool that promotes healthy, independent living by emphasising people's ability to stay active and participate in their community. It is designed for people who are having difficulties with everyday activities and it includes a self-assessment through which individuals can identify and access necessary aids / adaptations.

The Hospital at Home service is staffed by a multidisciplinary team made up of consultants, GPs, nurses, Allied Health Professionals (including a Dietician, Occupational Therapists, physiotherapists and a Speech and Language Therapist) and health care support workers who all specialise in the care of older people with acute medical problems in the community. Patients referred to the service are assessed in their own home and a care and treatment plan is developed by the Hospital at Home team with input from the individual and their family.

For many patients, the prospect of being admitted to a hospital can be upsetting as it can mean separating them from the people, pets and familiar surroundings that create a feeling of safety. Many older people admitted to hospital can also experience a loss of independence, lower self-esteem and reduced mobility. That is why admission to hospital should only happen when clinically necessary and, in many cases, the Hospital at Home service is able to provide the treatment and support required to allow people to be cared for in the comfort of their own home.

FOCUS ON PREVENTION, EARLY INTERVENTION AND MINIMISING HARM

Minimise the harm of long-term health conditions, ill-mental health, substance use, or neglect through early intervention and action. Focussing on prevention, early intervention and minimising harm will improve the wellbeing, quality of life, health and independence of individuals. In the long-term, we anticipate this approach will reduce or delay the need for care services and lower overall costs. Our approach to prevention, early intervention and minimising harm includes:

Addressing the wider determinants of health

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.

Health inequalities are often the product of wider social determinants of health, including income, deprivation, standard of housing and level of education.

Our three localities have very different needs in terms of health inequalities. Falkirk Central, for example, has a significantly larger proportion of its population living in the most deprived areas than the East or West localities. People experience comparatively worse outcomes in terms of key health indicators including life expectancy, early mortality, alcohol and drug related hospital admissions as a consequence.

Through our health promotion activities we will seek to improve health-related behaviours, including smoking, diet, substance use and physical activity. Another aim of our health promotion activities is to enable people to increase control over, and to improve, their own health.

Falkirk HSCP also works with partners from the public sector, third sector and our communities to help address the wider determinants of health.

Minimising harm for vulnerable people

People with care and support needs, such as older people or people with disabilities, are more likely to be abused or neglected. We have a duty under the Adult Support and Protection (Scotland) Act 2007 to work together with partners to support and protect adults

who are unable to safeguard themselves, their property and their rights.

Our aim is to prevent abuse or neglect, while ensuring that the individual's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

Gender Based Violence is a significant public health issue. Public Health Scotland note that 'The physical, emotional and psychological consequences of Gender Based Violence can be profound and damaging. They are predictors of poor health and strong risk factors for poor health outcomes'.

Reducing harm from substance use

Over recent years, rates for both alcohol and drug-related hospital admissions have been increasing in Falkirk. Our efforts to address the effects of substance use will be focussed on:

- early intervention aimed at those who are at risk of developing problem substance use
- prevention through addressing the cultural, social, physical and economic environments in which people make choices about drug and alcohol use; and
- harm reduction to reduce the negative consequences of substance use

Developing more person-centred models of care can also help to address health inequalities. Some people may face barriers to accessing care if their specific needs are not taken into account (e.g. barriers arising from language, cultural differences, physical access to facilities).

Improving mental health and wellbeing

Feedback received when preparing the Strategic Plan highlighted a need to address mental health and wellbeing. Evidence suggests that the pandemic has had an adverse impact upon mental health, as people experienced loneliness, bereavement, disruption and uncertainty.

Health and social inequalities are also a significant contributing factor to mental health. Deprivation is strongly linked with poorer mental health and wellbeing. People with mental health problems can face a 'spiral of adversity'[iii] where factors such as employment, income and relationships are affected by their condition.

Our approach reflects the Scottish Government's Mental Health Strategy 2017-27, which notes that

‘Prevention and early intervention are key to minimising the prevalence and incidence of poor mental health and the severity and lifetime impact of mental disorders and mental illnesses.’

Prevention involves[iv]:

- Stopping mental health problems before they start
- Supporting those at higher risk of experiencing mental health problems
- Helping people living with mental health problems to stay well

Providing access to information and resources that support self-management and development of early intervention

Self-management support is when health and care services work in ways that ensure that people with long-term conditions have the knowledge, skills, confidence and support they need to manage their condition(s) effectively in the context of their everyday life[v].

Helping people to better manage of their own health has the potential to prevent ill health, reduce demand for services and improve access to support at the point of need.

The work of Allied Health Professionals (AHPs) (e.g. physiotherapists, occupational therapists, dietitians, podiatrists) is critical in supporting people to manage their wellbeing, live active and independent lives, become or remain economically active and participate in their local communities.

Technology can also assist by providing people with the information they need to take better care of their own health.

HOW WILL WE GET THERE?

We will:

- Work with Community Planning Partners to address the determinants of health and social inequalities
- Minimise harm for vulnerable people
- Improve mental health and wellbeing by:
    - Improving access to mental health treatment, and joined up accessible services
    - Improving the physical wellbeing of people with mental health problems
    - Developing a rights-based approach to mental health
    - Ensuring that fewer people struggle with feeling socially isolated or lonely
    - Working in partnership to reduce the number of deaths from suicide
- Provide access to information and resources that support self-management and development of early intervention
- Reduce harm from substance use by:
    - Focussing on education, prevention and early intervention aimed at those who are at risk of developing problem substance use
    - Taking a recovery orientated approach which reduces harm and prevents alcohol and drugs deaths
    - Supporting children, families and communities affected by substance use
    - Working to reduce the stigma related to substance use

WHAT WE ARE ALREADY DOING:

Helping communities to address the wider determinants of health - the Health Inequalities and Wellbeing Fund aims to develop community based services and projects that minimise health and social inequalities and improve people's health and wellbeing. Proposals for funding can be accepted from community and third sector groups and statutory organisations. The funding programme has been developed by representatives from the HSCP, Falkirk Council, CVS Falkirk & District, and Forth Environment Link. The programme has a total investment value to £780k until 31 March 2024.

Addressing harm from alcohol and drugs - the Falkirk Alcohol and Drug Partnership (ADP) and the Falkirk HSCP work jointly to deliver outcomes for local communities and to relieve the burden of alcohol and drug-related harm across the Partnership. This is done through better alignment of area-wide drug and alcohol and HSCP Mental health services. The ADP commissions a number of services to help address the harm from substance use.

Forth Valley Recovery Community (FVRC) is a volunteer-led community of people committed to making recovery happen in Forth Valley. FVRC put on alcohol free local events that provide opportunities to meet like-minded people, promoting health & wellbeing and recovery support. Services provided by FVRC include Recovery Cafes, Street Soccer Coaching Sessions and the Recovery Ramblers Walking Group.

The Forth Valley Family Support Service offer support to anyone in Forth Valley over the age of 16 who is affected by someone else's drug or alcohol use. This could be a direct family member, or even a friend or a colleague who is using substances. The Service offers a range of support, including one-to-one support, group support, bereavement counselling and access to Naloxone.

In August 2021, the Strategic Prevention Coordinator for Suicide and Drug Deaths came into post. This post has a direct remit for suicide and drug death prevention and is aligned to Public Health. At the same time, the Alcohol and Drug Partnerships were also awarded funding to support the recruitment of the Substance Use Death Reviewer post. This post brings additional capacity to support the multi-agency review of drug deaths. Both posts have a Forth Valley remit. FDAMH are funded by the Choose Life Fund to develop local suicide prevention work.

Falkirk Gender Based Violence Partnership – Falkirk Gender Based Violence Partnership (FGBVP) was reformed in 2020. The primary focus of the partnership has initially been to develop a local strategy.

FGBVP recognises the importance of a multi-agency approach towards tackling Gender Based Violence. The FGBVP brings together a range of statutory and voluntary agencies with the aim of improving agency responses to women, children and young people who have experienced male violence. The FGBVP believes that working together will result in better service provision, improved legal protection and help prevent further abuse to women, children and young people. The Gender Based Violence Partnership reports through the Public Protection Chief Officer Group who then report to the Community Planning Partnership board. These aims support the implementation and outcomes of the Scottish Government's Equally Safe Strategy.

Collaboration with the Community Planning Partnership - The HSCP have collaborated in the development of the Falkirk Plan 2021-2030. The Plan has been developed by community planning partners, based on research together with what communities have told us are the issues that are most important to them. Based on that, the Plan identifies six priority areas – or Themes:

- Working in Partnership with Communities
- Poverty
- Mental Health and Wellbeing
- Substance Use
- Gender Based Violence
- Economic Recovery

The HSCP is represented on each Theme's working group and chairs the Mental Health & Wellbeing and Substance Use Themes.

Partners are considering the impact of the cost of living crisis in the context of each theme and bringing relevant expertise and resource to mitigate the effect on communities. For example, the HSCP recently commissioned Energy Action Scotland to deliver energy awareness training to 90 members of staff and volunteers from across the Falkirk area. The purpose of the training was twofold; to equip frontline staff and volunteers with foundation knowledge to be able to provide basic advice to the people that they support and to benefit them personally.

ENSURE CARERS ARE SUPPORTED IN THEIR CARING ROLE

Assist, inform, and empower unpaid carers to manage their caring role and have a fulfilled life outside of caring.

Unpaid Carers are the largest group of care providers in Scotland, providing more care than the NHS and Councils combined. Without support, many unpaid carers would not be able to continue providing care, which would then place extra demand upon public services.

The Carers (Scotland) Act 2016 came into effect on 1 April 2018. The Act extends and enhances the rights of carers. The 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.

Within Falkirk, 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.

Unpaid carers have experienced significant difficulties through the Covid-19 pandemic, and this has impacted each carer personally in very different ways. As restrictions have eased, carers have been left with new challenges to both their own physical and mental health and of those they care for. They also now face new financial pressures impacting on their own finances and the availability of support services, which may have been reduced or overwhelmed in terms of capacity.

HOW WILL WE GET THERE?

The commitments below broadly define Health and Social Care responsibilities to all carers within Falkirk, including both young and adult carers. Our responsibilities towards all groups of carers are presented in greater depth and clarity within our Falkirk Carers Strategy:

- Identify unpaid carers, including those that are harder to reach
- Support, inform, and empower unpaid carers as they manage their caring role
- Enable unpaid carers to have a life outside of caring
- Fully engage unpaid carers in the planning and shaping of services
- Raise awareness, including within communities, of unpaid care and the demands and pressures of caring roles, reducing disadvantage and discrimination
- Recognise and value unpaid carers as individuals with their own unique circumstances, and as equal partners in care.

WHAT WE ARE ALREADY DOING:

Adapting to changing circumstances - despite the challenging circumstances presented to us during the pandemic, the Carers Centre has continued to provide a full range of services and support to carers of all ages, including one to one support, group support activities, carer training, and involvement opportunities. In addition, in response to feedback from local carers about the need for better communication, up to date information, and ongoing emotional support, funding from the Falkirk Partnership was secured to employ a Digital Development Worker and two Telephone Support Workers. This has allowed the centre to extend service provision and reach.

Developing flexible respite options - overnight respite budgets were used flexibly during the pandemic, and this continues, increasing options for respite breaks. Flexible respite includes using hours of support at home where breaks out-with the home have not been an option. Carers have been able to use up to £1000 per year from the respite budget to purchase items or activities that support their health and wellbeing. This is referred to as 'flexible respite funding' and was sometimes the main support to carers during the pandemic. The feedback received indicates that this has had a positive impact and flexible respite is therefore continuing as part of carer support.

Short Breaks- Since the beginning of the Covid-19 pandemic, the short breaks bureau team and the Self-Directed support team have been working in close partnership with the Falkirk and Clackmannanshire Carers centre to offer coordinated support for carers. In 2021-2022, 142 people were supported to take 282 breaks.

Helping carers to influence local services - Falkirk Health and Social Care Partnership was one of five local authority areas to take part in a Carer Representative Training Programme pilot, with training originally intended to start in 2020 but due to Covid-19 was moved to online in March 2021. The training has helped prepare carer representatives and increased their confidence and ability to engage and contribute meaningfully at meetings and to influence local development. The training has now been extended to include both carers and service users. The goal is to increase the representation of people with lived experience and encourage them to get involved in a range of strategic and operational-level service redesign meetings

SUPPORTING WORKSTREAM: WORKFORCE

Recruitment, retention, and celebration of staff across all services.

The Partnership brings together staff from across the NHS, Council, community health and social care services, and commissioned services from the third and independent sectors. Our workforce is our most valuable asset. Without our people we cannot achieve the ambitions within our strategic plan and providing invaluable care and support to those who require it would not be possible.

Covid-19 has, however, had a significant impact on our communities and workforce, leaving a legacy on services that is still being felt. Supporting our workforce by allocating our valuable and limited resources where they can add most value and through recognising colleagues for the exceptional difference they make every day is now a priority.

The Workforce Plan recognises that there are real recruitment problems and skill shortages in specific posts / professions across the partnership. Alongside the difficulties in recruiting and filling vacancies, the ageing demographics of our workforce will further impact on posts.

Challenges also exist with different pay scales and terms and conditions across the partnership and with independent care providers, which impacts on recruitment and retention. There are examples where roles can be filled by either NHS or Council employees, however the pay, conditions, and grading structure may be significantly different depending on which organisation employs the post holder.

Our Workforce Plan 2022-25 includes an action plan based on the following areas:

- To identify workforce needs, actions, and opportunities for collaborative working between colleagues and staff groups within the partnership
- Position the partnership as an employer of choice to attract talent
- Ensure the business strategy is underpinned by quality learning and development interventions at all levels
- Recruit and retain talent within the partnership, presenting health and social care as a valued and rewarding career choice
- Build and sustain a level of engagement with our workforce, by making employees feel valued,

motivated and committed to organisational goals, to look after the physical and mental wellbeing needs of the workforce

WHAT WE ARE ALREADY DOING:

Our workforce response to the Covid-19 pandemic - In March 2020, workplaces and communities faced disruption and challenges as a result of the global outbreak of coronavirus. There was an immediate need to change processes, introduce new Risk Assessments, and for more staff. These challenges have continued throughout the pandemic. The Partnership responded to the pandemic through creative and flexible approaches, including:

- Clear examples of joint working and how these can benefit the partnership and the wider community
- Flexibility demonstrated with many staff supporting different roles
- Sharing of knowledge and resources
- An increased focus on health and wellbeing of staff
- Joint working with Trade Unions to deal with unprecedented situations at pace
- Support provided to deliver new services within the partnership and across our community including vaccination centres, testing centres, self-isolation support, grant support
- Recruitment exercises to support our local needs including internal volunteer programmes.
- Excellent partnership working with third and independent sectors

Addressing recruitment and retention challenges - a Recruitment and Retention Working Group was established in May 2021 made up of representatives from the HSCP and Council Social Work Services. This cross-service group was tasked with finding solutions to significant recruitment challenges and to create initiatives providing incentives and opportunities in support of staff retention and career development. A cross-service staff reference group was also created to consult with and gather thoughts and ideas from operational managers and frontline staff

Social Work student placements continue to be offered, giving the opportunity to recruit those who are in their final year.

In the summer of 2021/22, Falkirk provided 15 student placements to Stirling University, Robert Gordon University, and the Open University. We work in partnership with Forth Valley College and attend recruitment fairs and bespoke events to secure student interest in a career in health and social care.

In 2021, we increased the number of placements offered to HNC Health and Social Care students trialling student placements across a wider range of services across the HSCP – including homecare reablement, telecare and mobile emergency service, dementia services, social work locality teams, and sensory services..,

SUPPORTING WORKSTREAM: TECHNOLOGY

Scotland's Digital health and care strategy sets out a vision to improve the care and wellbeing of people in Scotland by making best use of digital technologies in the design and delivery of services. The application of technology and digital approaches, as an integral part of quality, cost-effective care and support, can improve outcomes for individuals in home or community settings. Technology will play an instrumental role in achieving our priorities.

Digital technology presents transformative opportunities to widen access to services, encouraging access and intervention at the right time, in the right place. By capturing the right data we can better understand the needs of those who use our services, enhance collaborative care approaches and be better prepared for the challenges that lie ahead. As technology continues to develop, we will embrace innovation to ensure we continue to offer modern and efficient services.

People should have the opportunity to support their health and wellbeing by accessing the right technology, understanding its benefits and limitations, developing the necessary skills and being involved in the design and delivery of their digital services. We will engage with people, carers, communities and the workforce to promote digital skill development and to tackle digital exclusion.

Our person-centred approach promotes choice. As such, digital options should be offered to those who want them, but for those who don't, non-digital choices should be equally available.

Individuals should be better informed about how their personal information is used. With a better understanding of their own health and care information, individuals can be empowered to contribute to, or self-manage their care. In this way services can be delivered in a way that encourages personal decision making.

Digital technology supports our efforts to address climate change by reducing travel to appointments and reducing the use of paper.

WHAT WE ARE ALREADY DOING:

Supporting people to access digital services - Digital Inclusion Schemes: The Partnership participated in Digital Inclusion Schemes such as the Fairer Falkirk Digital Inclusion Fund and Connecting Scotland, where a small number of devices were acquired for individuals who were isolated or digitally excluded. A series of digital inclusion events called “Tech Tea Parties” are planned for 2022/2023. They will help individuals learn some basics about technology with support from AbilityNet, a volunteer group. Support for older people to learn how to use digital services also available in the community from the Scottish Seniors Computer Club.

Developing digitally enabled services - A bespoke app was developed allowing for communication between Community Link Workers and service users. This allows Link Workers to record necessary personal data and patient consent securely and efficiently for onward referral, securely and efficiently.

Using technology to support people to live independently at home - Technology Enabled Care and Telehealth approaches are currently used across health and social care services. These include the use of mobile devices to enable people to engage with health and care services from home, access clinical support remotely and make use of a range of specialist devices and equipment such as GPS trackers, movement sensors and alarms. Our MECS Service continues to provide telecare to support individuals to live independently at home knowing that a response service is on call to assist should they raise an alarm. This gives individuals independence and their families peace of mind.

Promoting preventative digital approaches - The Living Well Falkirk digital services were implemented by the Falkirk Health and Social Care Partnership and use technology to provide individuals in Falkirk with information and support at an earlier stage than through a formal Health or Care referral.

The online platform uses self-assessment to establish individual needs and offers appropriate advice, access to equipment and support to encourage individuals to build reserves, reactivate lost abilities, compensate with equipment were necessary and in this way avoid or reduce the need for care. By addressing this group’s needs in this way, it has the potential to decrease in referrals to community care teams and reduce waiting lists, while at the same time helping people to remain independent.

Widening access to services - The Near Me video platform enables services to offer video appointments to widen access to services in addition to face to face, telephone or email. Through this online platform individuals can access health or care services remotely. NHS Forth Valley and Strathcarron Hospice currently offer Near Me video appointments and the platform is being trialled in Social Work services and for Living Well Falkirk remote consultations. The platform enables individuals to attend appointments from the location of their choice, save travel, and provides a way of including carer support, interpreters or family members to join an appointment where appropriate.

SUPPORTING WORKSTREAM: COMMUNICATION & ENGAGEMENT

Clear, accessible, and inclusive communication is required to ensure everyone knows what services and support options are available to them, how to access support, and to help people engage with services.

In addition, the process of change is at the heart of improving outcomes and services for local people. To carry this out successfully, effective communication, engagement, and involvement of people who live and work in Falkirk will be key.

The Partnership's Communication Strategy (2021 - 2024) outlines how effective, flexible, and accessible communication can support the Integration Joint Board and local services to plan, deliver, and achieve their goals. The strategy sits alongside the Participation and Engagement Strategy (2021 – 2024), with stakeholder engagement and participation featuring as a key outcome throughout our communication methods.

As well as establishing inclusive communication standards, our Strategy identified three communication priorities, which apply to both internal and external communication activity:

- Be a champion for Falkirk's health and social care sector
- Build understanding of the Partnership's services and how to access them.
- Ensure effective communications across the integrated workforce.

Inclusive communication is good for everyone. By making everything easy to access and simple to understand, our message will go further. In turn, staff and partners working across our services should be able to navigate and link together support options, with confidence that the person using the service will have their needs met.

In our communities, people will be empowered to self-manage their own health and wellbeing, and will understand the ways of accessing support and the range of support available to them – across all of Falkirk's local services.

Feedback from internal and external audiences, whether it be the Partnership's patient panel, formal consultation methods, discussion at Board meetings, or exploring new tools is key to ensuring our approach meets the needs of local people.

WHAT WE ARE ALREADY DOING:

Developing new channels of communication - since the last strategic plan, the Partnership developed its first ever Communication Strategy, and has launched new channels of communication including social media, e-newsletters, regular blog posts, and increased use of proactive media relations.

Improving how we communicate our projects and workplans - communication strategies and workplans are embedded within key transformation projects, such as the Forth Valley Whole System Plan, Falkirk Community Hospital master planning, Falkirk Alcohol and Drug Partnership, Primary Care, and Intermediate Care projects.

Involving people in the planning of services - the Partnership also has a legal responsibility to involve people in the planning of support options and services, which involves consultation, engagement, and the promotion of opportunities to feedback and input into decisions.

Providing more opportunities for people with lived experience to be involved in service design and decision making processes – Falkirk HSCP have a Participation & Engagement Strategy that sets out the importance of people with lived experience being involved in HSCP planning, monitoring and decision making processes. We are required, by legislation to involve service users and carers in the Integration Joint Board and Strategic Planning Group, however we are keen to make involvement much wider.

During April and May 2022, the HSCP worked with Falkirk & Clackmannanshire Carers Centre, Carers Scotland, the Independent Living Association and Inclusion Scotland to design and deliver free training to people interested in being involved in either operational or strategic groups across the HSCP. The interactive training provided an overview of the HSCP and information about the importance and value of people being involved. Participants were also provided the opportunity to discuss and develop skills and tools to be confident in their involvement. Feedback included:

> *"Really interesting course."*
>
> *"I hadn't seen myself as a carer but now see myself as an advocate to other carers."*
>
> *"I learned a lot – found the negotiation part really interesting."*
>
> *"Gave me confidence to speak out."*

Training about how to include people effectively has also been developed for staff across the HSCP. We intend to continue the rollout of both courses. Partners are committed to supporting this development.

GOVERNANCE AND BEST VALUE

The IJB, as a public body, has a duty to make arrangements to secure Best Value. As defined by Audit Scotland, Best Value is concerned with "good governance and effective management of resources with a focus on improvement to deliver the best possible outcomes for the public".

With this in mind, the IJB's governance framework is intended to support continuous improvement and better outcomes, whilst striking an appropriate balance between quality and cost.

The main features of the governance framework are:

- Strategic decision making is governed by the IJB's key constitutional documents including the Integration Scheme, Standing Orders, Scheme of Delegation, Financial Regulations and Reserves Policy.
- A Code of Conduct for all IJB Board members, including a Register of Interests.
- The IJB's vision, outcomes and priorities are set out in the Strategic Plan, which contributes to the strategic priorities and outcomes contained in the Community Planning Partnership's Local Outcomes Improvement Plan (LOIP) and the national health and wellbeing outcomes framework.
- An Audit Committee with a remit which includes risk management, corporate governance and all matters relating to internal and external audit. Terms of reference are regularly reviewed and an annual workplan agreed.
- The Clinical and Care Governance Committee provide assurance to the IJB on the systems in place for delivery of safe, effective, person-centred care in line with the IJB's statutory duty for the quality of health and care services. An annual work plan is in place to ensure all key pieces of work are covered. The Terms of Reference are also reviewed annually.
- The Audit Committee, Clinical and Care Governance Committee and Joint Staff Forum provide regular assurance to the IJB by providing approved minutes of their meetings and provide Annual Assurance Statements to the Board, detailing the membership, attendance, business and frequency of meetings.
- There are regular Board Development Sessions which are opportunities to brief Members in detail on important items of business in advance of Board meetings. This supports the improvement of Members' scrutiny of Board business.

The IJB must also make arrangements to secure continuous improvement in performance. The Partnership uses a Forth Valley-wide Performance Management Framework to monitor its progress. Regular performance updates are provided throughout the year to the Integration Joint Board. The Partnership also publishes an Annual Performance Report as required by the Public Bodies (Joint Working) Regulations 2014.

RISK MANAGEMENT

The Risk Management Strategy sets out the principles and approaches to risk management which are to be followed by the Integration Joint Board and staff within the Health and Social Care Partnership.

Its objective is to achieve a consistent and effective application of risk management and enable it to be embedded into all core processes, forming part of day-to-day management activity and supporting the delivery of Strategic and Commissioning plans.

Strategic risks represent the potential for the IJB to achieve or fail to meet its desired outcomes and objectives as set out within their Strategic Plans.

Many of the strategic risks are recognised in the Strategic Plan, including:

- Demographic pressures
- Capacity and infrastructure
- Partnerships with communities, the third sector, independent sector, housing sector and others
- Workforce pressures
- Whole systems transformation

The Strategic Risk Register is reported to the Audit Committee on a regular basis. The Committee review whether internal controls are in place to identify, respond to and manage our strategic risks.

FINANCE AND RESOURCES

The Integration Joint Board is primarily funded for services through contributions from the statutory funding partners, Falkirk Council and NHS Forth Valley. The delegated resources are used by the Board to direct the two partner organisations to deliver health and social care services set out in the Integration Scheme. The Integration Joint Board has a duty to set a balanced annual budget aligned to the Strategic Plan.

PARTNERSHIP BUDGET

The HSCP budget for 2022/23 totalled £255.922m. Falkirk Council provided £85m of the total and NHS Forth Valley provided £170.9m. Figure 6 provides a breakdown the budget by service area.

MEDIUM TERM FINANCIAL PLAN

The Medium Term Financial Plan outlines 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 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. The Partnership Funding Investment Plan 2021-2024 provides an overview of the range of funds available for discharge by the IJB. A progress update is available from the IJB meeting papers, 2nd September 2022 .

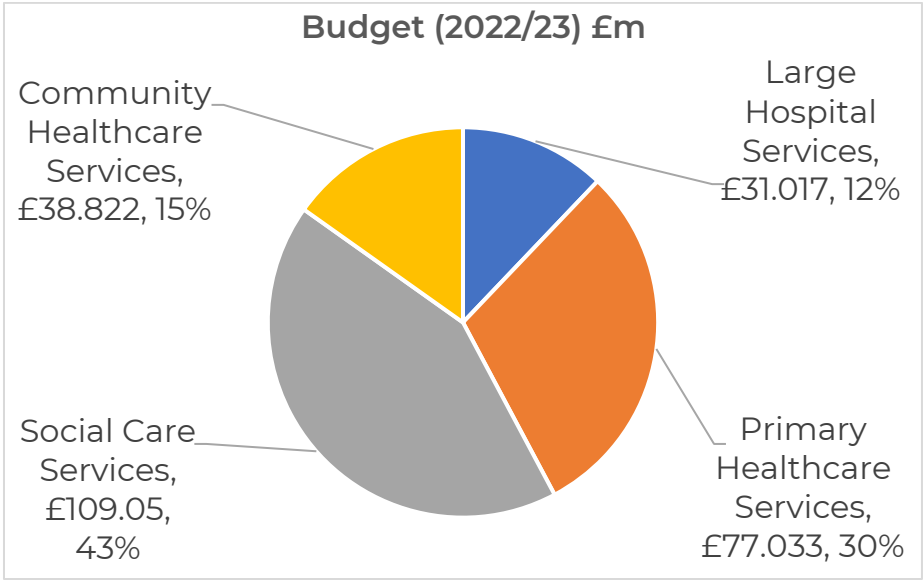


Figure 6: Budget by service area, 2022/23

MARKET FACILITATION

Market facilitation is defined as 'the process by which strategic commissioners ensure there is diverse, appropriate and affordable provision available to meet needs and deliver effective outcomes both now and in the future.'

Market facilitation will help us and our partners take a strategic approach to understanding and meeting local need for adult social care and support.

It also recognises the role that social care and support partners have in actively contributing towards economic growth in the Falkirk area, whilst creating employment opportunities for Falkirk residents. This is also in line with the Fairer Scotland Duty.

Our Market Facilitation Plan will be reviewed to take account of the ambitions outlined in the Strategic Plan.

We need to make sure people who use services can choose from a variety of care and support providers and have a variety of creative support options available to them. We will achieve this by:

- actively sharing with current and potential providers the intelligence we have on population trends, the current demand for and costs of care, and what future demand and the social care and support economy might look like;
- making our ideas known about how we believe the market needs to change over time, in response to changing service user expectations and economic, demographic and legislative conditions;
- being clear with providers about how we will intervene in the market, through the investment we make and the encouragement we give, to achieve a balance in supply and demand;
- explaining why, if it arises, there is a need to reduce budgets in some areas and increase spending in others, giving organisations who wish to grow and adapt to new circumstances time to do so
- engaging with providers and discussing their long-term business plans and, where appropriate, consider whether support to strategic business planning is needed

MEASURING PROGRESS

Falkirk Health & Social Care Partnership is currently refreshing its existing Performance Management Framework.

The focus for the Performance Management Framework is the delivery of the priorities set out in the Strategic Plan, national outcomes, statutory requirements, and operational efficiency. This forms the basis of performance reporting to the Integration Joint Board and the Annual Performance Report.

The Scottish Government has developed National Health and Wellbeing Outcomes supported by a Core Indicator Set to provide a framework for Partnerships to develop their performance management arrangements.

As part of the Annual Performance Report the Partnership reports progress against the Core Indicator Set. This supports us in understanding how well our services are meeting the needs of people who use our services and communities.

The Partnership's Integration Joint Board receives regular Performance Reports. These reports ensure the Board fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services. They also provide information on performance against targets and measures set out in the Strategic Plan.

Performance indicators will be reviewed, further developed and mapped against the National Health and Well Being outcomes as well as Strategic Plan outcomes and priorities via a strategy map to ensure there is a direct link.

CORE SUITE OF INTEGRATION INDICATORS

NI 1	Percentage of adults able to look after their health very well or quite well
NI 2	Percentage of adults supported at home who agree that they are supported to live as independently as possible
NI 3	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided
NI 4	Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated
NI 5	Percentage of adults receiving any care or support who rate it as excellent or good
NI 6	Percentage of people with positive experience of care at their GP practice
NI 7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
NI 8	Percentage of carers who feel supported to continue in their caring role
NI 9	Percentage of adults supported at home who agree they felt safe
NI 10	Percentage of staff who say they would recommend their workplace as a good place to work
NI 11	Premature mortality rate per 100,000 persons
NI 12	Emergency admission rate (per 100,000 population)
NI 13	Emergency bed day rate (per 100,000 population)
NI 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)
NI 15	Proportion of last 6 months of life spent at home or in a community setting
NI 16	Falls rate per 1,000 population aged 65+
NI 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections
NI 18	Percentage of adults with intensive care needs receiving care at home
NI 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)
NI 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency
NI 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home
NI 22	Percentage of people who are discharged from hospital within 72 hours of being ready
NI 23	Expenditure on end of life care, cost in last 6 months per death

APPENDIX 1: HIGH LEVEL ACTION PLAN

PRIORITY: SUPPORT AND STRENGTHEN COMMUNITY-BASED SERVICES

Outputs	Action(s)	Year (1/2/3)
Develop integrated multi-disciplinary teams in communities so people can access a wider range of professionals and services in local GP Practices and localities, closer to their home, e.g. community nursing staff, link workers, allied health professionals, health improvement staff, mental health practitioners, social workers and pharmacy services. Create sustainable services for community-based urgent unscheduled care, aligned with wider community services and teams around General Practice and comprising advanced practitioners and care staff to respond rapidly to changing needs, offering people alternatives to acute hospital admission Continue working with the Scottish Government and local partners to implement the 2018 GP Contract that will enable GPs to provide a key role within the extended community based multi-disciplinary team	1.1. Further develop integrated multi-disciplinary locality teams 1.2. Develop Locality Plans to show how the Strategic Plan priorities will be delivered at local level, reflecting local priorities, needs and community issues 1.3. Integrate Primary Care into the Health & Social Care Partnership to support the development of community-based planning 1.4. Expand the provision of community based mental health and wellbeing support available via GP practices as part of the Mental Health and Wellbeing in Primary Care Services programme	2 1 1 3
Provide a range of short-term, targeted and specialist care and support services, offering alternatives to hospital admission and supporting timely hospital discharge to support people to live healthy, independent life at home or in a homely setting	1.5. Develop the new Care at Home Contract modernising the way that care at home is commissioned and delivered, moving away from a task and time-based model, to one that empowers recipients of care, enabling greater levels of person centred care 1.6. Implement the Home Care Review, re-shaping the service around dedicated reablement teams, urgent response provision and maintenance care provision	2 1

	1.7. As part of a new Forth Valley-wide Whole System Plan, develop the Falkirk Community Hospital Masterplan, which will contribute to the delivery of intermediate, community bed-based care. This work will also progress partnerships within the third sector to support and care for people within their communities. 1.8. Implement the new model of person-centred, community-led day care services that encourage social inclusion, independence and equity of access. This model will have three main elements: Inclusion and Independence Programme, Reablement Day Services and Maintenance Day Services 1.9. Work with partners and providers to develop new models of step-up / step-down intermediate care	3 2 1
People have the opportunity and choice to access local services and supports, which will enable them to live well in the community. This will include a range of options, from informal community supports through to statutory services, designed and delivered through collaboration between health and social care professionals, third sector partners and communities. These services and supports will be person-centred, helping people to improve and maintain their health, wellbeing and quality of life.	1.10. Implement Community Led Support strategy to design and deliver services in conjunction with people and communities 1.11. Develop our approach to collaborative commissioning to encourage the development of mutually-supportive provider networks 1.12. Work with partners to encourage, support and empower people to manage their own health and wellbeing	2 2 Ongoing

PRIORITY:

ENSURE PEOPLE CAN ACCESS THE RIGHT CARE, AT THE RIGHT TIME, FROM THE RIGHT PERSON

Outputs	**Action(s)**	**Year (1/2/3)**
Engage people in conversations about their goals, assets, safety, strengths and needs, with care and support centred around people's own health and wellbeing priorities and with a strong focus on early intervention and prevention	2.1. Engage people in conversations about their goals, assets, safety, strengths and needs, with care and support centred around people's own health and wellbeing priorities and with a strong focus on early intervention and prevention 2.2. Further develop the "Livingwell hub" concept to help integrate services with community support and provide opportunities for person led conversations 2.3. Work towards establishing the Getting it Right for Everyone model to provide greater consistency and continuity of care	Ongoing 1 3
Develop skills and practice to ensure the adoption of a human rights based approach to assessment, treatment, care and support	2.4. Engage people in the design of services (including commissioned services), especially those with lived experience 2.5. Develop an approach to commissioning based on quality and purpose of care – focused upon supporting people to achieve their outcomes 2.6. Continue to train employees with digital skills to support person centred care, including in the use of the new social work information management system	Ongoing 1 Ongoing
Provide people with access to clear and simple information, advice and support reflecting specific communication needs and preferences, including any issues with literacy, health literacy or language, so they can care for themselves and their families at home and know how to	2.7. Promote Self Directed Support options and apply the Scottish SDS Improvement Plan 2023 2.8. Utilise national communication toolkits and tailor local information which explains the role of each service – including GP, pharmacy, A&E, optometry etc.	2 Ongoing

access help, support and services when they need to	2.9. Help service users and families to better understand their rights to social care and support, being open and transparent about the level of support that can be provided	Ongoing
Provide people who require assessment, treatment, care and support (and those involved in their care) with access to local services free from barriers, behaviours and discrimination that may impact negatively on them, ensuring a positive contribution to their safety, tackling inequalities and promoting equality of opportunity and outcome	2.10. Achieve Communication Access UK Accreditation. This scheme, backed by the Royal College of Speech and Language Therapists, ingrains inclusive communication practices across services. (Also see actions 2.4, 2.5 and 2.6)	2
Establish clear pathways between primary care and locality teams, intermediate care, specialist services and acute care so that people benefit from access to the right care, from the right person at the right time as their needs change	2.11. Develop Intermediate Care Pathways, providing short-term support to help people recover and increase their independence, both in residential units and at home 2.12. Implement the Discharge without Delay programme in collaboration with acute NHS Forth Valley services and Clacks & Stirling HSCP 2.13. Develop the Discharge to Assess model, enabling people that do not require a hospital bed to be discharged with short-term support in their own home prior to assessment for their longer-term care needs 2.14. Further develop our approach to Single Shared Assessment to improve the experience of people transitioning between services	2 1 1 1
Focus on supporting people in their home environment with a home first approach adopted at all times, supported by seamless transitions through rehabilitation and reablement to long-term support and care, as well as high quality palliative and end of life care	2.15. Implement the Joint Loan Equipment Service review to establish a fully integrated equipment ordering system and improve turnaround times 2.16. Design / deliver training for the home care workforce to ensure they have the appropriate skills to deliver a true reablement model rather than a model with a reablement ethos 2.17. Support the implementation of the Scottish Government Palliative and end of life care: strategic framework for action	2 1 2

	2.18. Ensure that local housing is fit for purpose and that aids and adaptations are available when people need them (Also see actions 1.5, 1.6 and 1.8)	Ongoing

PRIORITY:

FOCUS ON EARLY INTERVENTION, PREVENTION AND HARM REDUCTION

Outputs	Action(s)	Year (1/2/3)
Address the wider determinants of health by working in partnership to promote healthy behaviours, reduce the impact of poverty and to ensure that people can access appropriate housing.	3.1. Integrate Health Improvement into the Health & Social Care Partnership 3.2. Work with the Housing Service to identify and address housing need 3.3. Work with Community Planning Partners to support the delivery of the outcomes within Theme 2 of the Falkirk Plan regarding Poverty and Theme 6 Economic Recovery 3.4. Work with Children's Services to embed the principles of whole family support into practice	1 Ongoing Ongoing 2
Minimise harm for vulnerable people	3.5. Work with partners to develop and implement an Adult Support and Protection improvement plan 3.6. Monitor training data to ensure completion of priority mandatory, Health and safety and public protection training 3.7. Work with Community Planning Partners to implement Theme 5 of the Falkirk Plan regarding Gender Based Violence, including the Gender Based Violence Strategy and Delivery Plan	1 1 Ongoing
Reduce harm from substance use by: • Focussing on education, prevention and early intervention aimed at those who are at risk of developing problem substance use • Taking a recovery orientated approach which reduces harm and prevents alcohol and drugs deaths	3.8. Deliver the Medication Assisted Treatment standards to help reduce deaths, and other harm, and to promote recovery 3.9. Develop a Falkirk Drug & Alcohol Partnership Strategy and Delivery Plan 3.10. Implement the National Mission on Drug Deaths: Plan 2022-2026 3.11. Work with Community Planning Partners to support the delivery of the outcomes within Theme 4 Falkirk Plan regarding Substance Use	1 2 3 Ongoing

• Supporting children, families and communities affected by substance use • Working to reduce the stigma related to substance use		
Improve mental health and wellbeing by: • Improving access to mental health treatment, and joined up accessible services • Improving the physical wellbeing of people with mental health problems • Developing a rights-based approach to mental health • Ensuring that fewer people struggle with feeling socially isolated or lonely • Working in partnership to reduce the number of deaths from suicide	3.12. Integrate Mental Health into the Health & Social Care Partnership 3.13. Develop local Dementia Strategy and align service provision 3.14. Implement the Dementia Strategy for Scotland 2023 3.15. Implement Mental Health and Wellbeing Strategy for Scotland 2023 3.16. Implement 'Creating Hope Together: Scotland's Suicide Prevention Action Plan 2022-2025' 3.17. Work with Community Planning Partners to support the delivery of the outcomes within Theme 3 Falkirk Plan regarding Mental Health and Wellbeing (Also see action 1.4)	1 2 2 2 1 3
• Provide access to information and resources that support self-management and development of early intervention	3.18. Develop accessible Digital Self-Management to help people with chronic conditions care for themselves and access support when required 3.19. Review Allied Health Professional services to ensure that there is an appropriate balance between universal, targeted and individual support (See actions 1.8, 1.12 and 2.2)	2 3

PRIORITY: ENSURE CARERS ARE SUPPORTED IN THEIR CARING ROLE

Outputs	Action(s)	Year (1/2/3)
Identify unpaid carers, including those that are harder to reach Support, inform, and empower unpaid carers as they manage their caring role Enable unpaid carers to have a life outside of caring Fully engage unpaid carers in the planning and shaping of services Raise community awareness of unpaid care and the demands and pressures of care roles, reducing disadvantage and discrimination Recognise and value unpaid carers as individuals with their own unique circumstances, and as equal partners in care	4.1 Implement the action plan from the Carers Strategy 2023-26.	3

SUPPORTING WORKSTREAM AND ACTIONS

Priority	Action(s)	Year (1/2/3)
Workforce	5.1. Implement the action plan of the HSCP Workforce Plan 2022-25, which is based on the following five pillars: Plan, Attract, Train, Employ, Nurture	2
Technology	5.2. Conduct a needs assessment to identify technology requirements for community-based services.	1
	5.3. Develop a Digital Health and Care Strategy to explain how we will develop digital services, make better use of technology to support independence, improve digital access, improve digital skills, co-design technology solutions with stakeholders, improve data sharing and make effective use of data	2
	5.4. Form a Digital Health and Care Programme to develop a roadmap of activities to deliver the Digital Health and Care Strategy.	2
	5.5. Progress digital health and care literacy initiatives to ensure that individuals are equipped with the skills and knowledge necessary to fully utilise these technologies.	2
Communication & Engagement	5.6. Implement the HSCP Communications Strategy 2021 – 2024 to improve perceptions of health and social care, create a better understanding the role of the Partnership and its services and improve internal communications	1
	5.7. Implement the HSCP Participation & Engagement Strategy 2021 – 2024 to put people at the centre of decisions about their care and support	1

APPENDIX 2: COMPARISON OF THE STRATEGIC PLAN PRIORITIES AND NATIONAL HEALTH AND WELLBEING OUTCOMES

NATIONAL HEALTH & WELLBEING OUTCOMES	***OUR STRATEGIC PRIORITIES***			
	Support and strengthen community-based services	Ensure people can access the right care, at the right time, in the right place	Focus on prevention, early intervention and minimising harm	Ensure carers are supported in their caring role
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	X	X	X	X
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.	X	X		X
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.		X		X
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	X	X	X	X
5. Health and social care services contribute to reducing health inequalities.	X	X	X	X
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.	X	X		X
7. People who use health and social care services are safe from harm.	X	X	X	X
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	X	X	X	X

*Our supporting workstreams of Workforce, Technology and Communication & Engagement support this National Outcome and each of the Strategic Priorities

GLOSSARY

A glossary of common terms and acronyms used within health and social care can be found at FalkirkHSCP.org/glossary

RELATED DOCUMENTS

This Strategic Plan is supported by and interlinked with a range of related strategies and policies, including:

- Annual Performance Reports & Performance Monitoring Reports
- Carers Strategy
- Communications Strategy 2021 – 2024
- Falkirk Integration Scheme
- Housing Contribution Statement
- Integrated Workforce Plan 2022-2025
- Joint Strategic Needs Assessments
- Market Facilitation Plan
- Participation and Engagement Strategy 2021 – 2024

[i] Scottish Government (2019), 'Framework for Community Health and Social Care Integrated Services', Available at: https://hscscotland.scot/couch/uploads/file/resources/frameworkcommunityhealthsocialcare/a-framework-for-community-health-and-social-care-integrated-services-07-november-2019.pdf, Accessed on: 13/01/2023

[ii] Scottish Government, 'A National Care Service for Scotland – Consultation', p.19, A National Care Service for Scotland - Consultation (www.gov.scot)

[iii] Public Health England (2019), Mental health and wellbeing: JSNA Toolkit, Available at: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit, Accessed on: 12/01/2023

[iv] Mental Health Foundation (2019), 'Prevention and mental health', Available at: https://www.mentalhealth.org.uk/sites/default/files/2022-06/MHF-Prevention-report-2019.pdf, Accessed on: 12/01/2023

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Falkirk Health and Social Care Partnership