



Clackmannanshire & Stirling

**Health & Social Care
Partnership**

Strategic Commissioning Plan 2019-2022



**Clackmannanshire
Council**



NHS
Forth Valley

Contents

Foreword.....	3
Background to Health and Social Care Integration	4
About Us	5
Localities	5
Which Health and Social Care Services are included within Integration?.....	8
Partnership Vision and Principles	10
Finance and Risk	13
Challenges and Opportunities.....	14
Clackmannanshire & Stirling Profile.....	15
What does this mean for you?	20
Achievements from our first Strategic Plan (2016-19)	21
Our Priorities for 2019-2022.....	22
Glossary.....	36
Development of this Strategic Commissioning Plan	38
Legislative and Strategic Context	39

Foreword

‘Enable people in Clackmannanshire and Stirling to live full and positive lives within supportive communities’

Welcome to the second Strategic Commissioning Plan 2019 – 2022 of Clackmannanshire and Stirling’s Integration Joint Board. It has now been 3 years since the Integration Joint Board was established, and there has been significant progress in developing health and social care services in this time.

We have been able to deliver our Health and Care Village, which will see true transformation in terms of bed based short stay assessment and Primary Care services and facilities. This coupled with emerging neighbourhood care team is beginning to develop into a locality model which will support service change further.

It is recognised that demand for services continues to shift as people live longer at home, with more complex needs. Our plan reflects this complexity and builds upon the measures taken over the duration of our first Strategic Plan for 2016-2019 with the ambition that we commit wholly to better integrate working which delivers improved outcomes for all of our citizens.

To do so, we need to reflect the uniqueness of our Health and Social Care Partnership, and to consider the medium term sustainability plans required to deliver upon our vision to enable people to live full and positive lives in supportive communities.

Integration is ultimately about people, and improving the experience of care for people using services as well as the people who provide care. To ensure that planning and delivery of services is centred on people there needs to be meaningful and sustained engagement with and for communities. This plan has been devised in consideration of this to reflect the aspirations of people and following considerable consultation and engagement. There is acknowledgement that we cannot merely do more of the same, but need to work collectively with communities to bring these aspirations to life.

We would like to take this opportunity to thank all of those who took the time to contribute to the development of this plan, and hope that your continued involvement will be possible as we start to implement our priorities over the next 3 years.



John Ford
Chair of IJB



Les Sharp
Vice Chair of IJB



Scott Farmer
Chair of Finance &
Performance
Committee

Introduction

Strategic Commissioning Plan

This document, the Strategic Commissioning Plan, describes how the Clackmannanshire and Stirling Health and Social Care Partnership will make changes and improvements to develop health and social services for adults over the next three years. This is a high level plan underpinned by a number of national and local policies, strategies and action plans which will be profiled and updated on the Clackmannanshire & Stirling Integration web-page. It will provide the strategic direction for how health and social care services will be shaped in this area in the coming years and describes the transformation that will be required to achieve this vision. The plan explains what our priorities are, why and how we decided upon them and how we intend to make a difference by working closely with partners in the Clackmannanshire and Stirling area.

The Strategic Commissioning Plan for Clackmannanshire and Stirling will take account of the Strategic Plan for the Falkirk partnership area, particularly where it relates to some of the specialist and hospital services which are planned and delivered across the Forth Valley area. The Plan will also take account of the Strategic Plans for other neighbouring partnerships, recognising that some services are planned on a regional basis and that some residents in the Clackmannanshire and Stirling Council areas access services delivered by neighbouring Health Boards.

Community Planning Partnerships

The Clackmannanshire and Stirling Health & Social Care Partnership will work closely with the Community Planning Partnerships in both Clackmannanshire (Clackmannanshire Alliance) and Stirling (Stirling Community Planning Partnership) to ensure that all efforts are aligned to the respective Local Outcome Improvement Plans.



About Us

Clackmannanshire & Stirling Health and Social Care Partnership

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Health Boards and Local Authorities to integrate the planning for, and delivery of, adult health and social care services. Clackmannanshire Council, Stirling Council and NHS Forth Valley have established a Health and Social Care Partnership across the Clackmannanshire and Stirling Council areas. The partnership approach extends to third and independent sector colleagues.

Integration Joint Board

The Integration Joint Board has representatives from Clackmannanshire and Stirling Councils, NHS Forth Valley Health Board, the Third Sector, representatives of those who use health and social care services, and unpaid carers. The Board, through the Chief Officer, has responsibility for the planning, resourcing and operational oversight of integrated services within the Strategic Plan.

Chief Officer

The Chief Officer is responsible for management of the integrated budget and ensuring integrated service delivery. The Chief Officer is accountable to the Integration Joint Board and to the Chief Executives of the Health Board and the Local Authorities for the delivery of integrated services.

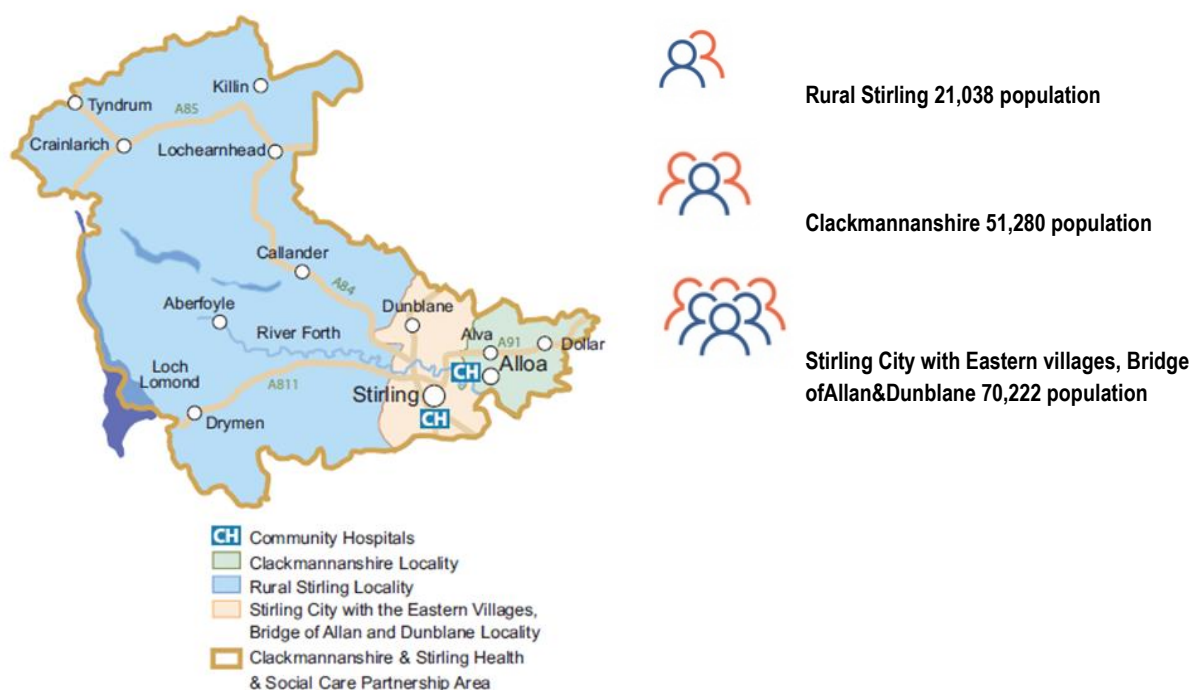


Localities

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the partnership to identify localities for the planning and delivery of services at a local level. A locality is defined in the Act as a smaller area within the borders of the partnership area. The development of localities will support the principle of collaborative working across primary and secondary health care, social care and third and independent sector provision. There will be a strong focus on community involvement and engagement aligned with the existing place based initiatives and Community Planning Partnership neighbourhood level activity across Clackmannanshire and Stirling. This will include community test sites and will support the wider aspirations for communities across the partnership area.

There are three localities within the Clackmannanshire and Stirling partnership: one locality in Clackmannanshire and two in Stirling. These three localities areas are sufficiently large to offer scope for service planning and development, while also providing scope for local involvement. The three localities are aligned as far as possible with the ways in which Primary and Secondary Health Services, Housing and Social Services, and other services, are currently delivered. The localities reflect the needs of Clackmannanshire and Stirling areas and recognise the differences between the large rural area and Stirling City.

The three localities are:



The leadership structure to support our localities is emerging, and there is a commitment that in the 3 years of this plan, these will become fully operational. Our engagement strategy will extend to further involve communities in developing meaningful locality delivery plans which reflect how our priorities will be met in each.

Clackmannanshire



2,227 Delayed Discharge
Bed Days Occupied in
2017/18



Suicide Rate
per 100,000 Population
Clackmannanshire 21.7
Scotland 13.3



14.2% People
Income Deprived
(12.2% Scotland)

Rural Stirling



22.5% of Population
Are Aged 65+
(18.7% Scotland)



5,775.8 Emergency
Hospital Admissions
per 100,000 Population
(7,601 Scotland)



179 Alcohol Related
Hospital Stays
per 100,000 Population
(680.8 Scotland)

Stirling City with the Eastern Villages, Bridge of Allan and Dunblane



Coronary Heart Disease
Rate per 1,000 Population
34.9 vs 42 Scotland



151.7 Drug Related
Hospital Stays
per 100,000 Population
(146.9 Scotland)



626 Estimated Number
With Dementia

Which Health and Social Care Services are included within Integration?

Our partnership is responsible for planning and commissioning integrated services and overseeing their delivery. These services cover all adult social care, adult primary and community health care services and the elements of adult hospital care which will offer the best opportunities for service redesign.

The health and social care partnership has a key relationship with acute health services and will work closely with the full range of Community Planning Partners to optimise wellbeing throughout the area. This approach includes working with third sector organisations, independent sector, and all of the other public sector bodies to deliver flexible locality based services, including services commissioned on a Forth Valley wide basis such as Alcohol and Drugs Services.

While doing so, we endeavour to make the most of opportunities to work in partnership directly with communities in the planning and design of services.

NHS Forth Valley

- District Nursing
- Services related to substance addiction or dependence
- Services provided by Allied Health Professionals in outpatient clinics or out of hospital
- Public dental service / Primary medical services (including out of hours) / General dental, Ophthalmic and Pharmaceutical services
- Services provided out-with a hospital in relation to geriatric medicine and palliative care
- Community Mental Health and Learning Disability services
- Continence and kidney dialysis services provided out-with hospitals
- Services that promote public health

Clackmannanshire Council & Stirling Council Services

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, assistance including aids and adaptations, and provision of gardening assistance
- Day services
- Respite provision
- Occupational therapy services
- Reablement services, equipment and telecare

There are other, hospital based, services that are included for planning purposes. This will ensure that we are planning for the whole pathway of care for individuals. These services are:



Accident and Emergency



Inpatient hospital services relating to General Medicine / Geriatric Medicine / Rehab Medicine / Respiratory / Psychiatry of Learning Disability



Palliative care services



Inpatient hospital services provided by General Medical Practitioners

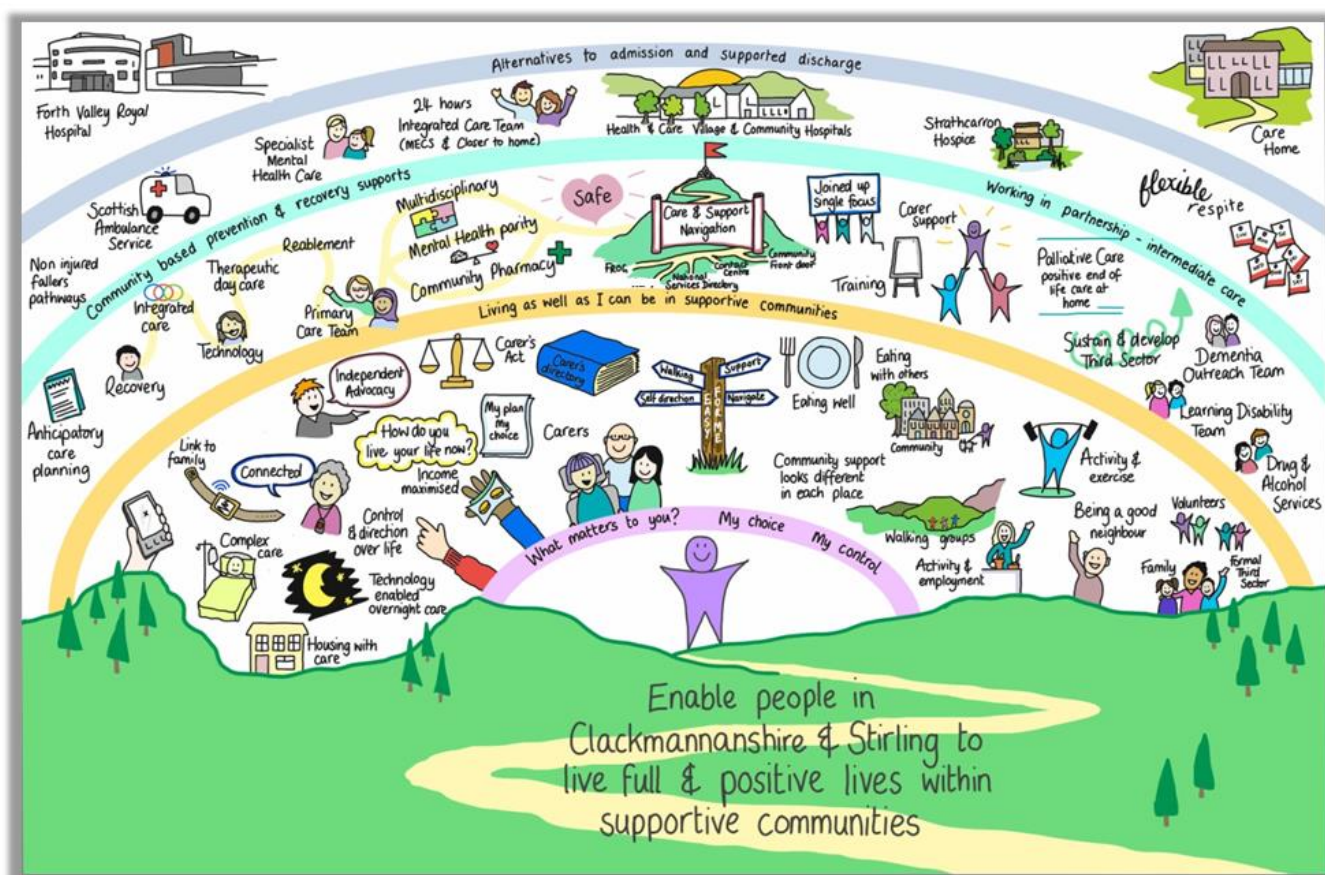


Hospital based Mental Health and addiction or dependence services

Partnership Vision and Principles

Our Vision is to enable people in Clackmannanshire and Stirling to live full and positive lives within supportive communities

To consider the meaning of this vision, a collaborative exercise has been done with a graphic artist and members of our Strategic Planning Group. They were able to illustrate what the vision means for us and our communities. This Rich Picture has been used in the development of this Strategic Commissioning Plan, guiding our discussions and next steps with our communities.



Principles

All integration activity must be delivered with full recognition of the Planning and Delivery Principles, as set out in the Public Bodies Act. The principles set out the values and approach that we will adopt whilst working together.

The main purpose of the integration planning and delivery principles is to improve the wellbeing of service-users and to ensure that those services are provided in a way which:

- are integrated from the point of view of service-users
- take account of the particular needs of different service-users
- takes 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
- respects 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
- protects and improves the safety of service-users
- improves the quality of the service
- are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
- best anticipates needs and prevents them arising
- makes the best use of the available facilities, people and other resources



There are nine National Health and Wellbeing Outcomes set by the Scottish Government that our Partnership is measured against. Progress is reported through the [Annual Performance Report](#).

National Health & Wellbeing Outcomes

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

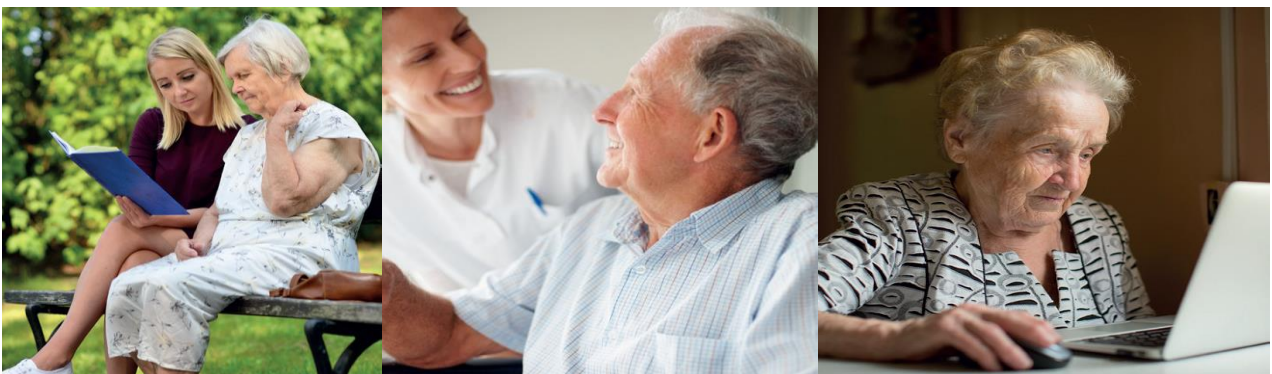


Partnership Finance

- The base 2018/19 budget for the Partnership totalled £181m.
- The demand for, and cost of, the services we deliver continues to outstrip available resources. To provide sustainable services to the Partnership population we currently estimate that we will need to make savings or service efficiencies of £5m to £6m each year over the coming 5 years.
- In order to achieve this we need to focus investment of the resources we do have on local and national priorities and achieve best value in everything we do. The overarching priority for the Partnership is supporting people to live in the own homes or homely settings as long as possible. Achieving this within the resources we have available will require difficult decisions to be made on how we spend public money.
- A Medium Term Financial Plan and Delivery Plan are being finalised to accompany this plan. These aim to ensure that we are able to deliver our vision to enable people to live well in supportive communities on a sustainable basis. This will take considerable service change and transformation over both the short and medium term aligning available resources to strategic and locality priorities
- Given the combination of growing demand and limited resources the approach to service design and transformation will require to be increasingly radical into the future,

Partnership Risk

- The Partnership maintain a Risk Register which is reviewed regularly and published within IJB Audit Committee papers which are available on our website



Challenges and Opportunities



Challenges

- Changing demographic means a continued and increasing demand for services, particularly for older people and people with multiple and complex conditions
- Increased suicide rate (per 100,000) in the Clackmannanshire locality
- Considerable variation in deprivation associated with health and wellbeing within the Partnership area
- Continued financial constraints
- Incomplete delegation of services

Opportunities

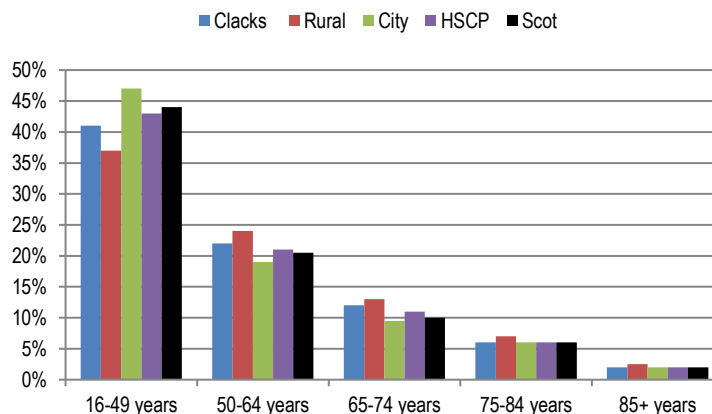
- Scope to build on the success of and further strengthen relationships with Third Sector, Unpaid Carers, and communities
- Expand the use of Technology Enabled Care to support people to live well and independently at home
- Build on progress to date in the delivery of Intermediate Care models, supporting people to live in their own homes or in a homely setting
- Build on and expand the use of multidisciplinary Primary Care teams and new Pharmacy models
- Improve opportunities to collaborate with Housing colleagues through our Housing Contribution work

Clackmannanshire & Stirling Profile

Population

A key aspect of determining the need of many health and social care services is the size and age distribution of the population. The Partnership has an estimated population of 145,450. The overall population is projected to increase by 5% by 2041. There are however differences in the age profile with the older aged population projected to increase considerably. There is a link between increasing age and multiple health conditions which increases the complexity of support needs

Adult Population



Life expectancy



Males

- Clackmannanshire: 76.7 years
- Stirling: 78.8 years
- Scotland: 77.1 years



Females

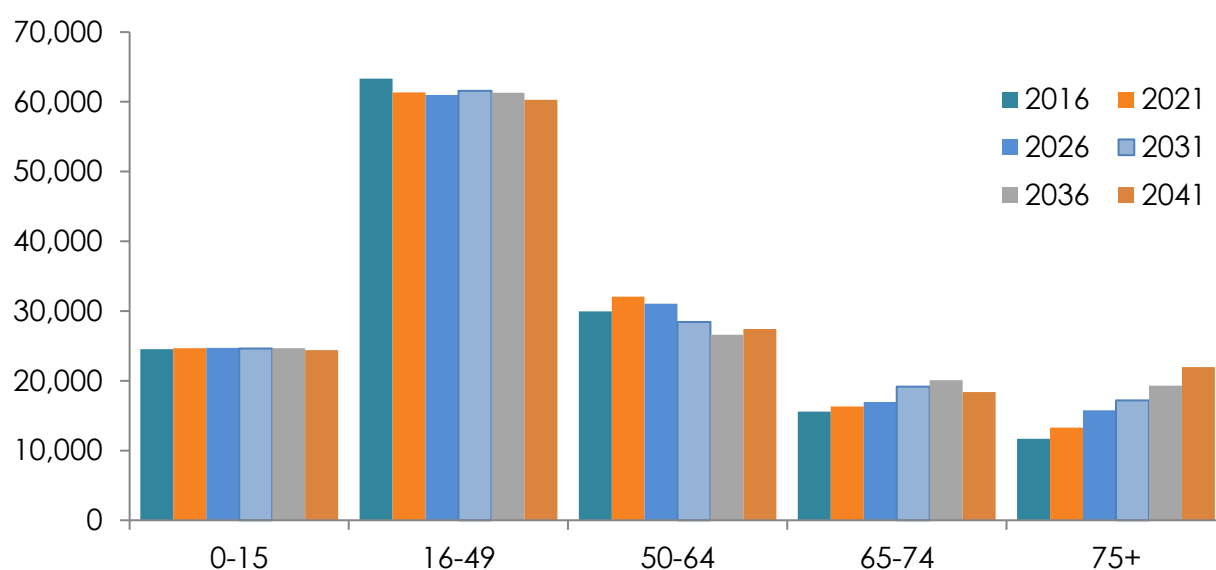
- Clackmannanshire: 80.2 years
- Stirling: 82.6 years
- Scotland: 81.1 years

Projected Population

Figure: Population Projections for Clackmannanshire and Stirling HSCP (2016 based)

The size and makeup of the future population will be a key consideration when assessing the impact of demand.

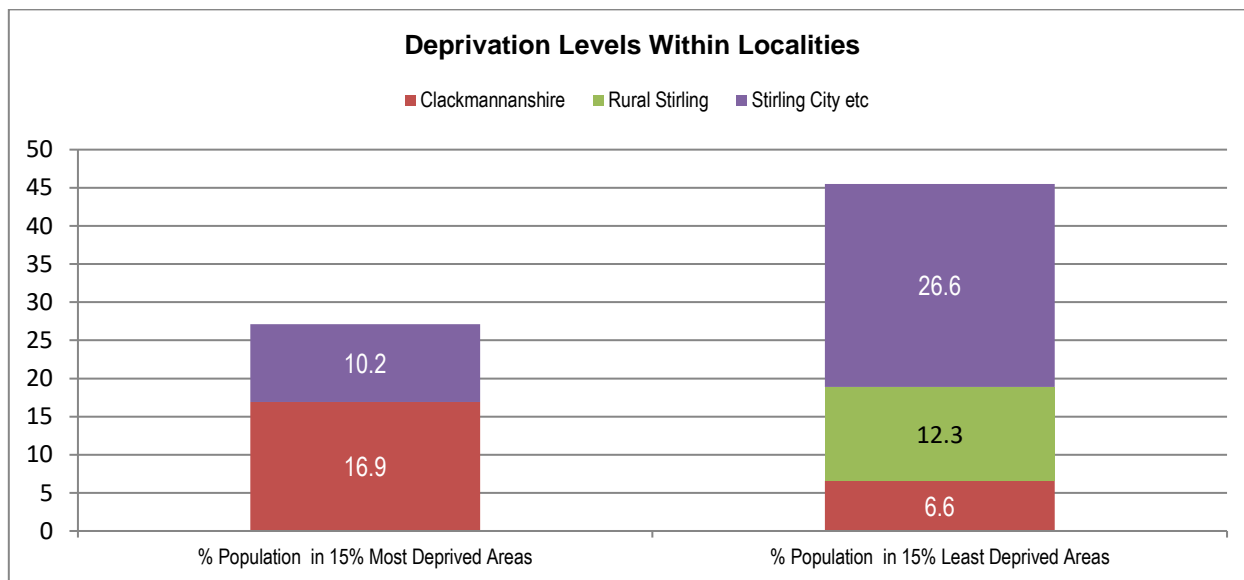
In Clackmannanshire the older population is predicted to increase at the same time as the working age population is decreasing. This means that at the same time as demand for services could be increasing, it could be more challenging to employ the workforce to meet this demand



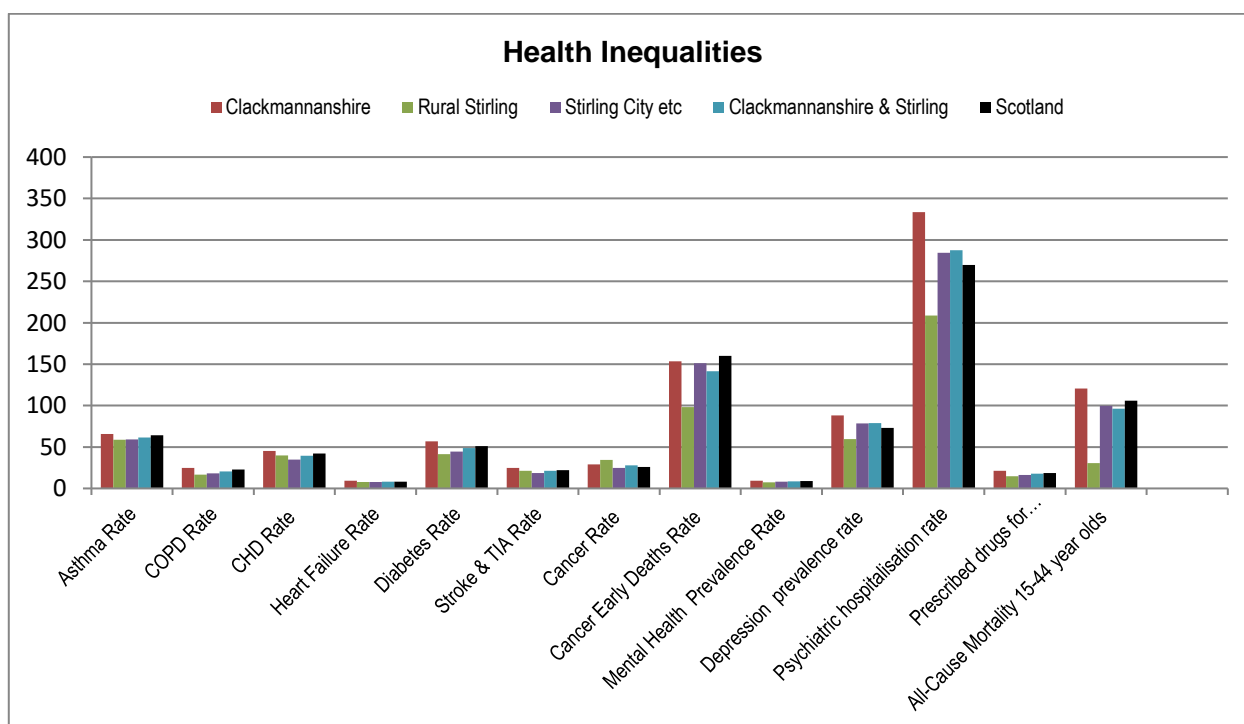
Source: National Records of Scotland (NRS) population projections

Inequality

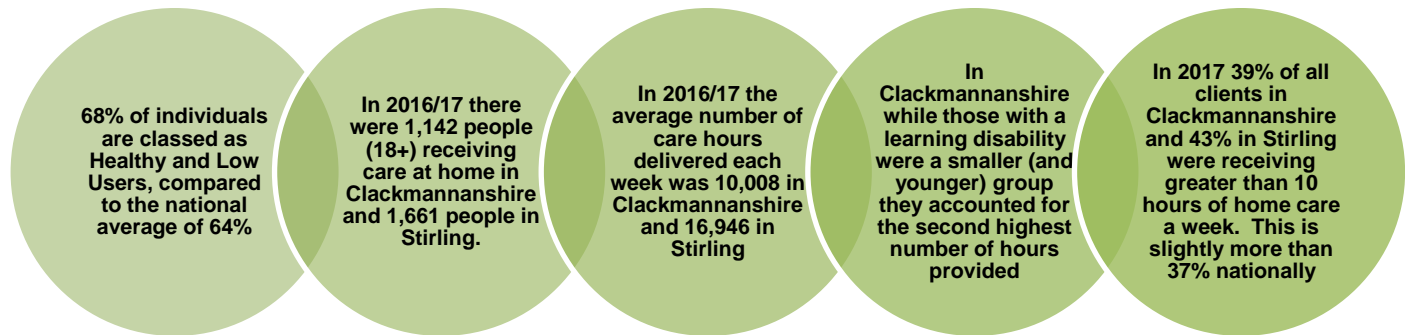
Research tell us that people who live in poorer areas in Scotland are more likely to die early from disease and have more years of ill health. Early death and illnesses associated with mental wellbeing, diet, drug use, tobacco and alcohol dependency, are more common in poorer areas than in richer areas. The leading causes of ill health or early death in Scotland are drug use disorders, heart disease, depression, lung cancer and Chronic Obstructive Pulmonary Disease (COPD).



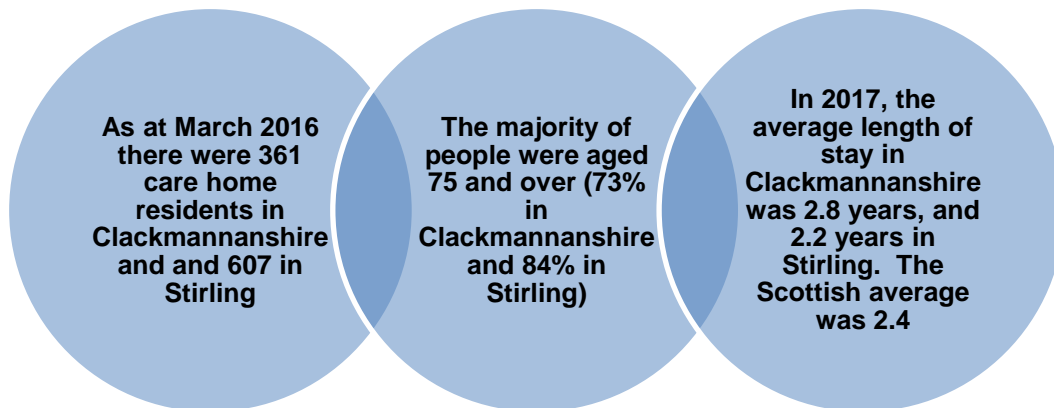
Mortality rates in Clackmannanshire are over 4 times higher in the most deprived areas than in the least deprived areas. In Stirling, mortality rates are more over 5 times higher in the most deprived areas than in the least deprived areas. However, Clackmannanshire has more areas of deprivation than Stirling overall.



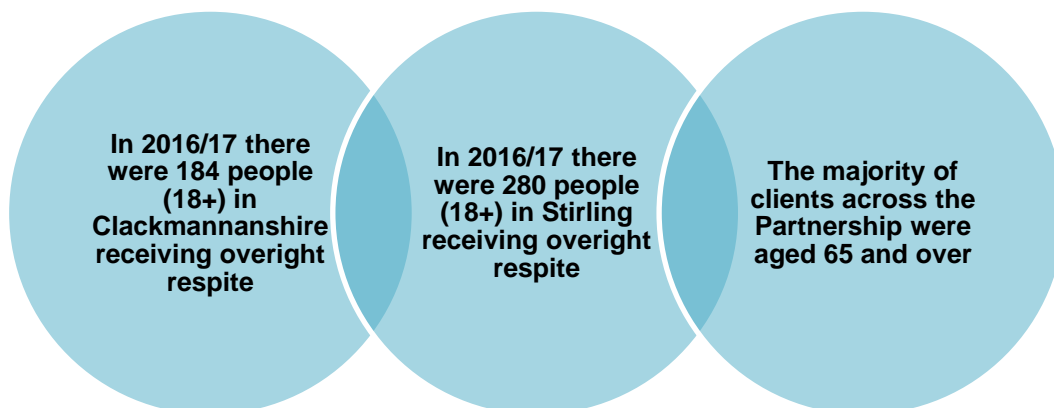
Care at Home



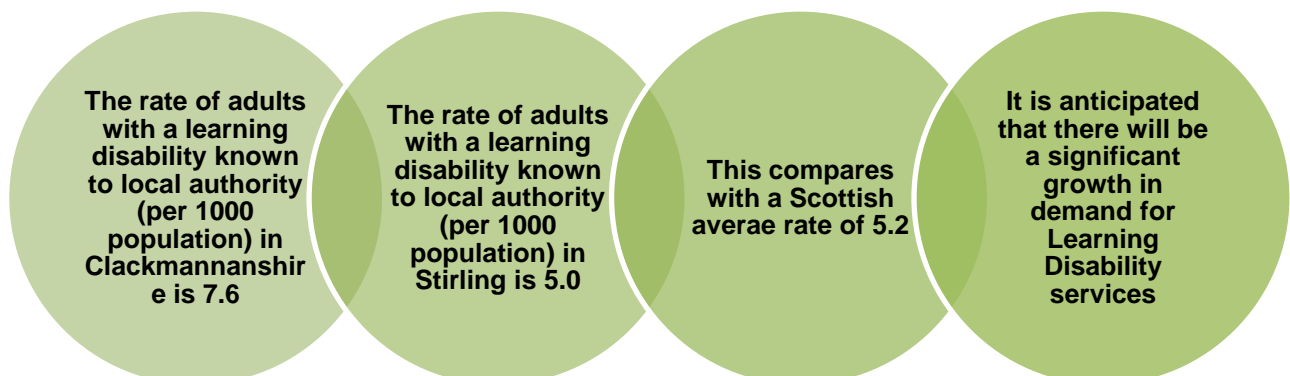
Residential care



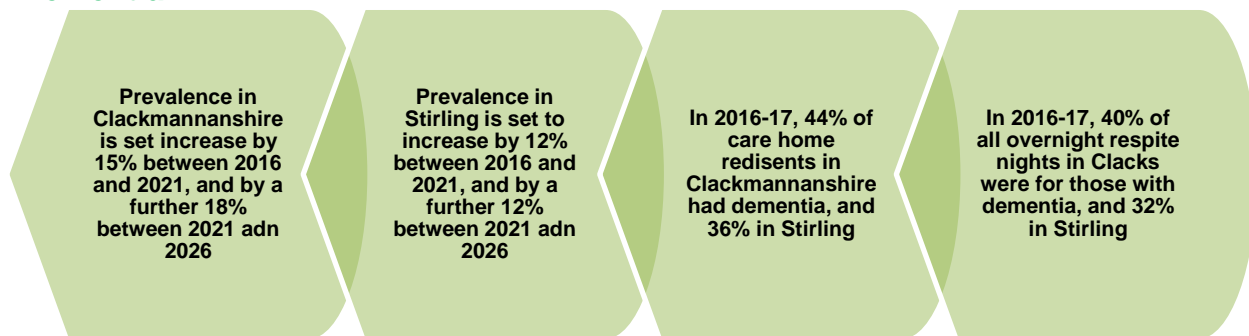
Respite



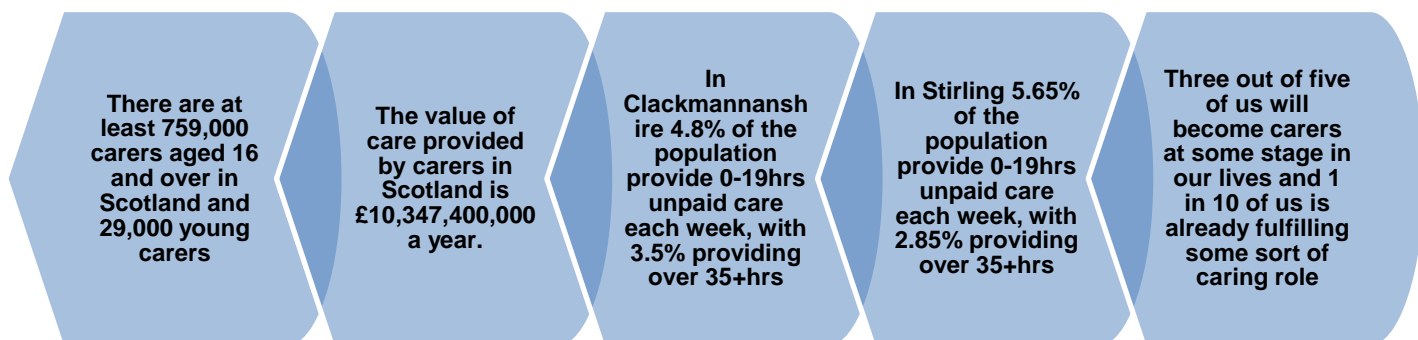
Learning Disabilities



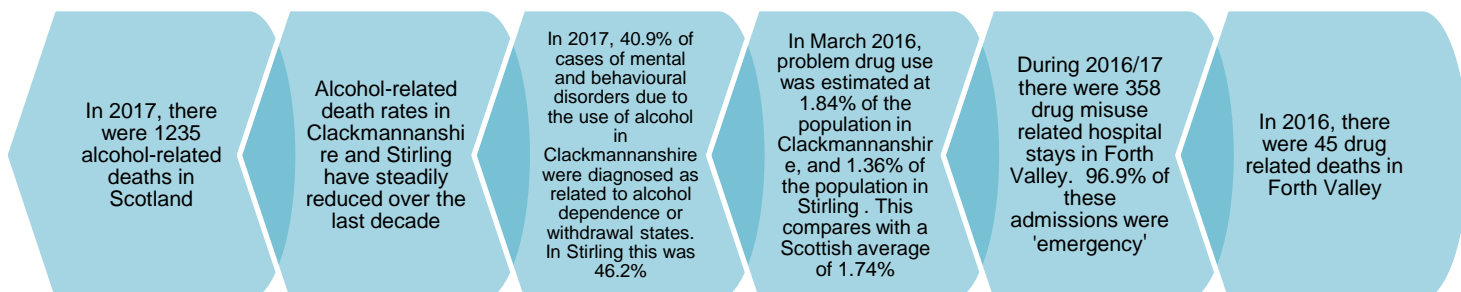
Dementia



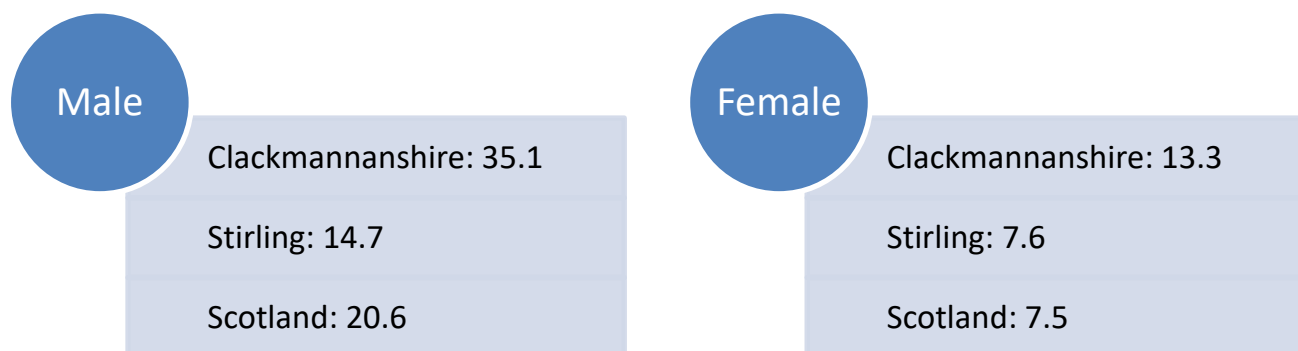
Unpaid carers



Alcohol and Drugs



Suicide rates (per 1000 population)



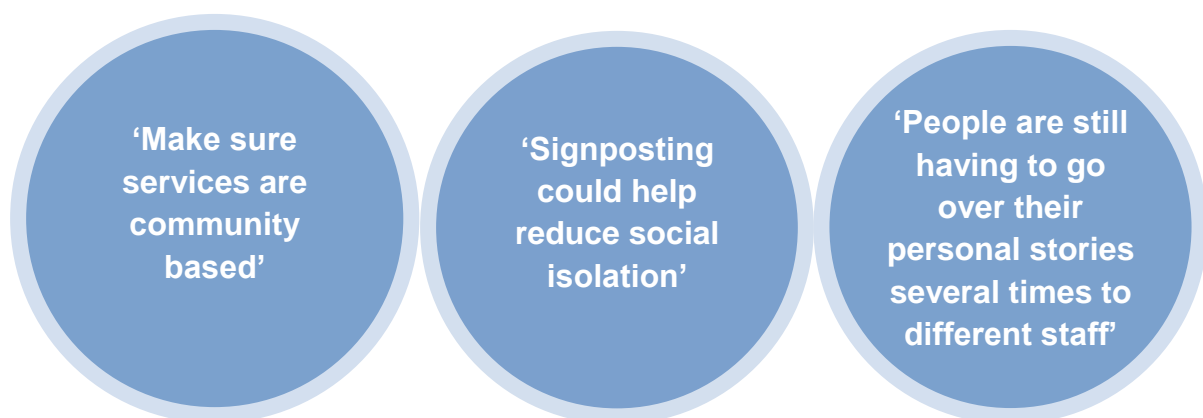
What does this mean for you?

‘Enable people in Clackmannanshire and Stirling to live full and positive lives within supportive communities’

By bringing health and social care services across Clackmannanshire & Stirling together, we have the opportunity to improve our outcomes through joint working, better communication, improved efficiency and reduced duplication.

The people of Clackmannanshire & Stirling will be at the heart of redesigning services. They will be involved in designing changes to services which will focus on people and put them first. Through working together, we can start to tackle the issues identified in our Strategic Needs Assessment.

We recognise the critical role of the whole workforce in determining the success of partnership working. It is essential that our plans are informed and owned by those who work most closely with service users, their families and carers and their local communities. This will include volunteers and staff from third and independent sector providers as well as those who work in statutory health and social care services. By recognising the strengths and all of the resources within partnerships and communities, and taking advantage of opportunities such as shared learning, we can maximise outcomes for people and improve wellbeing.



Achievements from our first Strategic Plan (2016-19)

Health and Care Village

- The construction phases for the main buildings of the Health and Care Village site were completed by Autumn 2018, allowing occupation of the GP and Minor Injuries Centre, Scottish Ambulance base, and Bellfield Centre (116 places for intermediate care)
- This innovative project establishes the Health and Social Care Partnership and is a model for the integrated approach intended across all teams and services.

Model of Neighbourhood Care

- The community of the rural south west of Stirling have identified the care of older people as a priority. We have been working together to develop a new and innovative model of neighbourhood care based on the Buurtzorg principles (person centred, staff autonomy and admission avoidance). This will change the way health & social care services are provided in the locality. The team will consist of staff currently delivering reablement, adult social care and nursing.

Intermediate Care/Care Closer to Home

- The Partnership have worked with the i-Hub division of Healthcare Improvement Scotland to review its intermediate care services. This has included the development of the core vision, values and pathways for the Health and Care Village complex, supported by the Strategic Commissioning service, as well as the creation of a logic model to identify key drivers relevant to our Reablement approach.
- This work has led to efficiency within core teams, as well as the development of an Intermediate Care Implementation Plan to focus on how services can effectively support people closer to home.
- This approach supports people at home, avoiding unnecessary hospital admission and development of plans to reduce unscheduled care.

Day Services for Older People

- Services to support older people offering day supports have been reviewed and plans to develop closer links with Third Sector groups have been made. This programme links to both the model of neighbourhood care, and the re-design of Ludgate House Resource Centre within the Clackmannanshire locality. The development of place based services which respond to the needs of local communities will support this approach.

Learning Disability and Mental Health

- Teams of health and social care staff have been integrated to redesign ensure Best Value and consistency of service across the Partnership. This includes the re design of day services and the wider use of Self-directed Support to support service users and their unpaid carers to exercise choice and control over their care.
- In addition there are other enabling activities ongoing, including development of an information resource to improve post diagnostic support for Autistic Spectrum Disorders.
- Our redesign of dementia services is in line with Scotland's national Dementia Strategy [2017-20]. We are working together to ensure more effective pathways across Forth Valley for people with dementia supporting access to the right support at the right time.

Primary Care Transformation

- The Primary Care Transformation programme has supported GP practices in Clackmannanshire over the last year to work together to implement a number of changes which aim to sustain access to primary care at a time of significant challenge. This has resulted in more than 200 new Primary Care Mental Health Nurse appointments per week being created, across the 7 GP practices, for people seeking GP support with mental health issues in Clackmannanshire.

Our Priorities for 2019-2022

Vision	Priorities	Enabling Activities				Strategies and Initiatives to deliver change
...to enable people in the Clackmannanshire and Stirling Health & Social Care Partnership area to live full and positive lives within supportive communities	Care Closer to Home	Technology Enabled Care	Workforce Planning and Development	Housing / Adaptations	Infrastructure	Intermediate Care Strategy
	Primary Care Transformation					Primary Care Improvement Plan
	Caring, Connected Communities					Carers (Scotland) Act 2016 Community Empowerment (Scotland) Act 2015 Free Personal Care for under 65's 'A Connected Scotland: our strategy for tackling isolation and loneliness and building stronger social connections' Public Health Priorities for Scotland
	Mental Health					Mental Health Strategy
	Supporting people living with Dementia					Dementia Strategy
	Alcohol and drugs					Forth Valley ADP Strategy



Care Closer to Home

What matters

Intermediate care is a core delivery priority of the Partnership. Bed based provision is demonstrated within the Bellfield Centre, an innovative, integrated service which was a cornerstone of the 2016-19 Strategic Plan. As this service became operational during winter 2018/19, the development of pathways, team and skills mix within the service, will continue to evolve over the next 3 years. It is important that this links to the core priorities and the Implementation Plan for Intermediate Care for the Partnership.

We know that many adults can be supported at home, even when unwell, and that to stay unnecessarily in hospital can be detrimental to people's ability to manage their own care, while leading to a loss of independence. This has led to a strong focus on reducing unscheduled attendance to acute services, at the same time as continuing to provide appropriate and timely support to reduce delays in discharge. The Partnership performs well in this, but more work is required to support people when unwell at home, and to develop further community pathways which Intermediate Care Services can do.

Care closer to home, via the Enhanced Care Team of community nursing and GPs provides assessment, treatment and care at home for a time limited period. It is key that this service becomes integrated with social care response via Reablement and Technology Enabled Care thus maximising efficiency of resources, and ensuring the appropriate skills mix within the workforce.

What we are already doing

We provide services closer to home which are defined as Intermediate Care. These services provide a bridge between health and social care, with the aim of supporting people to live in their own homes or in a homely setting, reducing dependence on acute hospital facilities. These services are important in avoiding unnecessary hospital admission and reducing delays in discharge.

The Partnership provides a range of Intermediate Care Services including:-

- Step up/down bed based care
- Reablement – care at home
- Enhanced Care Team – healthcare at home, avoiding hospital admission
- Technology Enabled Care

What we will do

- To support more people to stay well at home requires a review of our Care at Home services to improve timely access and build enablement approaches. We will do this in collaboration with all partners across the independent and Third Sector.
- As services become embedded in the Bellfield Centre, there will be lessons from this which will be able to be applied to the bed based services within Clackmannanshire Community Healthcare Centre.
- It is important that we continue to reduce and avoid people becoming delayed in their discharge from hospital, and there is a requirement to work closely with acute services to do so.



IC Implementation
Plan.doc



The Bellfield Centre

Delivery of the Health and Care Village was a cornerstone of the previous Strategic Plan, and the opening of the Bellfield Centre in November 2018, has given us a fully integrated Health and Social Care service to support older people to recover from illness, or regain personal skills, in a homely therapeutic environment.

Partnership working has been at the forefront since the opening of The Bellfield Centre. Positive work has been ongoing to provide a safe and effective level of support to people using the service. Relationships have been built between teams to ensure that there are opportunities to support people at the right time with the right person, minimising the possibility of re admission to acute services. Evidence of Partnership working can also be seen in the roles of all staff working in the Bellfield Centre including – GP's, Intermediate Care Workers and Assistants, Registered Mental Nurses, Physiotherapists, Pharmacy, Occupational Therapists, Nursing Assistants, Speech & Language Therapists, - all to ensure the person at the centre of the care receives the best support they can.

The partnership working of this project includes the development of a Third Sector Hub at the front door, public space of the Centre, led by Artlink Central. The best ways to maximise the use of this space is being led by the Third Sector to ensure that it retains a community focus which builds connections for people returning home. An Artist in Residence has been appointed and will support people using our service to find their creative side as well as work with users and their carers to personalise the living environment.

As this service develops, it will seek to tackle isolation and loneliness, while providing community links to support people living with dementia.

Primary Care Transformation

What matters

We know that access to GPs and primary care support matters greatly to people and to the wider health and care system. We asked the public at two public partnership forums, in September 2018, what matters when seeking healthcare advice or support. They said;

- **Quick access** to the right professional or service, be it GP, Physiotherapist, specialist care or other. "we want to nip health problems in the bud"
- **Good Communication** between health and care professionals and people "we don't want to be bounced between services and professionals"
- **To be informed** about new ways of working in clear and understandable language.

What we are already doing

The Primary Care Improvement Plan encourages GP practices to work together and take a multi-disciplinary approach to improving primary care. This involves developing the role of health professionals such as pharmacists, physiotherapists, mental health professionals and advanced nurse practitioners and freeing up GPs to focus on the people who need them most.

For example; we know that 10-20% of GP appointments are for people seeking help with mental health problems so, we now have mental health primary care nurses in 21 GP practices across Clackmannanshire and Stirling.

What we will do

We will scale up the support to all GP practices in Clackmannanshire and Stirling through implementation of our Primary Care Improvement Plan. The key components of this are:

Vaccination Transformation

Vaccine delivery will change in light of the increasing complexity of vaccination programmes in recent years. This change will see the development of a community vaccination team who will maintain the highest levels of immunisation and vaccination uptake.

Pharmacotherapy Support

Pharmacists will support activities in all general practices. They will provide services including acute and repeat prescribing and medication management activities.

Additional Professional Roles

Practitioners, such as physiotherapists, mental health practitioners and advanced nurse practitioners will work closely with GPs. They will be a first point of contact to assess and direct care for urgent health issues, muscle and joint problems and mental health issues.

Link Workers

Community Links Worker works directly with patients to help them navigate and engage with wider services. We will employ link workers to support people in the most socio-economically deprived communities, assisting people who need support because of (for example) the complexity of their conditions or rurality.

[Primary Care Plan](#)

Best in Class

Joint pains can be like a wake-up call from your ageing alarm clock.

Over 500 people in Clackmannanshire have now experienced our "Best In Class" approach to supporting people with lower limb arthritis. This approach offers direct appointments with a physiotherapy Joint Pain Advisor in GP practices and also welcomes anyone to join the Active Clacks Hip and Knee classes in Alva and Alloa. The first contact physiotherapy model will be rolled out across all GP practices over the next two years, offering discussion, assessment and practical advice on activity, diet, relaxation and lifestyle choices which can help people recover the spring in their step.

Caring, Connected Communities

What matters

Anyone can become an unpaid carer at any time in their lives, and they should be supported appropriately to do so. Our consultation highlighted the importance in providing meaningful support to unpaid carers making this a key priority for us.

Having support available within local communities is important to people's sense of wellbeing and belonging. People have told us that they wish to remain in their own communities and access services and support there if required.

We also know that isolation and loneliness can have a detrimental impact on people's wellbeing, while person-led health and social care can alleviate this. Development of planned community supports with Third Sector and Housing organisations will be important to improving access to informal supports.

What we are already doing

Models of Neighbourhood Care

We have been working with a Community Reference Group in rural Stirling South West, known as the Balfron Neighbourhood Care Group. This group, made up of local people involved in care, volunteering and representatives from local Community Councils, has been advising the development of the Models of Neighbourhood Care team and has been actively considering ways to keep older adults safe and healthy. This has included local dementia friendly awareness events, the support of lunch clubs and walking groups and considering gaps in services within each rural area. The group allows for a partnership between formal health and care services and informal supports within communities that promote well-being particularly for older adults. Local people advise they feel more connected to issues about care.

Unpaid Carers

Unpaid carers have been involved in co-producing our Carers Strategy and have been active in developing our approaches to meet the outcomes of unpaid carers under the requirements of the Carers (Scotland) Act 2016 which was implemented on the 1st April 2018. The Act has provision to identify and support carers. The developments so far have included:

- Developing an adult carer support plan for adult carers
- Improve ways to identify carers
- Development of a short break statement

Unpaid carers have told us that support to continue in their role is important to them, and there is a need to improve respite opportunities with better access to Self-directed Support.

Third Sector Supports

There are many areas of activity across the Partnership to support people by building community resilience via the Third Sector. We have employed a Third Sector Engagement Officer via our Third Sector interfaces, who seeks opportunities to connect communities and support them in developing projects and initiatives which promote well-being and reduce inequalities.

What we will do

- We have developed a Carers Strategy and will work with unpaid carers to support them in their invaluable role by implementing this in full
- There are greater opportunities to support care and connected communities with the Third Sector to reduce isolation and loneliness of older adults. The neighbourhood care model will be expanded to other localities, linked to GP clusters
- Communities depend on good quality housing options for everyone, and we will expand housing with care opportunities across all localities.

The Carers Strategy for the Partnership is available on our [website](#)

'Support and empower unpaid carers, third sector and communities'

Mental Health

What matters

Scotland's Mental Health Strategy calls for parity of esteem with physical ill health. Services across the partnership are working to ensure that people accessing services for support with mental health problems do not experience a lesser service than those accessing support for physical ill health.

What we are already doing

Over the past three years there have been significant changes in how we deliver Mental Health Services with redesign of existing teams and additional resources to meet the increasing demands on service. There is now a joined up, 24/7 Mental Health Assessment Services based in FVRH which also fields calls for people calling NHS 24 with Mental Health Concerns. This helps deliver a seamless journey for patients and supports multi-professional collaboration with Primary Care Colleagues. Advanced Practice roles have been scoped and will provide key elements of Mental Health Services in the future.

The partnership has also begun engaging on the strategic commissioning of Third Sector Mental Health Services. This work is invaluable in ensuring cohesive working between all partner organisations delivering care and providing access to support.

A redesign of Psychological therapies has improved the efficiency of the referral process and ensures that communication with referrers and patients is effective.

A Suicide Prevention Plan is being produced to ensure that this worrying pattern is effectively tackled within communities and with individuals. This will be done in line with the national Suicide prevention action plan: every life matters.

What we will do

- We will implement the commissioning strategy of Third Sector Mental Health Services to ensure improved joined up working across our Partnership.
- There will be further group efforts to support those in high need with Primary Care, Police and acute services. This will improve outcomes for people using mental health services, and reduce reliance on emergency care.



MH STRTAEY
2017-27.pdf

Dementia Friendly Communities

Across Stirling and Clackmannanshire new community-based groups have been established, with a focus on being dementia friendly. Being 'dementia-friendly' means people living with dementia, and their loved ones are included, especially in choices and planning. This means their ideas and preferences are taken into account, and then plans and activities are suited to what people want, like and enjoy.

Dunblane and Clackmannan have been involved in this way of listening and organising, with co-operation and collaboration between people from various community groups, including schools, churches, businesses, development trusts, community councils and the health centres. These two communities are unique in their own ways, however they have a new similar factor which is evident in their regular community activities where children, teenagers, retired people and many older adults meet up in local venues with volunteers and do things they enjoy together, with good outcomes for everyone. Sharing memories is a regular part of these happy times, with music, pictures, games and life stories being sources of enjoyable conversation, smiles and laughter. Every gathering includes time for a cuppa and nibbles. The people getting together at these groups have doubled in number since getting started. Some groups are smaller and include quieter activities. New groups are setting up in other communities, building up a network across the area. Co-ordination, co-operation and enthusiasm of people in their communities have enabled these developments to happen and flourish.

Supporting People Living with Dementia

What matters

Scotland's third National Dementia Strategy moves away from a healthcare model and places more emphasis on people being supported to live well within their own communities following a diagnosis of dementia, as well as reducing the amount of time people with dementia spend in a hospital environment.

There is also an emphasis on the importance of good quality post diagnostic support and the impact this can have on outcomes for people with dementia. It is therefore important that all people newly diagnosed and beyond, as well as their carers, have access to support that suits their needs.

What we are already doing

The Health and Social Care Partnership is working to ensure that services delivered to people with dementia are as seamless as possible and that people get access to the right support at the right time.

We know that people with dementia wish to remain at home for as long as possible and ensuring that people with dementia and their families remain included in their communities, and in society more generally, should be the 'norm'. Dementia Friendly community groups are established within the partnership with the aim of working with local businesses and service providers to raise awareness of dementia and what role they can play in supporting individuals and their carers. Work is also being explored with primary care and community teams to try and reduce the number of avoidable admissions to hospital where possible. When people do have to be admitted to hospital the aim is that they are cared for in a person centred manner, in an appropriate environment, by staff who are knowledgeable in this area and that length of hospital stays are minimised.

The Bellfield Centre in the Health and Care Village includes the 'Castle Suite' which is an intermediate care environment designed to support people with dementia and provide a specialist assessment either as an alternative to a hospital admission or as a 'step down' from hospital.

Post diagnostic support for people diagnosed with dementia is an area we need to improve our performance on and this has involved reviewing the current system and processes. The plan is to have an integrated team comprising of Nursing, Social Work and Alzheimer's Scotland Staff. This will form the Dementia Outreach Team (DOT) which will provide support from the point of diagnosis right through the journey for people with dementia and their carers.

What will we do

- Develop a Forth Valley Health and Social Care Dementia Strategy which will highlight future priorities for focus over the next 3 years
- Continue to progress the redesign of services in order to provide post diagnostic support to people with a diagnosis of dementia in a multi-professional way which meets the individual needs of the person and their carers
- Spread dementia friendly community work to all areas within the partnership with the Third Sector

'Social isolation and loneliness really important issue, especially for people affected by dementia'

Alcohol and Drugs

What matters

We have learned from examining our data that we have high numbers of people who are passing through many of our partnership services and perhaps have not had their needs fully met, we intend to stop the “revolving door” situation, improve outcomes and treatment retention rates for those people with complex social and health issues who require support, as do their families.

We intend to increase awareness of the recovery capital and opportunities for recovery support that exists in Clackmannanshire and Stirling. We have one of the most successful Recovery Communities/ Recovery Cafe Networks in Scotland in our partnership.

What we are already doing

In Clackmannanshire and Stirling we have very good track record of delivering against the National Quality Principles for Substance Services (Health and Social Care Standard) Our services underwent a review by the Care Inspectorate in 2016 and were considered to be performing well. Since then we have delivered against the key improvement areas that arose from this work, which are laid out within the ADP Service Improvement Plan.

We perform very well against the Alcohol and Drug Partnership / NHS national target which measures the waiting time for people accessing Drug and Alcohol Services; we demonstrate excellent performance against the Alcohol Brief Intervention (ABI).-NHS Local Delivery Plan Standard.

What we will do

We intend to work jointly with the Clackmannanshire and Stirling ADP to deliver outcomes for our community and relieve the burden of alcohol and drugs related harm, together, across the partnership. Our Alcohol and Drug Partnership will revise their local delivery plan to support the objectives and strengthen our joint governance arrangements to align our reporting.

We have a role to support other our partners to ensure that we educate the wider population on the harms associated with substance use as part of our prevention strategy. We will work with Educating partners within the setting of school, college, university and workplace to promote reduced consumption of alcohol and drugs.

There is a need to widen knowledge and awareness of substance use within all of our services within the partnership and to improve routes for referral between services. We will ensure that the revised pathway is marketed appropriately to social care / health staff for to increase the treatment ratio levels across the life stages for those with substance use problems. This will include a focus on older adults and the impact of alcohol misuse within the home. We plan to deliver a programme entitled “Older and Wiser,” which is focussed on substance use of older adults. This programme will be delivered to all social care and health staff across the partnership.

Additionally, transitional support for older adults who have long term substance use histories will be improved, ensuring better routes to recovery are maximised for people with an Alcohol Related Brain Injury.

Through a thorough review of our commissioning arrangements for those who require at home or residential / day care , we will ensure that appropriate therapeutic/ rehabilitative interventions are in place within care homes/ residential / day care settings to support recovery and improve the quality of life of those affected.

Over the life of the Strategic Plan we will implement the new national drug and alcohol information system (DAISy) this will allow us to track performance and outcomes data for people who are on their recovery journey.

[ADP Needs Assessment](#)

Enabling Activities

Technology Enabled Care

Workforce Planning and
Development

Housing/Adaptations

Infrastructure



Enabling Activities Technology Enabled Care

What matters

It is expected that analogue phone lines will be replaced with digital technologies by 2025. This will have a significant impact on Telecare Services, which are currently reliant upon analogue phone lines. To address this, the Scottish Government TEC Programme and Digital Office have developed a workstream specific to the needs of Telehealthcare Services, which is using an Agile approach to identify new and innovative ways in which digital technology could support people to live well in their communities.

Full opportunities for digital technologies will only come with what is described as “end-to-end” systems i.e. when the Alarm Receiving Centre operates on a superfast broadband network as well as the base equipment used by the service user.

What we are already doing

Technology Enabled Care (TEC) can be used successfully to support people with care needs and those that care for them, to have greater choice and control over their own lives; and enable them to live well in their own homes for longer with greater independence and safety, while reducing the need for unplanned or over care.

We have seen a net increase across the partnership in people accessing technology to support them with their care needs, with key achievements of:-

- Increased provision of basic Telecare community alarm units.
- Increased provision of monitoring equipment such as falls monitors, smoke and heat detection, front door contacts etc.
- Testing of digital technologies.
- Increased use and awareness of GPS technologies to support people living with dementia to remain safe in their own homes.
- Improved referral pathways have been developed with Scottish Fire and Rescue Service to promote access to Home Safety Visits, including information sharing to support people to keep safe.
- Testing of improved referral pathways with Scottish Ambulance Service to support the care needs of uninjured fallers in the communities.

What we will do

- The partnership will build on these developments to invest in digital technologies which modernise services for adults. This will support people to manage their conditions better, and connect to health and care, as well as to their communities
- The response team will be reviewed in line with the priorities to support more people Closer to Home
- The use of digital technologies with Independent and Third Sector colleagues will be expanded upon



Strategic Map 12th
January 2017.pptx

Prevention through partnership working

The Partnership is represented at the Community Falls and Bone Health Group which has led to the development of a Non- Injured Fallers Pathway with Scottish Ambulance Service. This supports the use of social care responses to people who have fallen but are not injured, reducing unnecessary admissions to hospital. Scottish Fire and Rescue have worked with us and our colleagues in Public Health to identify pathways for people who use mental health services, as well as older adults using our Technology Enabled Care Service, encouraging home safety visits. These help people to reduce their risk of fires, but also other safety aspects in their homes.

Enabling Activities

Workforce Planning and Development

What matters

The following statements reflect the strategic intention for the development of the workforce across the Clackmannanshire and Stirling Partnership.

- Through an approach of caring together, we will ensure a workforce that is fit for the future of Health and Social Care.
- We will create workforce development plans that ensure the availability of a flexible, responsive workforce with the right skills, in the right place and at the right time to help ensure that our service users get the right level of support early enough to deliver on our strategic outcomes.
- We will ensure our workforce feels engaged with the work they do and are supported and empowered to continuously improve the information, support, and care and treatment they provide.
- At the heart of the care and support provided will be a culture of collaboration putting the service user at the centre and creating connections between partner organisations to share skills, knowledge and resources to deliver improved services and outcomes.
- We will ensure that our workforce delivers best value, making the best use of available resources within an environment that strives for quality, efficiency, safety and integration at every opportunity.

What we are already doing

At a local level, Clackmannanshire and Stirling Councils and NHS Forth Valley are building on existing common working practices to put in place robust arrangements with the aim of providing better, more integrated adult health and social care services. The Partnership knows that the workforce is the single most important resource in delivering high quality services and the transformation required to ensure the delivery of the Scottish Government 2020 Vision for Health and Social Care.

The ever changing nature of these services is complex and challenging. Clackmannanshire and Stirling Councils and NHS Forth Valley, in collaboration with partners and stakeholders seeks to ensure that the health and social care workforce of tomorrow, both paid and voluntary, are knowledgeable and skilled and able to respond to changes that the sector demands. The full benefits of integration of health and social care services can only be realised when services appear seamless from the perspective of users and carers. Successful workforce planning is pivotal to this.

What we will do

- We will review our Workforce Plans in light of guidance from Scottish Government and the Ministerial Strategic Group to ensure that they are meaningful and reflect the ethos of collaboration across the whole system.

The Workforce Plan for the Partnership is available on our [website](#)

Enabling Activities

Appropriate Housing/Adaptations

What matters

In our consultations, people told us that good quality housing was important to them. When someone is faced with disability or frailty, they can find their home is unable to meet their needs. Appropriate adaptations to their home (both minor and major) can support someone to live more independently.

Meanwhile, there is an identified need for more appropriate ranges of housing with care for all care groups and ages across communities. To successfully achieve place based care and support in people's own communities, a range of housing options are required.

This not only provides the opportunity for people to live well within their own community, it allows for safe and effective development of care closer to home, reducing travel and "down time" of care providers, and maximising the time that can be offered in supporting people in meeting their identified outcomes.

What we are already doing

The Partnership is working closely with Housing services in both Clackmannanshire and Stirling Council. In developing a new Housing Contribution Statement for 2019-2022, there are aspirations that this relationship will develop further, with a focus on place based care and support within local communities.

Overall, to achieve improved outcomes across the population it is important that Integration Authorities and Strategic Housing Authorities work closely together on key aspects of housing support including:

- Assessing the range of housing support needs across the population and understanding the link with health and social care needs;
- Identifying common priorities that are reflected in both the Local Housing Strategy and Strategic Plan;
- Identifying and making best use of resources to meet the housing support needs of the local population.

An innovative approach has been taken in developing a new housing with care model within the town centre of Alloa, with construction taking place over 2019/20. This development has been done in collaboration with Housing colleagues, and Stirling University, along with the Contractor, and will provide opportunities for people to live and access the town centre as well as other local amenities and services.

The Housing Contribution Statement of Clackmannanshire and Stirling Councils is available on our [website](#)

What we will do

- Housing with Care should reflect the needs and expectations of communities. We will develop these in collaboration with our housing, independent and Third Sector colleagues
- Adaptations to people's home can act as a prevention to needing higher resourced services. This service will be reviewed to ensure that it is responsive to need

Technology Enabled Care

The Technology Enabled Care Service has worked closely with other partners to ensure a service that offers service users ways to use technology to manage their own care safely at home.

The service has been working closely with Third Sector and Independent providers of care at home and in care homes. We have worked to raise the profile of Technology Enabled Care and worked with assessment teams in the community and in hospitals to ensure Technology Enabled Care is used initially instead of being used at the end of an assessment. This is described as a "**Tec first approach**". Awareness sessions and open days have also taken place to support unpaid carers and advise them of the benefits of

Enabling Activities Infrastructure

What matters

Through our governance structure, and supported by a robust Clinical and Care Governance mechanism, we can ensure that services are safe, that we minimise risk and that we learn from any mistakes which occur.

Regular monitoring of a range of performance indicators - benchmarked against comparable Partnerships - helps us to identify trends and potential issues, and to assist with management decisions about the ways in which services are delivered and resources allocated.

ICT systems which are functional and reliable can free up staff time to spend with our service users, and information sharing between Partner organisations creates smoother pathways for the users of our health and social care services. New technology can support people to remain independent at home, maintaining greater control and choice over their wellbeing and support.

What we are already doing

Governance

The Integration Joint Board (IJB) for Clackmannanshire and Stirling Health and Social Care Partnership is made up of representatives from Clackmannanshire Council, Stirling Council, NHS Forth Valley, Third Sector representatives, service users and carers. The Integration Joint Board, through its Chief Officer, will have the responsibility for the planning, resourcing and the operational oversight of a wide range of health and social care services.

The IJB has established two sub committees: the IJB Audit Sub Committee, and the IJB Finance Sub Committee to help fulfill its statutory responsibilities.

Clinical and Care Governance

The Forth Valley Clinical and Care Governance Framework (CCGF) is an overarching framework in place across two Integrated Joint Boards (IJBs) in Forth Valley – Clackmannanshire & Stirling, and Falkirk. The framework describes the process that provides assurance to the IJBs that high quality, safe care in respect of the functions described in the IJBs Integration Schemes is consistently delivered.

Performance

Our performance management framework is an important delivery mechanism for ensuring quality improvement and safe and effective care. It describes governance and accountability and the review of priorities that is part of ongoing management and decision making which is aligned to local, regional and national planning priorities determined through the planning process.

ICT

Huge advances in technology in over the past five years have brought about significant changes in the way we support and care for our service users. This is described more fully in the Technology Enabled Care section of this Plan.

The next steps will concentrate on moving the agenda further into the digital setting, making sure that our systems are safe and secure and that our infrastructure is resilient, using shared systems across the Partnership where possible.

There is a need to replace our social work systems, and to ensure that these are fit for integrated working. A replacement social work information system will be commissioned which will be fully accessible across the whole system, and will promote real time and remote working.

What we will do

- Single systems working which integrates teams, resources and information will be developed to meet the priorities of our localities and communities. This will include improving management systems, and enabling staff to work in a single system
- Continue to closely monitor and review our performance and report on this in ways which support benchmarking with others to promote best practice and learning

[Clinical and Care Governance Framework](#)

[Performance Management Framework](#)

[Digital and eHealth Strategy 2018 – 2022](#)

How will we know we have been successful?

As well as reporting annual on performance against the national outcomes, we have identified a range of positives to measure success.

Outcomes for People

- People are more informed and empowered to take control of their own health
- People receive the right support from the right person / service at the right time
- People are involved in and make decisions about care and support
- Improved access to local community based supports
- Reductions in isolation and loneliness
- Admissions to hospital will be reduced
- People are safer via remote monitoring
- People will have confidence in the services they receive
- People are able to live in their communities

Outcomes for the Workforce

- Improved shared skills and experience
- Positive working environment
- The workforce have the knowledge, skills and confidence to fulfil their roles
- Job satisfaction is high and recruitment and retention is improved
- Development of personal leadership and job satisfaction
- Improved knowledge of community networks
- A digitally competent workforce
- Improved workforce experience
- Staff will be able to access the necessary learning and development to make the most of their skills and knowledge
- Staff will be able to work collectively to develop cultures to shared learning and competence
- Efficiency of access to deliver care
- Safe environments to work within

Outcomes for the System

- Reduced delays in discharge from acute hospital settings
- Variations and Delays in care and support are minimised
- People are able to stay at home for longer
- Waiting times targets are adhered to.
- Waste and inefficiency is minimised
- The system is data rich
- People remaining at home for longer resulting in less dependency on 24 hour care facilities
- Reduction in avoidable presentations to/stays in hospital
- Efficiencies in use of time and resources
- Reduction in “over-care”.
- The organisation will have robust and safe services, retaining skills knowledge and experience
- There will be meaningful succession planning
- Place based care can be supported

Glossary

Accident & Emergency (A&E) Services	Emergency Departments (Forth Valley Royal Hospital Larbert); Minor Injury Units (Stirling Community Hospital), community A&Es or community casualty departments that are GP or nurse led. See also Emergency Department (ED).
Acute services	A branch of 'secondary' health care where a patient receives short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery.
Admission	Admission to a hospital bed in the same NHS hospital following an attendance at an Emergency Department service.
Admission rate	The standardised figure representing the number of admissions attributed to a group or region divided by the number of people in that group (the population).
AHP	Allied Health Professionals are a range of professionals who provide preventative interventions. They can include; Dietitian, Occupational therapist, Physiotherapist, etc. More information can be found in this link http://www.gov.scot/Topics/Health/NHS-Workforce/Allied-Health-Professionals .
Anticipatory Care Plan (ACP)	For individuals, particularly those with long term conditions, to plan ahead and understand their health to help have more control and to manage any changes in their health and wellbeing. It's about knowing how to use services better, helping people make choices about their future care.
Attendance	The presence of a patient in an A&E or ED service seeking medical attention.
Attendance rate	The number of attendances attributed to a group or region divided by the number of residents in that group (the population).
Balance of Care	Shifting the Balance of Care describes changes at different levels across health and care systems, all of which are intended to bring about better health outcomes for people, provide services which reduce health inequalities, promote independence and are quicker, more personal and closer to home.
Benchmark	A benchmark is a standard or point of reference against which other things can be compared.
CAB	Citizens Advice Bureau
Census	An agreed date to take a snapshot count to measure agreed information e.g. Annual Care Home Census on 31 March and the monthly Delayed Discharge Census on the last Thursday of every month.
CCHC	Clackmannanshire Community Healthcare Centre
CPP	Community Planning Partnership (Stirling), Clackmannanshire's CPP is called the Alliance.
COPD	Chronic obstructive pulmonary disease (lung disease).
Delayed Discharge	A delayed discharge is experienced by a hospital inpatient who is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons.
Discharge to Assess	'Discharge to Assess' approach supporting people to leave hospital, when safe and appropriate to do so, and continuing their longer term care and assessment out of hospital.
Emergency Department (ED)	The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. 4 hour wait standard - is that new and unplanned return attendances at an ED service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care.
Enablers	These are people or things that help to make something happen.
GP Cluster	A grouping of GP practices who work together to discuss the quality of care provided to patients in the locality. Each GP cluster will have a GP designated as a Cluster Quality Lead who will have a coordinating role within the cluster.
Health and Social Care Integration	Integrating health and social care services has been a key government policy for many years. What Is Integration? - short guide Clackmannanshire and Stirling Health & Social Care web page
High Health Gain	The term used for the group of people who collectively account for 50% of the total health expenditure of their local area during the financial year.
Holistic	A holistic approach looks at the "whole" person, not just individual parts.
ICF	Integrated Care Fund. Additional resources available to health and social care partnerships to support delivery of improved outcomes from integration help drive the shift towards prevention and tackling inequalities. http://www.gov.scot/Resource/0046/00460952.pdf
iHub	Healthcare Improvement Scotland's Improvement Hub (iHub), supports health and social care organisations to redesign and continuously improve services https://ihub.scot/about/who-we-are/
In Scope	Services that are delegated to the Partnership Integration Scheme
Integration Joint Board (IJB)	A legal body established under the Public Bodies (Joint Working) (Scotland) Act 2014. The Parties to our IJB are Clackmannanshire and Stirling Councils and NHS Forth Valley. The Parties agreed the Integration Scheme for our Health and Social Care Partnership, which sets out the delegation of functions by the Parties to the IJB.

Intermediate Care/STA	An umbrella term used to describe services which provide a bridge between health and social care with the aim of supporting people to live in their own homes, or in a homely setting, reducing dependence on acute hospital facilities.
iMatter	A staff experience continuous improvement tool http://www.staffgovernance.scot.nhs.uk/monitoring-employee-experience/imatter/
ISD	The Information Services Division (ISD) is a division of National Services Scotland, part of NHS Scotland and provides health information, statistical services and advice to support the NHS in progressing quality planning and improvement in health and care. http://www.isdscotland.org/
LDP	Local Delivery Plan standards for NHS http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/NHS-Performance-Targets
Locality Planning	A locality is defined in legislation as a smaller area within the borders of an Integration Authority – their purpose is to provide an organisational mechanism for local leadership of service planning.
MECS	Mobile Emergency Care Service https://www.clacks.gov.uk/social/mecs/https://my.stirling.gov.uk/services/housing/adapting-homes/telecare
MSG	Ministerial Strategic Group for Health and Community Care agreed an initial framework for measuring progress against national priorities. http://www.gov.scot/Publications/2016/03/4544/5
NI	National Indicator. In this case, the suite of National Core Integration Indicators set by the Scottish Government to help measure performance. http://www.gov.scot/Resource/0047/00473516.pdf
Palliative Care	For people with an illness that can't be cured, palliative care makes them as comfortable as possible, by managing pain and other distressing symptoms. It also involves psychological, social and spiritual support for the person and their family or carers.
Primary Care	The first point of contact for health care for most people, mainly provided by GPs (general practitioners) but community pharmacists, opticians and dentists are also primary healthcare providers.
RAG	Is a quick visual way of identifying areas of concern or progress that is good, not so good, or poor. It refers to the use of colours Red Amber Green.
Reablement	Services for people with poor physical or mental health to help them accommodate their illness, by learning or re-learning the skills necessary for daily living.
Readmission	This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay.
SAS	Scottish Ambulance Service
Self Directed Support (SDS)	This gives people choice and control over their individual budget which helps to buy services, such as help with dressing and personal care, to help meet agreed health and social care outcomes. http://www.audit-scotland.gov.uk/uploads/docs/report/2017/nr_170824_self_directed_support_summary.pdf
SSSC	The Scottish Social Services Council (SSSC) is the regulator for the social service workforce in Scotland.
Technology Enabled Care (TEC)	Technologies which have the potential to transform the way people engage in and control their own healthcare, empowering them to manage it in a way that is right for them.
Telecare	Telecare is technology to help people to stay living independently at home for longer.
Third Sector	An umbrella term for a range of organisations belonging to neither the public nor private sectors (e.g. voluntary sector or non-profit organisations). http://ctsi.org.uk/
Transformation Care Fund	Primary Care Transformation Fund - allocated over three years to GP practices to prototype the new vision for the GP contract, including those wishing to use new ways of working to address current demand. This work will inform the design of primary care in the future. https://news.gov.scot/news/primary-care-investment
Unscheduled Care	NHS care which is not planned in advance, or is unavoidably out with the core working period of NHS.
Website	Clackmannanshire & Stirling HSCP https://nhsforthvalley.com/about-us/health-and-social-care-integration/clackmannanshire-and-stirling/

Development of this Strategic Commissioning Plan

Consultation and Engagement process

The Strategic Plan was developed as a result of a series of engagement events held during late 2018 and early 2019, including:

- Open public events in each of our Localities
- Clackmannanshire and Stirling Public Partnership Forums
- Various community interest groups
- Various staff meetings

This was followed by a public consultation survey which ran between 11 February and 8 March 2019.

The process undertaken to develop the Strategic Plan has been underpinned by the Partnerships desire to ensure the participation and engagement of all stakeholders, and the resulting comments have shaped the final version of the plan.

A report outlining the results of the consultation process will be made available on the Clackmannanshire & Stirling Integration website.

Next Steps

The Strategic Plan for the Clackmannanshire & Stirling Partnership is based on a Strategic Needs Assessment and draws on a range of existing initiatives and plans which are consistent with the vision and outcomes for the Partnership.

The Strategic Needs Assessment along with the National Outcomes, the Housing Contribution Statements for Clackmannanshire and Stirling Councils, the Performance Framework, and each of the supporting delivery plans (in the form of the various strategies which are hyperlinked within this document) all form part of the Strategic Plan.

During the life of the Strategic Plan further work will be carried out to develop the detailed priority and implementation plans; the three Locality Plans; and a review of our Market Facilitation Plan.



Legislative and Strategic Context

This plan is written within a wider context of health and social care reform in Scotland. Primarily, the Integration Joint Board for Clackmannanshire and Stirling has been established under the Public Bodies (Joint Working) (Scotland) Act 2014, with further legislative and policy requirements informing how the IJB directs services.

National	Local
<ul style="list-style-type: none">•The Public Bodies (Joint Working) (Scotland) Act 2014•The Social Care (Self-directed Support) (Scotland) Act 2013•Community Empowerment (Scotland) Act 2015•Equality Act 2010•Alcohol, Drug and Tobacco Strategies•Carers (Scotland) Act 2016	<ul style="list-style-type: none">•Joint Strategic Commissioning Plan for Older People's Care 2013-2023•Autism strategy•Mental Health strategy•Dementia Strategy•Clackmannanshire and Stirling Integrated Carers Strategy implementation Plans•Clackmannanshire and Stirling Integrated Care Programme•NHS Forth Valley 'Shaping the Future' Healthcare Strategy 2016-2021•Forth Valley Primary Care Improvement Plan 2018-2021

Carers (Scotland) Act 2016

This legislation provides a framework to support unpaid carers with the support they require to continue in their caring role if they wish to do so. It has a range of new provisions relating to the identification, assessment and support of unpaid carers, while promoting well-being through carer support plans.

Community Empowerment (Scotland) Act 2015

This legal framework for community planning gives rights to community bodies, and requires the publication of Local Outcome Improvement Plans (LOIPs) via community planning partnerships. There are consistent messages within both LOIPs of Clackmannanshire and Stirling to support the need for partnership approaches to effectively tackle inequalities in society. This plan is mindful of the need to reduce inequalities and promote lifestyles and choices which are conducive to good health.

[Stirling Council Local Outcomes Improvement Plan \(LOIP\) 2017-2027](#)

[Clackmannanshire Council Local Outcomes Improvement Plan \(LOIP\) 2017-2027](#)

Free Personal Care for under 65's

The Scottish Government has committed to the extension of free personal care to all under 65's regardless of condition from 1 April 2019. The extension of the previous policy will have implications which will be reflected within the Medium Term Financial Plan for the Integration Joint Board, as well as assessment and review implications to ensure appropriate delivery and access to this policy.

A Connected Scotland: our strategy for tackling isolation and loneliness and building stronger social connections

The Scottish Government published its first strategy to tackle isolation and loneliness in December 2018. This document establishes a set of values within which all people are treated with kindness, dignity and compassion.

Public Health Priorities for Scotland

The Public Health Priorities for Scotland were launched in June 2018 by the Scottish Government and COSLA. These priorities were developed through a process of extensive consultation and reflect a consensus on the most important things Scotland as a whole must focus on over the next decade to improve public health and address health inequalities. They are intended as a foundation for public services, Third Sector, community organisations and others to work better together to improve health, address health inequalities, and empower people and communities to support more preventative approaches.

The 6 Public Health Priorities resonate with the vision of Clackmannanshire and Stirling Health and Social Care Partnership to live well in supportive communities, and there is a need for the Partnership to work closely with colleagues in Public Health to develop preventative approaches which are sustainable and socially inclusive.

Scotland's Digital Health and Care Strategy

This strategy was published in 2018 and addresses the potential of digital technologies in supporting people to live better, connected lives, while accessing their health and care supports in new, innovative ways. The two main aims of this strategy are to empower citizens to better manage their health and well-being, while building appropriate systems and governance which support the effective flow of information between and within services to enable the transformation of health and social care.

Clackmannanshire & Stirling Health and Social Care Partnership webpage

First Iteration of HSCP Strategic Plan 2016-19: The Strategic Plan sets out how services will be delivered across Clackmannanshire and Stirling over this three years period. It explains what the Partnership's priorities are, why and how they were decided upon.

Strategic Needs Assessment – Add hyperlink once SNA approved

NHS Forth Valley Dementia Strategy, 2017-2020: This is a three year strategy which aims to continually improve the care and experience of people with dementia across Forth Valley. Its shared vision is that by 2020 NHS Forth Valley will be a 'Dementia Friendly' community recognised as delivering safe, effective and person centred care for the population of Forth Valley. NHS Forth Valley's Healthcare Strategy (2016-2021) supports people with dementia by identifying the need for enhancement of community based services as well as psychiatric liaison services for older adults in the hospital.

Shaping the Future – Healthcare Strategy 2016-2021: The strategy was developed following a major review of clinical services across Forth Valley. It outlines ten key priorities which will guide how local health services will be delivered across Forth Valley over the next five years. These are prevention, person-centred, inequalities, personal responsibility, closer to home, partnership working, planning ahead, minimising delays, reducing variations and workforce.

The effectiveness of strategic planning in the Clackmannanshire and Stirling Partnership

Following an inspection jointly undertaken by the Care Inspectorate and Healthcare Improvement Scotland between January and June 2018, their findings were published in a report in November 2018. The report notes areas of good practice and makes recommendations on how the HSCP can move forwards more effectively and efficiently with the integration of Health and Social Care.

Health and social care integration: update on progress

In November 2018, Audit Scotland published a report suggesting that while some improvements have been made to the delivery of health and social care services, Integration Authorities, councils and NHS boards need to show a stronger commitment to collaborative working to achieve the real long term benefits of an integrated system

Health and Social Care integration: progress review

In February 2019, a report was issued from the Ministerial Strategic Group for Health and Community Care, which reviewed the progress and drew together proposals for ensuring the success of integration.

Health and Care Standards Scotland's new Health and Social Care Standards – my support, my life, were published in June 2017, for use from April 2018. These standards seek to provide better outcomes for everyone using health and social care services in Scotland, ensuring that a human rights approach is in place to uphold individual respect and dignity.

Suicide prevention action plan: every life matters is the new action plan from Scottish Government designed to continue the work from the 2013-2016 suicide prevention strategy.