Clackmannanshire and Stirling

Strategic Plan

2016 - 2019

Health and Social Care Partnership

Contents

Foreword

Our vision is to enable people in the Clackmannanshire and Stirling Health & Social Care Partnership area to live full and positive lives within supportive communities.

Clackmannanshire Council, Stirling Council and NHS Forth Valley have put in place new partnership arrangements to deliver adult health and social care services. This is to improve the health and wellbeing of our residents. We want to ensure that people have healthier, fuller lives and live as independently and safely as possible in their own communities. We will also make best use of all of the resources available to address the agreed priorities for the partnership.

We know that the proportion of older adults in our population is increasing and that more people have complex needs. We also know that there are significant differences and inequalities – between and within our communities. We are committed to working with all our partners to prevent and reduce inequalities, promote equality of access and tackle patterns of ill health in communities.

We want to ensure that we engage with individuals and their unpaid carers at an early stage in their care journey and avoid, wherever possible, unplanned admissions to hospital. Getting involved at an early stage can lead to better long term outcomes. People living with a number of long-term and complex health conditions have a better quality of life when they are able to manage and be more in control of their health and care.

We have developed this three-year plan which sets out how we will deliver services to meet current need but also the needs of the population in the future. Fundamental to this will be making best use of resources to deliver efficient and effective health and social care.

This plan has been developed with help and comment from many individuals and groups. We would like to take this opportunity to thank everyone who has given their time to attend events, respond to the consultation questions, and contributed to sections of the plan. All of your involvement is appreciated and over the coming years we look forward to engaging with everyone who has an interest in health and social care to help deliver on our Plan.

Shiona Strachan
Chief Officer,
Clackmannanshire & Stirling,
Health and Social Care Partnership

Background to Health & Social Care Integration

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 will also be extended 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.

The Strategic Plan

This document, the Strategic 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 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.

Localities

The Clackmannanshire & Stirling Partnership area will be divided into three smaller areas called localities. 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. Further service and condition related planning will be undertaken over the coming period including the development of locality and neighbourhood plans to tailor services to local circumstances.

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 Single Outcome Agreements.

The Case for Change

Why do we need to change?

We recognise that the way we provide care needs to change in order to meet both current and future challenges. If we do nothing, health and care services as they are will not be able to deliver the high quality service we expect. Research at a national level along with local conversations has shown that there are a number of reasons why we need to change, which include:

- Those who use our services are asking us to deliver more integrated care
- More people are living longer, many with a range of conditions and illnesses, therefore demand for existing services is changing
- We need to continuously improve services and contribute to better personal outcomes
- There is an opportunity to make better use of public resources.

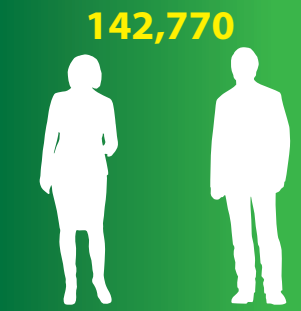
In the following graphs and tables we present a snap shot of information that helps to show the scale and nature of the need for Health and Social Care services across Clackmannanshire & Stirling and some key characteristics of the current population.

A Strategic Needs Analysis containing much more comprehensive information, statistics and analysis relating to a range of conditions specific to each local authority area will be published in 2016. Further work will be undertaken during 2016 to provide Strategic Needs Analysis information at a more local level and this will be used to inform the locality planning work referred to previously on page 3. This will ensure implementation is tailored to specific local needs for example needs experienced in rural areas or areas where there are higher levels of drug or alcohol misuse.

Profile of Clackmannanshire Council & Stirling Council Areas

The total population of Clackmannanshire is expected to stay relatively stable between now and 2037 while the population of Stirling is expected to rise steadily up to 2037. During this period we expect to see a pronounced increase in the number of people aged 65 years and over in both areas, and this includes a more than doubling of the population of people aged 75 years and over.

Clackmannanshire and Stirling Population 2014

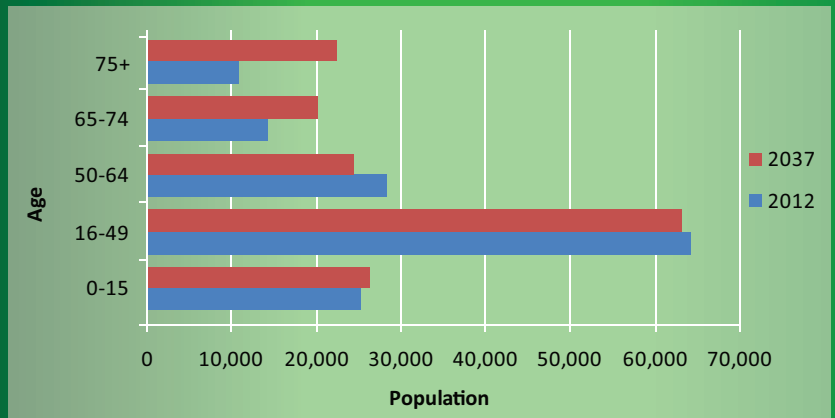


Age 0-15	24,618	17.2%
Age 16-49	63,021	44.1%
Age 50-64	28,926	20.3%
Age 65-74	14,942	10.5%
Age 75+	11,263	7.9%

Source: NRS 2014 mid-year population estimates.

The table above tells us that in 2014 Clackmannanshire & Stirling had a combined population of 142,770, with 73,674 females and 69,096 males.

Population Projections and Age Distribution Clackmannanshire and Stirling



Source: NRS 2014 mid-year Population estimates

The bar chart above shows age groups for the population of Clackmannanshire & Stirling in 2012 and estimated figures for the same age groups in 2037.

Household Composition
Clackmannanshire and Stirling

	C & S	Scotland
One-person household, aged under 65	18.5%	21.6%
One-person household, aged 65+	12.8%	13.1%
Couple / family everyone aged 65+	8.5%	7.5%

Source: 2011 Census

The table above shows the make up of households in Clackmannanshire & Stirling compared to Scotland from the 2011 Census.

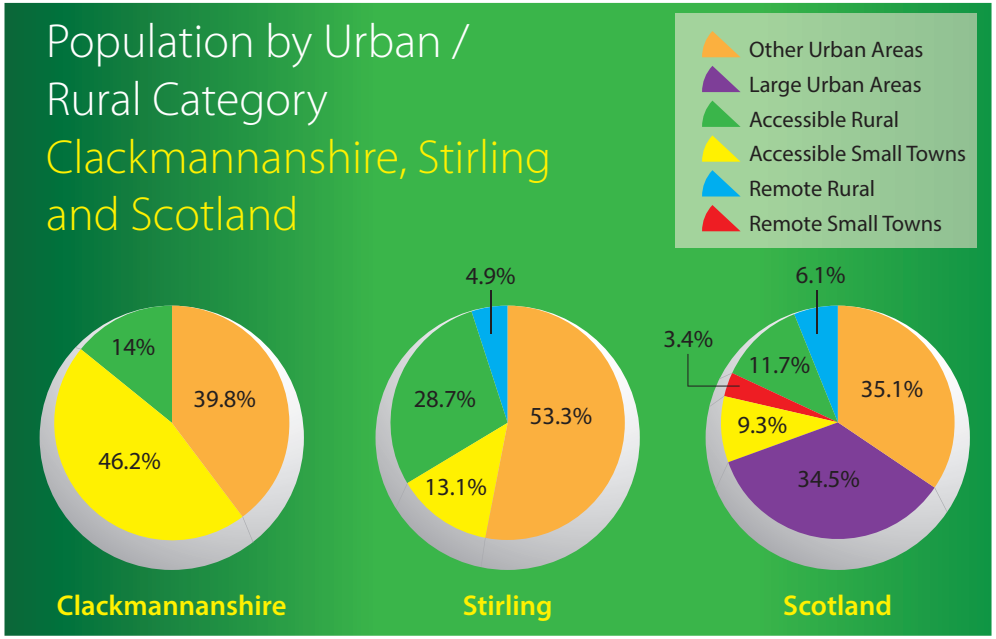
People with a Disability
Clackmannanshire and Stirling

People with a Learning Disability known to GP practices *	707
People with a Physical Disability ^	9,252
People with a severe mental health condition known to GP practices ❖	1,178

* Source: QOF register 2014
^ Source: 2011 Census
❖ Source: QOF as at March 2014

The combined 'People with a Disability' information presented above compares favourably to equivalent rates across Scotland. Clackmannanshire has slightly higher than the national average rates of people who have learning disabilities and people who have physical disabilities. Stirling has below the national average rates for all three classes of disability and Clackmannanshire also has a lower than the national average rate of people who have a severe mental health condition known to GP practices.

Population by Urban / Rural Category
Clackmannanshire, Stirling and Scotland

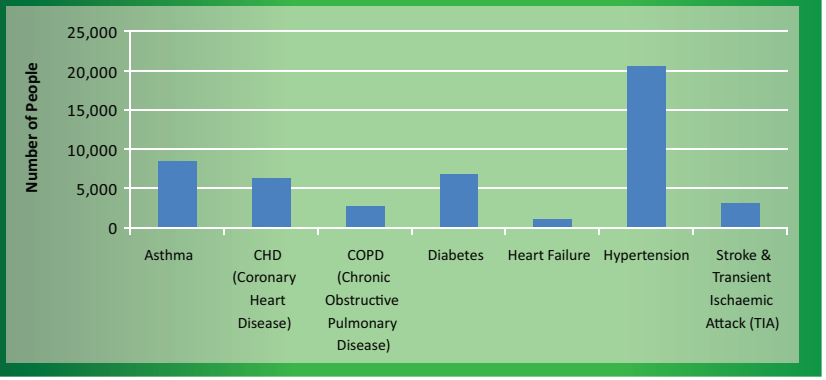


Source: Scottish Government Urban/Rural Classification 2013/14 and National Records of Scotland.

The Population by Urban / Rural Category information presented above shows that both Clackmannanshire and Stirling have a significantly different pattern of settlement types and locations compared with the average for Scotland. Neither Clackmannanshire or Stirling have any Large Urban areas.

It should be noted that Stirling has just over one third of its population living in a combination of Accessible Rural and Remote Rural areas compared with 14% in Clackmannanshire and almost 18% on average across Scotland.

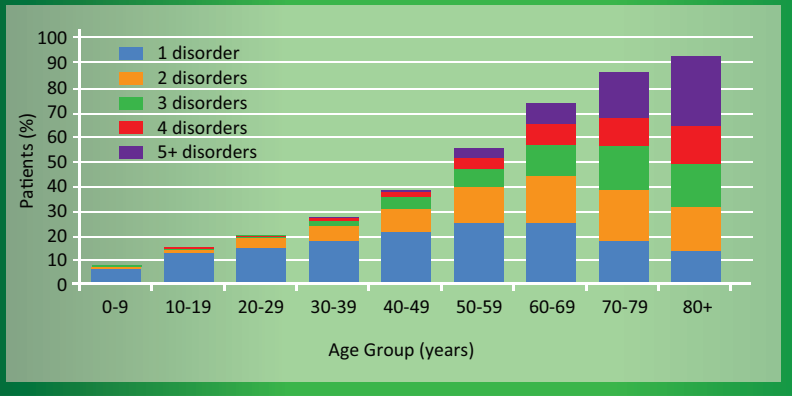
Long Term Conditions
Clackmannanshire and Stirling



Source: QOF as at March 2014

The bar chart above shows the number of people in Clackmannanshire & Stirling with a long term condition such as asthma or hypertension.

Estimated Number of Long Term Conditions by Age Group Clackmannanshire and Stirling



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

The bar chart above shows the percentage of patients by age category and the number of long term conditions they are estimated to have.

Dementia Clackmannanshire and Stirling

People diagnosed with Dementia **1,073**

Alzheimer Scotland estimate of number of people with Dementia **2,345**

Source: QOF as at March 2014

The table above shows (based on 2014 data) there are 1,073 people diagnosed with Dementia in Clackmannanshire & Stirling, while Alzheimer's Scotland estimate the number of people living with Dementia in Clackmannanshire and Stirling to be approximately 2,345.

Hospital Inpatient Care 2010-12
Clackmannanshire and Stirling

People who had emergency admissions to hospital **26,107**

People aged 65+ with two or more emergency admissions in a year **2,891**

Source: ScotPHO Health and Wellbeing Profiles 2014

The table above shows (based on 2014 data) that there were 26,107 emergency admissions to hospital from Clackmannanshire & Stirling during 2010 to 2012 and of those admissions 2,891 people were aged 65+ and had 2 or more emergency admissions within a 12 month period.

The Estimated Number of Long Term Conditions by Age Group graphic to the left demonstrates that as the proportion of older adults increases in Clackmannanshire and Stirling there will be an increase in the number of people with multiple long term conditions e.g. diabetes; heart and lung conditions.

People with more than one long term condition are currently making many trips to hospital clinics to see a range of specialists which might be coordinated in a better way.

Alcohol & Drug Misuse
Clackmannanshire and Stirling

Indicator	Clackmannanshire	Stirling	Scotland
Alcohol related hospital stays*	510.5	456.2	696.9
Alcohol related mortality*	38.9	16.7	21.4
Drug related hospital stays*	79.9	89.5	124.6
Drug related mortality*	14.7	6.6	10

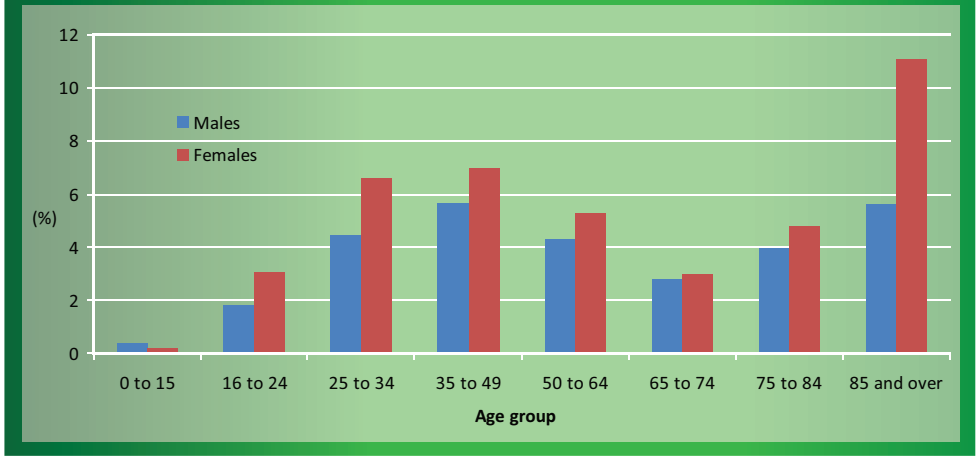
Source: ScotPHO Drug Profile 2013/14 *rate per 100,000 population

Alcohol related mortality is the rate per 100,000 people where alcohol is the underlying cause of death. The rate in Clackmannanshire was slightly above the national rate in 2009, fell below the national average for the following three years, only to rise above it in 2013. In Stirling, the alcohol related mortality rate has been below the Scottish average in each year from 2009 to 2013.

In 2012/2013 across Clackmannanshire and Stirling there were an estimated 1,450 people aged 15-64 experiencing problem drug use. Problem drug use can lead to a number of health and social problems. The estimated prevalence of those with a problem drug use has increased in Clackmannanshire and Stirling between 2009/10 and 2012/13.

This is in contrast to Scotland as a whole, where the estimated percentage of the population experiencing problem drug use has fallen slightly.

Long Term Mental Health Conditions, Percentage of Population within Gender and Age Group.
Clackmannanshire and Stirling



Source: 2011 Census

The bar chart above is taken from the 2011 household census. The bar chart illustrates the percentage of the population in Clackmannanshire and Stirling who have identified themselves or someone in their household as having a mental health condition, split across gender and age. The question does not define a mental health condition or take into account multiple mental health conditions.

The Carers Strategy for Scotland 2010-2015 states that "Carers are equal partners in the planning and delivery of care and support. There is a strong case based on human rights, economic, efficiency and quality of care grounds for supporting carers. Without the valuable contribution of Scotland's carers, the health and social care system would not be sustained. Activity should focus on identifying, assessing and supporting carers in a personalised and outcome-focused way and on a consistent and uniform basis."

The green box below highlights how many people have been identified as providing unpaid care in the Clackmannanshire and Stirling Partnership area and acknowledges there are likely to be many more.

Carers

12,958 People in the Clackmannanshire and Stirling Partnership area identified themselves as unpaid carers. (2011 Census)

Approximately 1/3 of these unpaid carers are known to local services

It is estimated that there are as many as **10,000** more unpaid carers in the Partnership area – 23,000 in total (Scottish Health Survey, 2013)

1,386 carers in Clackmannanshire provide **50** plus hours unpaid care per week (2011 Census)

1,991 carers in Stirling provide **50** plus hours unpaid care per week (2011 Census)

Our Vision and Outcomes

Our Local Vision and Outcomes

Our **Vision** is to enable people in the Clackmannanshire and Stirling Health & Social Care Partnership area to live full and positive lives within supportive communities.

Our local outcomes are based on the national Health and Wellbeing Outcomes and were developed in partnership with all stakeholders:

- **Self-Management** - Individuals, their unpaid carers and families are enabled to manage their own health, care and wellbeing;
- **Community Focused Supports** – Supports are in place, they are accessible and enable people, where possible, to live well for longer at home or in homely settings within their community;
- **Safety** - Health and social care support systems help to keep people safe and live well for longer;
- **Decision Making** - Individuals, their carers and families are involved in and are supported to manage decisions about their care and wellbeing;
- **Experience** – Individuals will have a fair and positive experience of health and social care

Outcomes

There are nine National Health and Wellbeing Outcomes set by the Scottish Government that our Partnership will deliver against:

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.

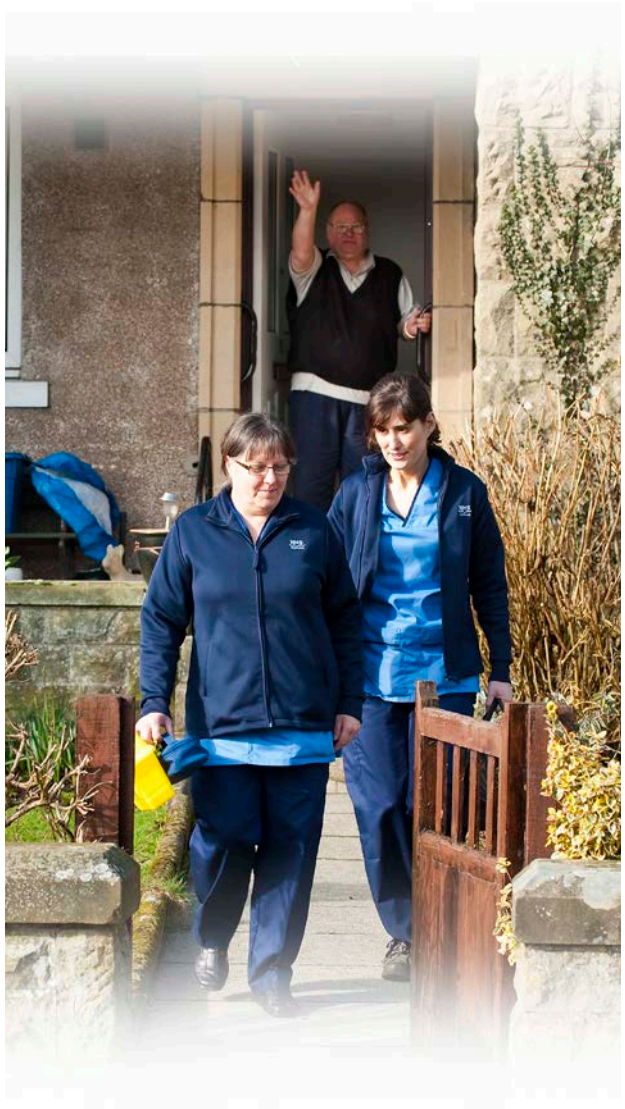
How we will achieve Improved Outcomes

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

What does all of this mean for you?



Services working in partnership

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.

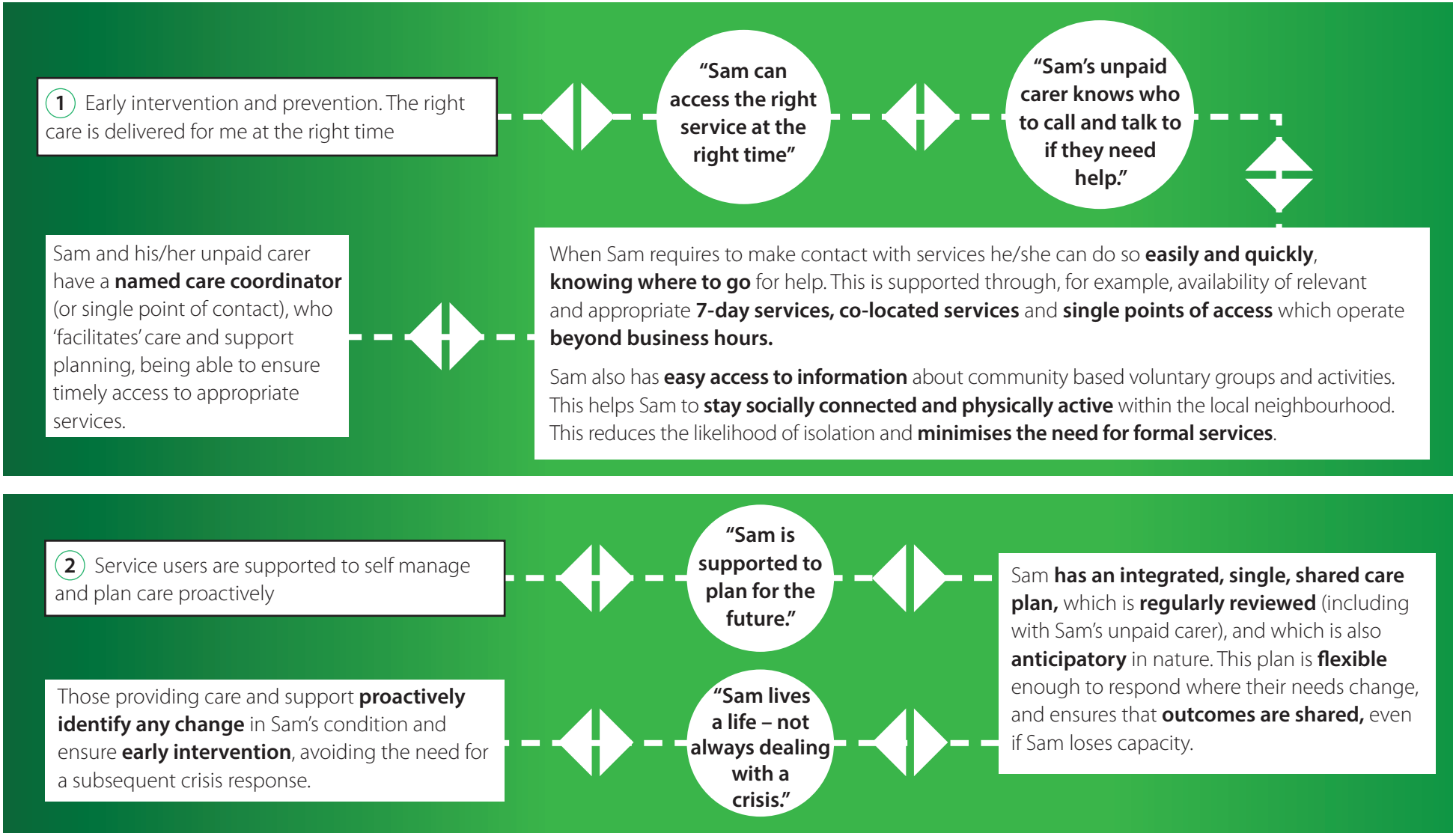
We recognise the critical role of the whole workforce in determining the success of partnership working. It is essential that our plans are informed and owned by those who work most closely with service users, their families and carers and their local communities. This will include volunteers and staff 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.

We held staff engagement events across Clackmannanshire and Stirling and these were attended by colleagues from the third and independent sectors as well as health and social care staff. We encouraged and supported participants to imagine a more integrated future and asked them to describe what this would look and feel like from the perspective of an individual using health or social care services. The individual was given a generic name - Sam - so that they could be either male or female. Everyone's 'Sam' experienced different health and care needs and was in contact with different services. Through completing this exercise, we identified key themes that would enable integrated services to make things better for Sam.

In the following section we will describe the key themes.

Key Themes and Ambitions

Keeping SAM at the centre and using material gathered as part of the engagement sessions and from other events, we have identified our ambitions for what an 'integrated future' should look like for each Theme:



3 Service Users exercise Choice & Control

"Sam takes on responsibilities for his/her care and has fewer unnecessary intrusions into his/her life"

Sam is **supported to self-manage**, through education and awareness-raising. This is balanced by ensuring that Sam and Sam's unpaid carer know who to contact/where to go, should he/she need help. **Technology solutions** are in place which enables Sam to be more independent, by providing care closer to home. Care is better co-ordinated, with fewer people involved, consistent faces, and a frequency of involvement matched to Sam's needs.

Sam is **well- informed,** has a clear understanding of **what to expect and from whom**, and is able to access all of the necessary information. Sam is in control, having **choice and ownership** of care arrangements (e.g. through Self-directed Support), including **where and when it is provided.**

"Sam has the information to make decisions about what he/she needs."

4 Staff are skilled and supported to deliver person-centred and integrated care

"Sam's care is wrapped around his/her needs, not the other way round."

Sam and Sam's unpaid carer receive **high-quality, holistic, person-centred, outcomes-focussed** care, which meets their individual needs and is **effectively coordinated and streamlined** even when moving between services.

5 Carers are supported to look after their own health and well-being and are recognised as equal partners in the design and delivery of care

"Sam's unpaid carer is fully involved and engaged as an equal partner by all health and care providers"

Unpaid carers are themselves **well-supported**, their own needs having been assessed and met in a timely manner.

6 There is a focus on Rehabilitation, Recovery and Reablement across all services. There are fewer avoidable admissions and discharge planning is effective and efficient.

"Sam does not require unplanned, emergency, hospital care"

If Sam is admitted to hospital; effective joint planning takes place (including with Sam's unpaid carer) to ensure a **smooth, safe and timely discharge. Rehabilitation and reablement** services are in place which help Sam to remain at home, or to return home quickly, but safely, following a period in hospital.

7 Services work together with communities to improve access to services and build capacity – working with third sector and community groups across and within localities. This reduces health inequalities within and across our communities.

"Sam is able to stay at home and participate in community activities"

"Sam and Sam's unpaid carer have access to additional, targeted information and advice to support them to manage their health & care needs"

This is supported through improved availability and use of **assets within the community**.

Our Priorities

In order to address the key themes presented on the previous pages and to achieve our ambitions for Sam **we will**:

- **Further develop systems to enable front line staff to access and share information** across professions and organisations. This will enable people receiving services, named care coordinators, and other relevant staff to minimise the time spent duplicating assessment and maximise opportunities to create 'seamless' personal outcomes focused care.
- **Support more co-location of staff from across professions and organisations** to enable working in an integrated way where this facilitates the best quality of care, support, and enablement/independence to be achieved.
- **Develop single care pathways** which recognise that there are many more conditions than services available. While one size doesn't fit all there are benefits to be had from providing consistent and predictable processes.
- **Further develop anticipatory and planned care services** for people with multiple long term conditions. This will include people with dementia and will be tailored to meet people's preferred personal outcomes and maximises their ability to be actively involved in managing their own conditions.
- **Provide more single points of entry to services** where named care coordinators help people receive more holistic services. Internal links will be made to any other services and supports needed rather than service users approaching each service anew.

- **Deliver the Stirling Care Village** to realise many of the expected benefits of greater levels of Health & Social Care Integration. This will include improved personal outcomes and reduced numbers of assessments by demonstrating many of the innovations noted above.
- **Develop seven-day access to appropriate services** to maximise quality of care; the potential for rehabilitation and recovery; and flow through acute and community services.
- **Take further steps to reduce the number of unplanned admissions to hospital and acute services** by supporting more prevention, early intervention (including Technology Enabled Care), and community based services. This includes medical and social forms of prevention that could impact on future health such as providing information about local groups and activities that can help people stay socially connected and physically active along with more 'Keep Well' style health screening and support.

The decisions associated with our priorities identified in this section of the Strategic Plan will be based on the efficient and effective use of available resources, what we already know works well in this area, and from the evidence base and findings of well conducted local, national, and international research.

Case Studies

We already have good examples of how joined up working between health, social care, the independent and third sector can make a difference. We know that our staff are keen to build on existing relationships and remove barriers to joined up working. The focus will be on co-locating and integrating teams, starting where there is already evidence of joint working, and supporting more streamlined and coordinated pathways for those who use our services.

Below are some examples that have been shared with us about how services across Clackmannanshire and Stirling are working together to support better outcomes:

Mary had a Stroke and was admitted to hospital. She is now ready to go home, but not yet able to live independently on her own as she did before.

Mary needs help with everyday tasks such as showering, walking, meal preparation and shopping. This usually involves Homecare, Physiotherapy, Occupational Therapy, meal delivery, social care for some equipment and emergency alarm as well as potentially some other community based supports.

Through one assessment, by an Occupational Therapist from the Integrated Reablement Team, Mary agrees a care plan which deals with all of her needs. Equipment is promptly provided and the Reablement Home Carers visit Mary twice a day to help her return as far as possible to her former independent self.

Mary is reviewed regularly by the Occupational Therapist or Physiotherapist and after three months Mary no longer needs homecare. With the Reablement Home Carers support she has met her goals of walking to the local shop and carrying out most everyday tasks.

With some extra bathing equipment, meal delivery service and a community alarm, Mary feels safe and happy to live at home independently

Janet is 27 and has a long term mental illness. She lives at home on her own. She has found it difficult to maintain relationships with family and friends. While she would very much like to work, this has been difficult due to frequent episodes of mental illness. Janet has experienced times of crisis in her life and she has been detained in hospital due to significant concerns about her safety in the community.

Janet is now supported by the Integrated Mental Health Team based at her local Resource Centre. She has a key worker who has supported Janet to develop care management and risk management plans.

Having these arrangements in place enables Janet and those that support her to recognise when her mental health is fragile and what supports are likely to enable Janet's mental health to stabilise once again. She can contact her key worker and, if necessary, a prearranged plan can be put in place before a crisis results in her returning to hospital.

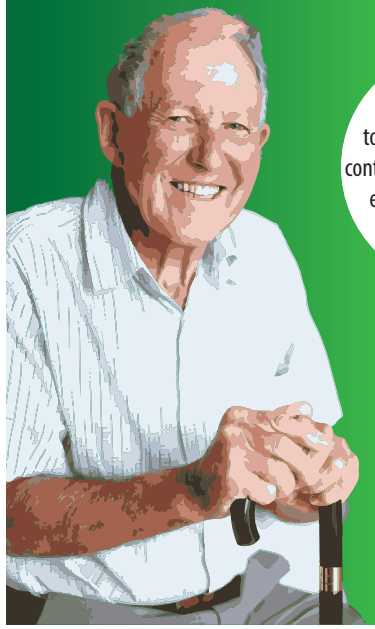
With Janet feeling confident that services will support her in the way which she has identified as being effective and at the time she needs them, she is confident that she can cope better through developing social contacts in group work settings and by undertaking voluntary work with a view to employment in the future.

Janet has avoided falling into crisis and has not required emergency treatment in many months. She continues to be able to access support as and when she has identified she requires it. She feels far more in control.

Mr Brown (81) lives at home with his wife and had fallen three times during the night within 4 months. The social care Mobile Emergency Care Service (MECS) had been called each time. Mrs Brown is frightened that her husband will not be able to stay at home with her if he keeps on falling. She wants to continue to care for him but she does not know how she can do this and keep them both safe.

MECS support a falls pathway and they automatically alerted the falls service to Mr Brown's case and a full falls assessment was offered and completed.

The assessment identified that Mr Brown had difficulty locating the toilet at night, he had a recent diagnosis of dementia, his medications made him drowsy and his mobility was slower than would be expected.



Mr Brown is now able to safely go to the toilet at night and continues his falls prevention exercises with his wife. He has not fallen again.

Mr Brown was offered an enhanced Telecare solution in the form of an alternative sensor light. He was also offered a short course of therapeutic day care where he learned strength and balance exercises and he saw his GP to discuss his medication.

Mrs Brown was supported to access a regular short break to enable her to both continue within her caring role and to sustain a life out with it.

Mrs Smith was a resident in a local Independent Sector Care Home for the last six months of her life, due to a progressing life limiting condition.

NHS Forth Valley and Strathcarron Hospice have supported the care home staff to develop good quality skills and knowledge about providing quality end of life care.

Care home staff were able to initiate sensitive conversations with Mrs Smith and her family regarding progression and management of her illness early in her care.

Through sensitive discussion an advanced care plan tailored to her needs was developed. This included her wishes regarding her physical, psychosocial and spiritual outcomes and also decisions with regards to resuscitation. Her GP was involved and key information on her medical records updated.

Mrs Smith died peacefully in her care home with her family present. The family felt their mother had a good death and her care had been excellent.

Due to anticipating needs and planning for advanced care, no crisis arose, no Out of Hours medical calls were required and no admission to hospital was necessary.

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 will be 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.

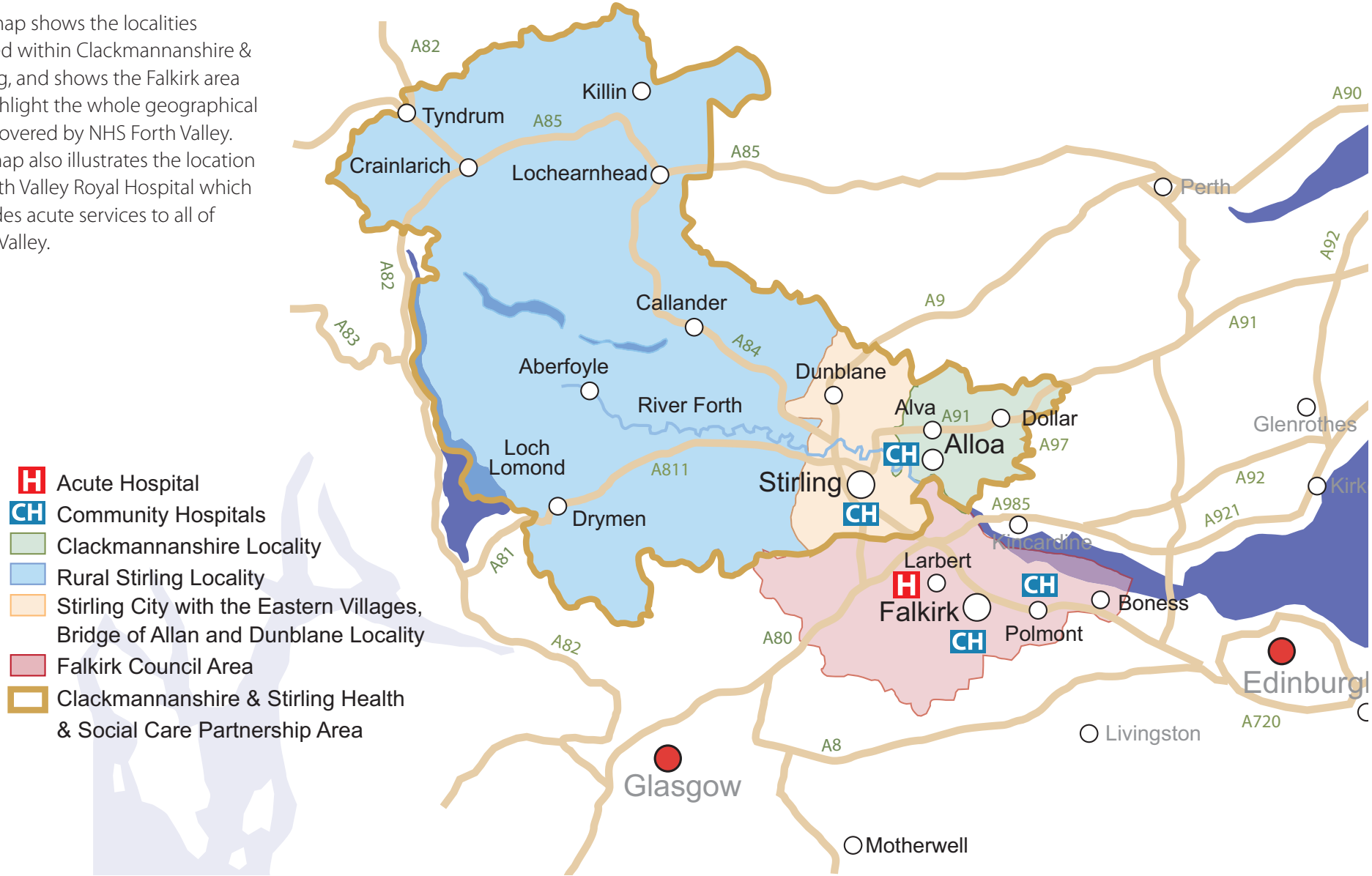
The three localities are:

- Clackmannanshire - Population 51,280
- Stirling City with the Eastern Villages, Bridge of Allan and Dunblane - Population 70,222
- Rural Stirling - Population 21,038

*Population figures are mid year estimates from 2013 Scottish Neighbourhood Statistics

Geographical Profile of Forth Valley

This map shows the localities created within Clackmannanshire & Stirling, and shows the Falkirk area to highlight the whole geographical area covered by NHS Forth Valley. The map also illustrates the location of Forth Valley Royal Hospital which provides acute services to all of Forth Valley.



Which Health and Social Care Services are included within Integration?

Our partnership will be 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 will have 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 will include 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 will make the most of opportunities to work in partnership directly with communities in the planning and design of services.

NHS Forth Valley Services

Community based services

- 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, and provision of assistance including aids and adaptations, and gardening assistance
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement 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 listed below.

- 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

Housing Contribution Statements

Housing providers have for many years contributed positively to improving health and well-being across our communities. It is not only about enabling independent living for people, but also being more effective in helping to prevent admissions to hospital, alleviating delayed discharge and contributing to tackling health inequalities affecting the population.

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.

Housing Contribution Statements have been developed for Clackmannanshire and Stirling on an individual local authority basis and can be accessed on the Clackmannanshire & Stirling Integration web-page.

Snapshot of Local Services

Did you know?

Across Clackmannanshire and Stirling:

Community Nurses provide more than **1500 home visits and treatment room appointments each week.**

Community Rehabilitation Teams (ReACH) assess more than **60 new people** who have been referred with rehabilitation / reablement needs, and make around **300 community based visits, each week.**

Social Services commission **11,500 hours per week of post reablement Personal Care at Home** from private sector providers that is provided free of charge to service users.

Integrated Mental Health Services in Clackmannanshire **receive 200 appropriate referrals per month** and strive to maximise the proportion of referrals that are picked up by community based mental health services (current target is 65%). A similar approach is being adopted across Stirling.

Care Homes for Older People contracted with Social Services are at 90% occupancy levels with **228 beds across 4 care homes in Clackmannanshire** and **511 beds across 13 care homes in Stirling.**

The Financial Plan

Partnership Budget

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

The partnership budget for 2016/17 totals £165.265m.

The budget is made up from contributions from the NHS Forth Valley, Clackmannanshire Council and Stirling Council as follows:

	£m
Clackmannanshire Council	£15.322
NHS Forth Valley	£115.912
Stirling Council	£29.524
Partnership Funding	£4.507
Total Partnership Budget 2016/17	**£165.265**

The partnership budgets have been set taking into account:

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

Financial and Economic Outlook

The UK Spending Review published in November 2015 and the subsequent Scottish Draft Budget set out the short to medium outlook for public finances of year on year real term reductions in overall public expenditure until 2020. This financial settlement is set against the demographic pressures outlined within the Strategic Needs Assessment and the need to redesign services to meet our vision and outcomes. The Integration Joint Board will require to ensure that all of the redesigned and commissioned services contribute to the delivery of the eight priorities identified within this Strategic Plan. This will be achieved through a process of review and closer alignment of the changes already underway within the partner agencies during 2016/17.

In the early part of financial year 2016/17 the Partnership will develop a Financial Plan to underpin this Strategic Plan setting out how it intends to best utilise the resources available to meet the priorities stated within this plan. It is the intention to develop a Financial Plan covering 3 years to allow medium to longer term service planning.

Development of this Strategic Plan and Next Steps

The improved service delivery methods proposed as part of Health and Social Care Integration have not been developed in isolation. The approaches detailed in this plan are the result of many cycles of continuous improvement, national guidance and strategies, and many local strategies and plans. A summary of some of the national guidance and legislation, local strategies, plans, processes and events is provided below:

- National
  - The Public Bodies (Joint Working) (Scotland) Act 2014;
  - The Social Care (Self-directed Support) (Scotland) Act 2013; and
  - Community Empowerment (Scotland) Act 2015.
  - Equality Act 2010
  - Alcohol, Drug and Tobacco Strategies
- Local Plans and Strategies
- Joint Strategic Commissioning Plan for Older People's Care 2013-2023
- Autism strategy
- Mental Health strategy
- Clackmannanshire and Stirling Integrated Carers Strategy implementation Plans
- Clackmannanshire and Stirling Integrated Care Programme

Developing the Plan & Consultation

The Strategic Plan was developed as a result of a series of engagement events held during 2015 and it was consulted upon between the 18 November and the 24 December 2015. The resulting comments have shaped the final version of the plan. A report outlining the results of the consultation process is available on the Clackmannanshire & Stirling Integration web-page.

Participation and Engagement

The process undertaken to develop the Strategic Plan has been underpinned by the Partnerships desire to ensure the participation and engagement of all stakeholders. A Participation and Engagement Strategy is available on the Clackmannanshire & Stirling Integration web-pages.

How will we know we have been successful?

A Performance Framework is being developed based on national guidance and national and local indicators. This will also help to measure progress against the national and local outcomes. The framework is available on the Clackmannanshire & Stirling Integration web-page.

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, the Participation & Engagement Strategy, and the Easy Read version 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 the Market Facilitation Plan.

Glossary

Acute Care is a branch of health care where people receive active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. Acute care services are generally provided in a formal hospital setting.

Anticipatory Care / Plans can take many forms however it is expected to help reduce avoidable and unscheduled acute admissions for people with pre-existing conditions. The purpose of advanced/ anticipatory care planning is to support the individual to have greater choice, and control of care preferences through communication across the support team, across agencies and across care settings.

The **Body Corporate** Model is a model of integration where a Health Board and Local Authority delegate the responsibility for planning and resourcing service provision for health and social care services to an Integration Joint Board, established as a separate entity.

Health Inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. Health Inequalities do not occur randomly or by chance, but are socially determined by circumstances largely beyond an individual's control. These circumstances disadvantage people and limit their chance to live a longer, healthier life.

The **Housing Contribution Statement (HCS)** sets out the arrangements for carrying out the housing functions delegated to the Integration Authority under the Public Bodies (Joint Working) (Scotland) Act 2014.

The **Independent Sector** encompasses those traditionally referred to as the 'private' sector. It includes organisations of varying types and sizes, amongst them single providers, small and medium sized groups and national providers.

Long Term Conditions (LTC) are conditions that last a year or longer, impact on many aspects of a person's life, and may require ongoing care and support. The definition does not relate to any one condition, care group or age category, so it covers adults and older people as well as children and mental as well as physical health issues. Common long term conditions include epilepsy, diabetes, some mental health problems, heart disease, chronic pain, arthritis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease (COPD).

Reablement is about giving people the opportunity and the confidence to relearn/regain some of the skills they may have lost as a result of poor health, disability / impairment or entry into hospital or residential care. As well as regaining skill, reablement supports service users gain new skills to help them maintain their independence.

ReACH is an NHS Forth Valley Service which provides outreach Physiotherapy and Occupational Therapy services covering "**Re**habilitation & **A**ssessment in **C**ommunity & **H**ome".

Strategic Commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together, often from a pooled or aligned budget. (National Steering Group for Strategic Commissioning 2012)

The **Strategic Needs Assessment** is an analysis of the health and social care needs of the population to inform and guide service planning. The main goal of the Strategic Needs Assessment is to accurately assess the health and care needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities.

Technology Enabled Care refers to the use of telehealth, telecare and telemedicine in providing care for people that is convenient, accessible and cost-effective. These services use technology to support people to live safely and independently in their own homes, and can be helpful to people at risk of falls.

Glossary

The **Third Sector** is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as self-help groups and community groups), social enterprises, mutuals and co-operatives. It also includes local intermediary organisations (Third Sector Interfaces).

A further glossary of terms can be found on the Clackmannanshire & Stirling Integration web-page.

Publications in Alternative Formats

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