West Dunbartonshire
Health & Social Care Partnership

STRATEGIC PLAN

2015-16

CONTENTS

ACKNOWLEDGEMENTS

This Strategic Plan was formally approved at the first meeting of the West Dunbartonshire Health & Social Care Partnership Board on the 1st July 2015, this date being the integration start day from which these new arrangements commenced.

The Chief Officer and the Senior Management Team would like to thank everyone who contributed to the development of this Strategic Plan; and all those staff and colleagues who continue to work so hard to deliver high quality services to the communities of West Dunbartonshire.

Please send any feedback on this Strategic Plan to:

Mr Soumen Sengupta - Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership
soumen.sengupta@ggc.scot.nhs.uk

INTRODUCTION

The Scottish Government's Public Bodies (Joint Working) Act (Scotland) 2014 sets out the arrangements for the integration of health and social care across the country. In December 2013, the Council and the Health Board formally agreed to transition their Community Health and Care Partnership to a Shadow Health and Social Care Partnership; and for its Community Health & Care Partnership Committee to assume the role of Shadow Integration Joint Board. This decision enabled both the Council and the Health Board to jointly develop, constructively consult with stakeholders and then agree the arrangements for joint working as required by the Act, building on the effective integrated arrangements that had already been successfully developed locally; and reflecting on the considerable learning and insights that accrued in doing so.

The approved integration scheme for West Dunbartonshire details the 'body corporate' arrangement by which the Health Board and the Council have agreed to formally delegate health and social care services for adults and children to a third body, which is described in the Act as an Integration Joint Board. The Integration Joint Board for West Dunbartonshire is known as the *West Dunbartonshire Health & Social Care Partnership Board*.

The West Dunbartonshire Health & Social Care Partnership Board's:

- **Mission is to improve the health and wellbeing of West Dunbartonshire residents.**
- **Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.**
- **Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.**

Appendix 1 lists the health and social care services delegated by the Health Board and Council to the Health & Social Care Partnership Board. The purpose of this Year One Strategic Plan is to set out how the Health & Social Care Partnership Board will begin to use its allocated resources to deliver the National Health and Wellbeing Outcomes prescribed by the Act, namely that:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.

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

Given that children and families health and social care services and criminal justice social work services have also been delegated to the Health & Social Care Partnership Board the specific National Outcomes for Children and Criminal Justice will also be addressed here, i.e.:

- Our children have the best possible start in life and are ready to succeed.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
- We have improved the life chances for children, young people and families at risk.
- Community safety and public protection.
- The reduction of re-offending through implementation of the Whole Systems Approach to youth offending.
- Social inclusion and interventions to support desistance from offending.

The Health & Social Care Partnership Board is responsible for the operational oversight of *West Dunbartonshire Health & Social Care Partnership* (WD HSCP), which is the joint delivery vehicle for those integrated services delegated to the Integration Joint Board (except for NHS acute hospital services); and through the Chief Officer, who is responsible for the operational management of the Health & Social Care Partnership. These arrangements for integrated service delivery will be

conducted within an operational service delivery framework established by the Health Board and Council for their respective functions, ensuring both organisations can continue to discharge their governance responsibilities. The management of NHS acute hospital services is retained within the Health Board. In addition to local services provided for and with the residents of West Dunbartonshire, WD HSCP has formal responsibilities for a number of wider geographic functions:

- NHSGGC Eye Care Service.
- NHSGGC Musculoskeletal Physiotherapy Service.
- Management of Argyll, Bute and Dunbartonshire's Criminal Justice Social Work Partnership.

In keeping with the spirit of the participative approach of the previous Community Health and Care Partnership, this Strategic Plan has been informed by an understanding of perspectives of the strategic planning stakeholders specified by the Act (including staff side representation and the two localities identified within West Dunbartonshire) and from on-going engagement through the year with our citizens and service users, reflecting the cyclical commissioning process for the review of services. The specific local actions set out reflect on-going self-evaluation processes within the HSCP service areas; engagement within local Community Planning Partnership fora; and dialogue with both service user groups and the wider communities in West Dunbartonshire. It is underpinned by an appreciation of local health and social care needs (e.g. the area's health and wellbeing profile); and other relevant sources of evidence.

The delivery of this Strategic Plan represents a commitment on the part of all involved to establishing the new WD HSCP in an orderly fashion that emphasises continuity – and minimises potential disruption or uncertainty – for service users and staff; and that prioritises continuous quality improvement of services for the benefit of the local communities of West Dunbartonshire.

Keith Redpath
Chief Officer

STRATEGIC NEEDS ASSESSMENT

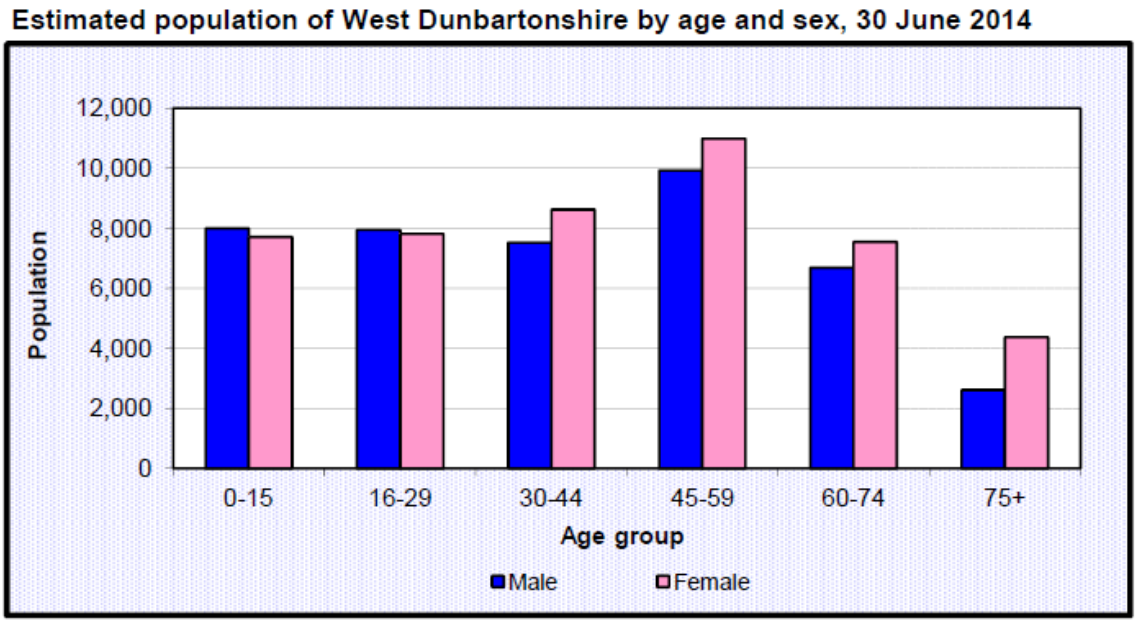
West Dunbartonshire lies north of the River Clyde encompassing urban and rural communities. According to the National Records for Scotland, the 2014 population for West Dunbartonshire is 89,730; a decrease of 0.1 per cent from 89,810 in 2013. The population of West Dunbartonshire accounts for 1.7 per cent of the total population of Scotland.

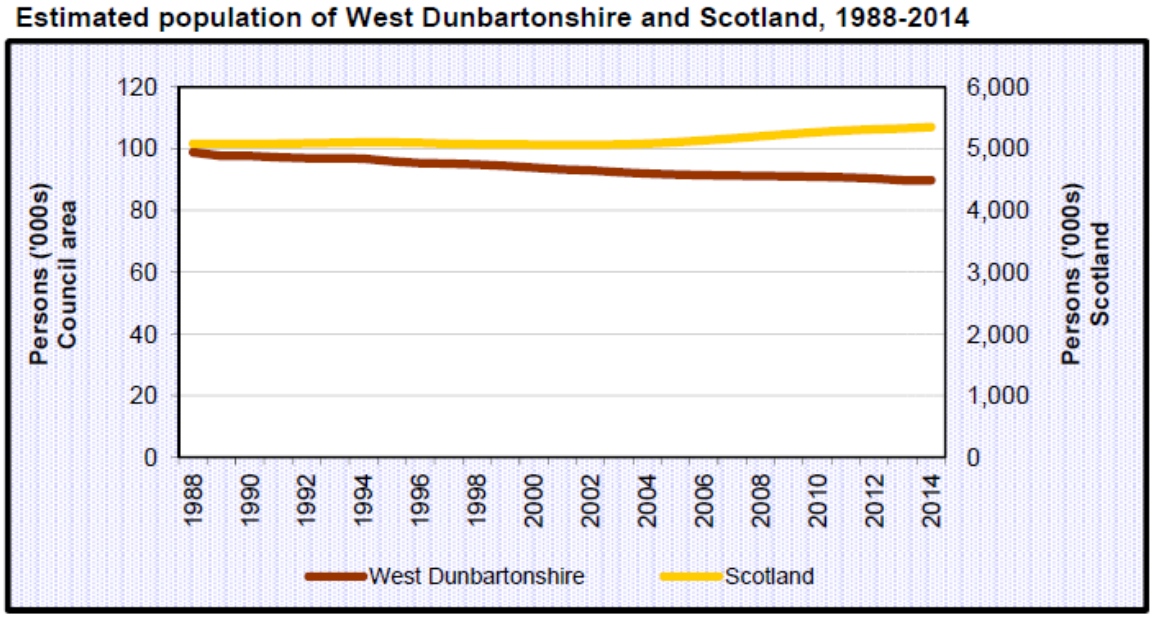
Age group	Male pop. West Dunbartonshire	Female pop. West Dunbartonshire	Total pop. of West Dunbartonshire	% of total pop. of West Dunbartonshire
0-15	8,001	7,702	15,703	17.5%
16-29	7,943	7,814	15,757	17.6%
30-44	7,527	8,623	16,150	18.0%
45-59	9,931	10,984	20,915	23.3%
60-74	6,679	7,540	14,219	15.8%
75+	2,615	4,371	6,986	7.8%
All ages	42,696	47,034	89,730	100.0%

Age group	Male pop. Scotland	Female pop. Scotland	Total pop. of Scotland	% of total pop. of Scotland
0-15	465,869	445,413	911,282	17.0%
16-29	488,533	487,504	976,037	18.3%
30-44	497,779	521,523	1,019,302	19.1%
45-59	563,177	593,612	1,156,789	21.6%
60-74	407,894	443,061	850,955	15.9%
75+	173,132	260,103	433,235	8.1%
All ages	2,596,384	2,751,216	5,347,600	100.0%

In West Dunbartonshire, 17.6 per cent of the population are aged 16 to 29 years. This is smaller than Scotland where 18.3 per cent are aged 16 to 29 years. Persons aged 60 and over make up 23.6 per cent of West Dunbartonshire. This is smaller than Scotland where 24.0 per cent are aged 60 and over.

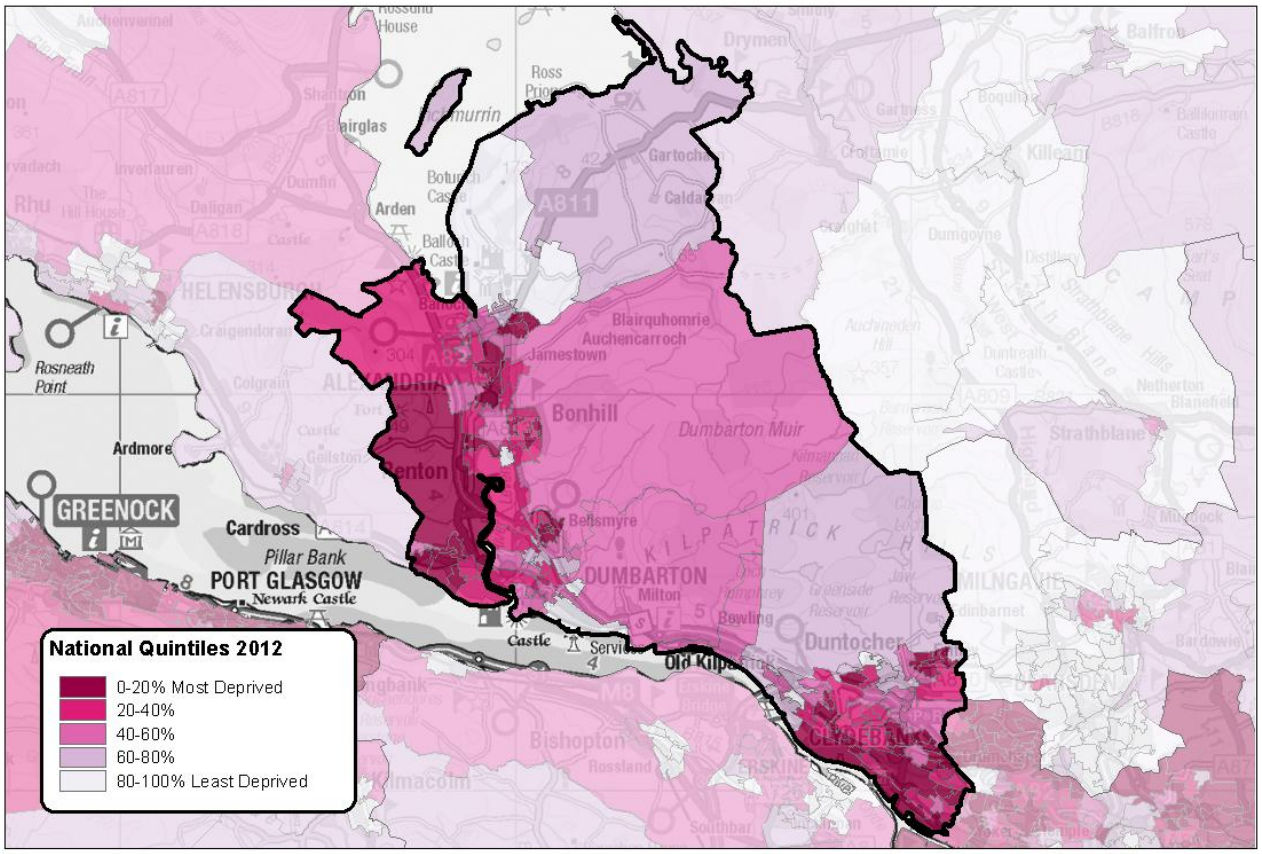
National and local evidence indicates that the population of West Dunbartonshire is ageing due to a combination of factors: that the number of births within the area is dropping; the number of people migrating to other council areas within the 15 – 44 age group is increasing; and the number of deaths registered annually is falling.



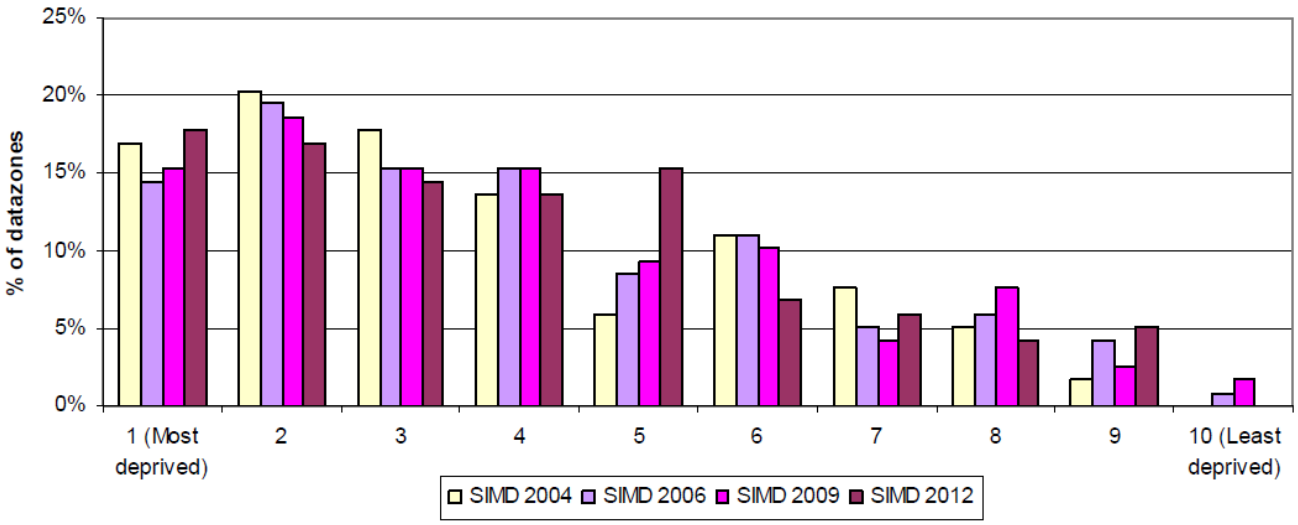


Since 1988, West Dunbartonshire's total population has fallen overall. Scotland's population has risen over this period.

The map below shows the levels of deprivation in West Dunbartonshire based on the most recent Scottish Index of Multiple Deprivation (SIMD 2012) published on 18 December 2012.



The decile graph below shows what percentage of West Dunbartonshire's datazones are found in each of the SIMD deciles.



Most of West Dunbartonshire's datazones are found in the more deprived deciles in SIMD 2012. This is similar to the pattern observed for SIMD 2009.

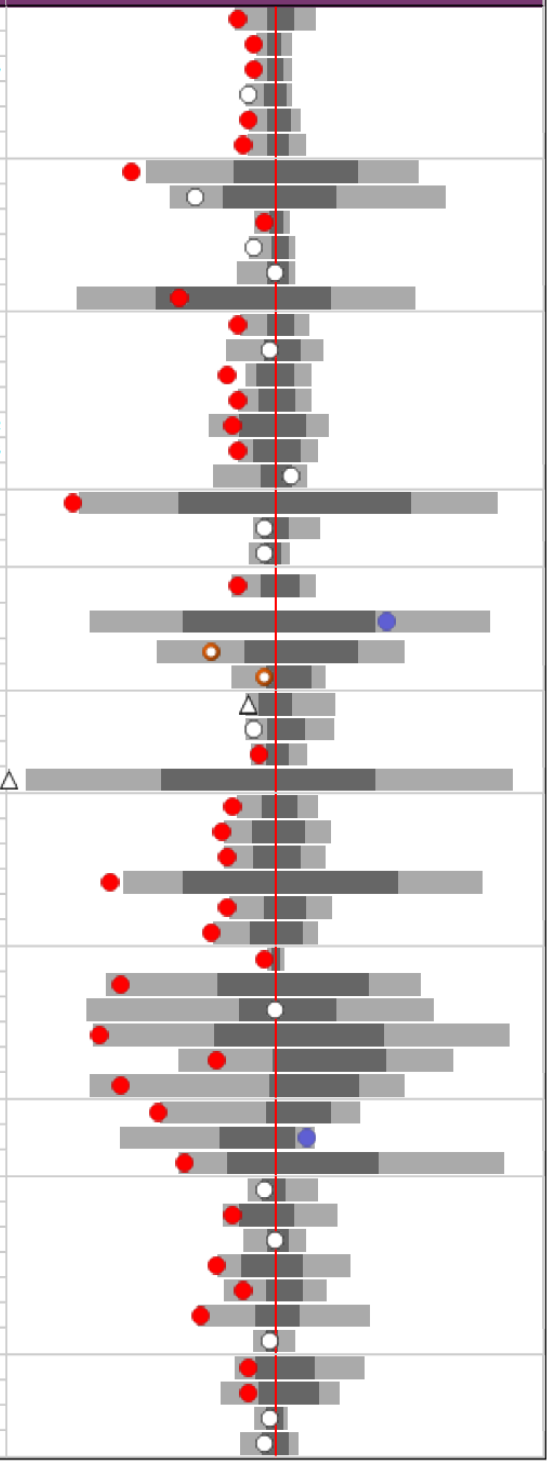
The most recent Health & Wellbeing Profile for West Dunbartonshire is summarised below.

ScotPHO Period: 2013

Health & Wellbeing Profiles (West Dunbartonshire)

Printed Date: 11-JUN-2015 15:09

Domain		Indicator	Period	Number	Measure	Type	National Average
Life Expectancy & Mortality	1	Male life expectancy [18]	2011	n/a	74.1	yrs	76.6
	2	Female life expectancy [18]	2011	n/a	78.7	yrs	80.8
	3	Deaths all ages [12]	2012	1,060	1,387.4	sr4	1,187.5
	4	All-cause mortality among the 15-44 year olds. [12]	2012	45	141.0	sr4	105.3
	5	Early deaths from CHD (<75) [12]	2012	62	81.9	sr4	60.7
	6	Early deaths from cancer (<75) [12]	2012	162	212.7	sr4	173.4
Behaviours	7	Estimated smoking attributable deaths [3,13,16]	2012	184	413.2	sr4	325.9
	8	Smoking prevalence (adults 16+) [3,14]	2013	142	27.0	%	23.0
	9	Alcohol-related hospital stays [15]	2013	832	975.9	sr4	704.8
	10	Deaths from alcohol conditions [17]	2011	29	32.8	sr4	23.8
	11	Drug-related hospital stays [12,15]	2012	99	113.9	sr4	116.6
	12	Active travel to work [3,14]	2013	23	11.0	%	16.0
Ill Health & Injury	13	Patients registered with cancer [12]	2012	575	714.7	sr4	634.1
	14	Patients hospitalised with chronic obstructive pulmonary disease (COPD) [12,15]	2012	572	705.8	sr4	659.9
	15	Patients hospitalised with coronary heart disease [12]	2012	445	553.8	sr4	440.3
	16	Patients hospitalised with asthma [12]	2012	108	116.8	sr4	91.2
	17	Patients with emergency hospitalisations [12]	2012	7,438	8,653.4	sr4	7,500.2
	18	Patients (65+) with multiple emergency hospitalisations [12]	2012	904	6,142.6	sr4	5,159.5
	19	Road traffic accident casualties [12]	2012	47	53.3	sr4	63.2
Mental Health	20	Population prescribed drugs for anxiety/depression/psychosis [3]	2013	17,783	19.8	%	17.0
	21	Patients with a psychiatric hospitalisation [12]	2012	278	322.0	sr4	291.6
	22	Deaths from suicide [17]	2011	15	16.4	sr4	14.5
Social Care & Housing	23	Adults claiming incapacity benefit/severe disability allowance/ employment and support allowance	2013	6,085	6.8	%	5.1
	24	People aged 65 and over with high levels of care needs who are cared for at home [3]	2013	399	40.7	%	34.7
	25	Children looked after by local authority [3]	2013	347	18.3	cr2	14.4
	26	Single adult dwellings	2013	17,439	38.9	%	37.7
Education	27	Average tariff score of all pupils on the S4 roll [13]	2012	n/a	182.0	mean	193.0
	28	Primary school attendance	2010	6,227	94.4	%	94.8
	29	Secondary school attendance	2010	5,075	90.1	%	91.1
	30	Working age adults with low or no educational qualifications [3]	2013	10,500	18.6	%	12.6
Economy	31	Population income deprived	2013	17,310	19.3	%	13.2
	32	Working age population employment deprived	2013	10,165	17.4	%	12.2
	33	Working age population claiming Out of Work benefits	2013	10,985	18.8	%	13.0
	34	Young people not in employment, education or training (NEET). [3]	2013	460	10.6	%	7.8
	35	Children Living in Poverty	2012	4,645	22.8	%	15.3
	36	People claiming pension credits (aged 60+)	2013	2,490	11.9	%	7.7
Crime	37	Crime rate	2013	5,208	58.0	cr2	40.5
	38	Prisoner population [3,13]	2012	199	273.5	sr4	171.2
	39	Referrals to Children's Reporter for violence-related offences [3]	2013	16	2.1	cr2	2.1
	40	Domestic Abuse [3]	2012	1,518	168.0	cr9	113.1
	41	Violent crimes recorded [3]	2013	139	15.5	cr9	12.7
	42	Drug crimes recorded [3]	2013	1,090	121.4	cr9	66.9
Environment	43	Population within 500 metres of a derelict site	2013	54,800	60.7	%	29.7
	44	People living in 15% most 'access deprived' areas	2013	5,034	5.6	%	15.0
	45	Adults rating neighbourhood as 'a very good place to live' [3,14]	2013	n/a	45.0	%	55.0
Women's & Children's Health	46	Teenage pregnancies [12]	2011	136	49.2	cr2	44.6
	47	Mothers smoking during pregnancy [12]	2012	244	24.9	%	20.0
	48	Low birth weight [12]	2012	19	2.0	%	2.0
	49	Babies exclusively breastfed at 6-8 weeks [12]	2012	144	15.0	%	26.5
	50	Child dental health in primary 1	2013	597	61.1	%	66.7
	51	Child dental health in primary 7	2013	269	32.9	%	47.7
	52	Child obesity in primary 1	2013	108	11.3	%	10.1
Immunisations and Screening	53	Breast screening uptake [12]	2011	2,799	69.3	%	72.5
	54	Bowel screening uptake [12]	2011	7,543	51.8	%	55.1
	55	Immunisation uptake at 24 months - 5 in 1 [12]	2013	1,030	97.9	%	98.2
	56	Immunisation uptake at 24 months - MMR [12]	2013	995	94.6	%	95.3



Notes:

3. Data available down to council (local authority) area only.
12. Three-year average number, and 3-year average annual measure.
13. Indicator based on HB boundaries prior to April 2014.
14. Two-year combined number, and 2-year average annual measure.
15. All 6 diagnosis codes used in the analysis; please see the technical report for more information.
16. Two-year average number, and 2-year average annual measure
17. Five-year average number, and 5-year average annual measure
18. Three year average for health boards, local authorities and Scotland. Five year average intermediate geographies

Spine Chart Key:

% =percent
cr2 =crude rate per 1,000 population
cr9 =crude rate per 10,000 population
mean=average
sr4 =age-sex standardised rate per 100,000 population to ESP2013. Please see Appendix I in the technical report.
yrs =years

Spine Chart Key:

- Statistically significantly 'worse' than National average
- Statistically not significantly different from National average
- Statistically significantly 'better' than National average
- Statistically significant difference compared to National average
- No significance can be calculated

The following tables show at a selection of high level indicators for the previous Community Health & Care Partnership to provide an overview of demand and performance.

Indicator	2013/14	2014/15	
	Value	Value	Target
Rate per 1,000 of children/young people aged 0-18 who are referred to the Reporter on non-offence grounds	33.15	33.15	33.15
Percentage of children who have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review	76.1%	76.1%	75%
Balance of Care for looked after children: % of children being looked after in the Community	89%	89.8%	89%
Number of children with mental health issues (looked after away from home) provided with support	50	64	23
Number of children with or affected by disability participating in sports and leisure activities	175	143	172
Percentage of child protection investigations to case conference within 21 days	80.2%	94.5%	95%
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%	100%
Percentage of Adult Support and Protection clients who have current risk assessments and care plan	100%	100%	100%
Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	98%	98%	98%
Number of adult mental health patients waiting more than 28 days to be discharged from hospital into a more appropriate setting, once treatment is complete	1	0	0
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	92.6%	92.2%	90%
PCMHT average waiting times from referral to first assessment appointment (Days)	28	16	14
Number of adult mental health patients waiting more than 14 days to be discharged from hospital into a more appropriate setting, once treatment is complete	1	0	0
No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013	2	0	0
No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015	5	1	0

Indicator	2013/14	2014/15	
	Value	Value	Target
Average waiting times in weeks for musculoskeletal physiotherapy services	9	16	9
Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	95%	95%	91.5%
Number of patients in anticipatory care programmes	1,024	1,645	1,200
Percentage of identified patients dying in hospital for cancer deaths	27%	29%	35%
Percentage of identified patients dying in hospital for non-cancer deaths	49.6%	38%	40%
Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	41%	39.2%	40%
Percentage of people receiving free personal or nursing care within 6 weeks of confirmation of 'Critical' or 'Substantial' need	100%	100%	100%
Crude rate of people aged 75+ in receipt of Telecare per 100,000	22,666	23,994	22,410
Percentage of adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes	51%	55%	55%
Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	98.2%	98%	96%
Number of patients on dementia register	613	638	672
Total number of homecare hours provided as a rate per 1,000 aged 65+	642.3	590.5	695
Percentage of homecare clients aged 65+ receiving personal care	82.7%	93%	82%
Percentage of people aged 65 and over who receive 20 or more interventions per week	51.3%	31%	45%
Percentage of people aged 65 or over with intensive needs receiving care at home	40.71%	40.2%	51%
Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	85%	87%	86%
Number of carers of people aged 65+ known to CHCP	1,348	1,446	1,680

The following tables show at a high level, a comparative snapshot of the different (former) CH(C)P areas demand for and impact on Acute Services, in particular delayed discharges , emergency attendances and admissions (noting that the time periods are different than for the previous table).

Crude rate of new A&E attendances per 100,000 against the agreed local targets

	Apr 14 - Mar 15	2014-15 Target	Variance %
East Dunbartonshire CHP	1589	2888	-45.0%
East Renfrewshire CHCP	1896	2888	-34.3%
Glasgow City CHP	2784	2888	-3.6%
Inverclyde CHCP	3066	2888	+6.2%
Renfrewshire CHP	2787	2888	-3.5%
West Dunbartonshire CHCP	1815	2908	-37.6%

Relative number of Emergency Admissions aged 65+ per 1,000 (Apr 14 - Mar 15)

	Rate of unplanned admissions per 1,000
East Dunbartonshire CHP	248
East Renfrewshire CHCP	225
Glasgow City CHP	315
Inverclyde CHCP	313
Renfrewshire CHP	305
West Dunbartonshire CHCP	282

Relative percentage of GP referrals to A&E

	Apr 14 – Mar 15
East Dunbartonshire CHP	10.0%
East Renfrewshire CHCP	13.8%
Glasgow City CHP	10.0%
Inverclyde CHCP	6.8%
Renfrewshire CHP	6.8%
West Dunbartonshire CHCP	9.7%

Comparative rate of acute bed days lost to delayed discharges (inc AWI)

	Apr 14 to Mar 15 Actual	Target	Variance %
East Dunbartonshire CHP	4,916	3,680	+33.6%
East Renfrewshire CHCP	2,896	2,415	+19.9%
Glasgow City CHP	38,152	26,555	+43.7%
Inverclyde CHCP	3,462	3,362	+3.0%
Renfrewshire CHP	5,325	8,104	-34.3%
West Dunbartonshire CHCP	5,802	3,819	+51.9%

Total number of individual patients - complex and non-complex - delayed across the year 2014

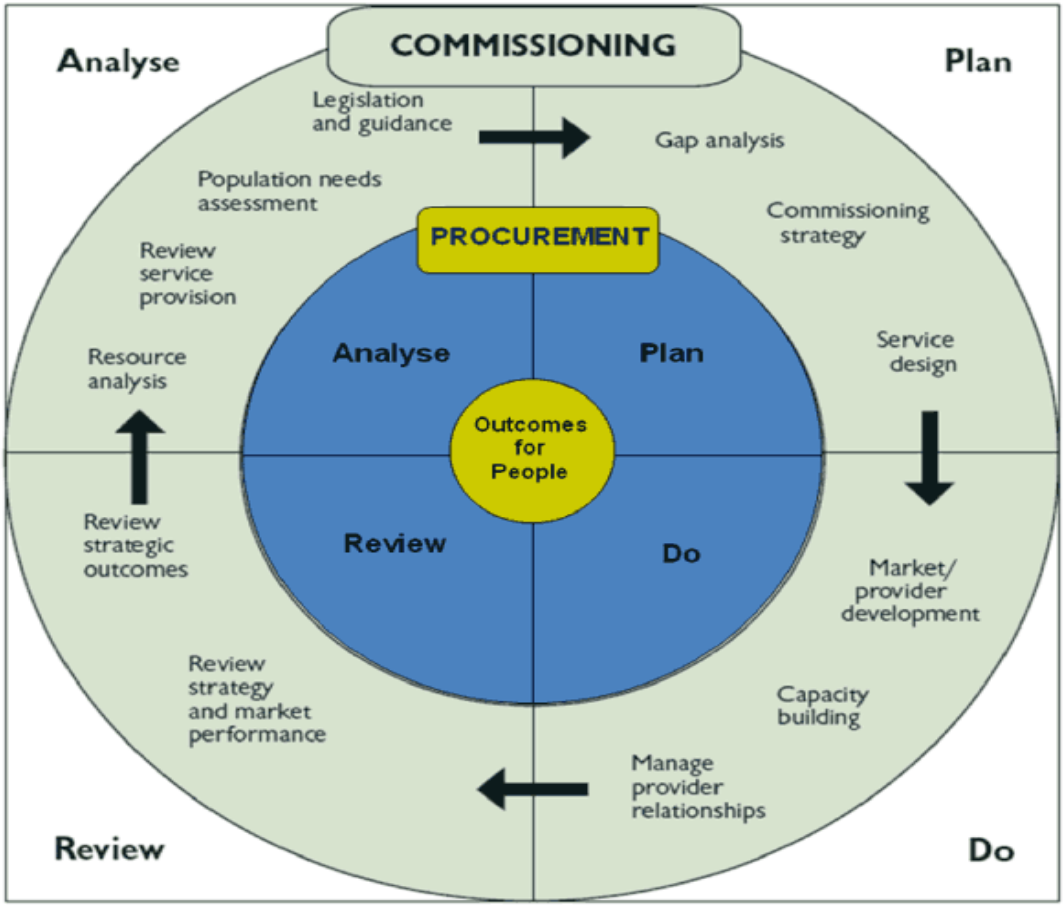
	Complex	Non Complex
East Dunbartonshire CHP	10	209
East Renfrewshire CHCP	1	167
Glasgow City CHP	70	1643
Inverclyde CHCP	2	195
Renfrewshire CHP	43	179
West Dunbartonshire CHCP	10	213

Relative rate of unplanned admission (Feb 14 - Jan 15)

	Total Population	No. of unplanned admissions	Rate of unplanned admissions per 100,000 population
East Dunbartonshire CHP	105,860	5379	5,081
East Renfrewshire CHCP	91,500	3827	4,182
Glasgow City CHP	596,550	26181	4,388
Inverclyde CHCP	80,310	4799	5,975
Renfrewshire CHP	173,900	9550	5,491
West Dunbartonshire CHCP	89,810	4328	4,819

STRATEGIC COMMISIONING CONTEXT

This Strategic Plan has been developed with regards to the strategic commissioning process advocated by Audit Scotland, and benefitting from on-going engagement with a full range of local stakeholders (including locality groups, the 3rd and independent sectors and communities).



West Dunbartonshire Council

West Dunbartonshire Council's mission is to lead and deliver high quality services which are responsive to the needs of local citizens, and realise the aspirations of our communities.
The Council's Strategic Plan 2012-17 identifies the following strategic priorities:

- Improve economic growth and employability.
- Improve life chances for children and young people.
- Improve care for and promote independence with older people.
- Improve local housing and environmentally sustainable infrastructure.
- Improve the wellbeing of communities and protect the welfare of vulnerable people.

The Council's Strategic Plan also stresses a commitment to assure success through:

- Strong financial governance and sustainable budget management.
- Fit-for-purpose estate and facilities.
- Innovative use of Information Technology.
- Committed and dynamic workforce.
- Constructive partnership working and joined-up service delivery.
- Positive dialogue with local citizens and communities.

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde's (NHSGGC) purpose is to deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities.

The NHSGGC Corporate Plan for 2013-16 sets out five strategic priorities:

- Early intervention and preventing ill-health.
- Shifting the balance of care.
- Reshaping care for older people.
- Improving quality, efficiency and effectiveness.
- Tackling inequalities.

The Scottish Government's 2015-16 Local Delivery Plan (LDP) for the NHS has six priorities:

- Health inequalities and prevention.
- Antenatal and early years.
- Person-centred care.
- Safe care.
- Primary care.
- Integration.

The NHSGGC Health Board has agreed a Strategic Direction that establishes how it will progress its five corporate priorities alongside the LDPs six improvement priorities over 2015/16; and that provides a framework for the overall planning system including the initial strategic plans which are being developed by the six HSCPs within the GGC area (of which this Strategic Plan is one).

Community Planning West Dunbartonshire

The aim of the Community Planning West Dunbartonshire is to work in partnership to improve the economic, social, cultural and environmental well being of West Dunbartonshire for all who live, work, visit and do business here. Single Outcome Agreements (SOA) are the means by which the Community Planning Partnership agrees its strategic priorities for the local area, express those priorities as outcomes to be delivered by the partners, either individually or jointly, and show how those outcomes should contribute to the Scottish Government's relevant National Outcomes.

The 2014-17 SOA for West Dunbartonshire focuses on the following interconnected priorities:

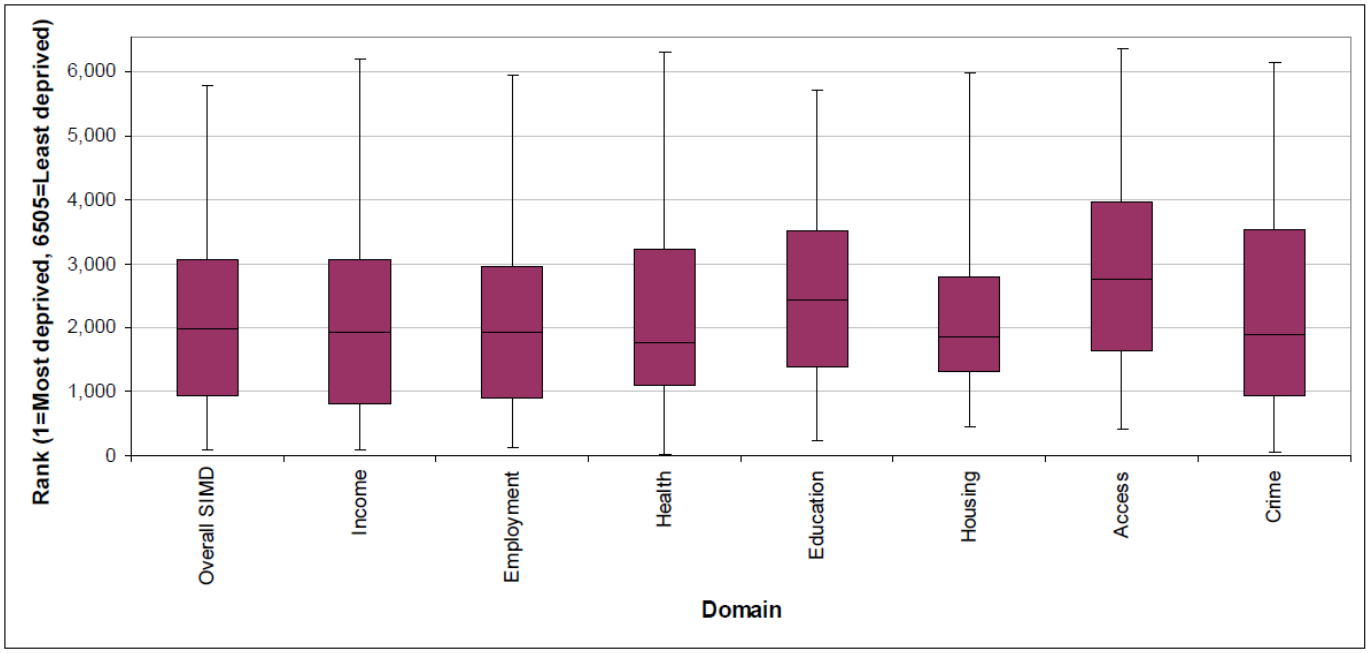
- Employability & Economic Growth.
- Supporting Safe, Strong and Involved Communities.
- Supporting Older People.
- Supporting Children and Families.

As a key partner within Community Planning West Dunbartonshire, the HSCP is committed to:

- Ensuring that community planning takes a streamlined approach to delivering outcomes.
- Demonstrating an appreciation that our priorities and outcomes are inter-connected.
- An emphasis on early intervention and prevention across all of our priorities.
- A commitment to pro-active and rigorous self-evaluation and scrutiny of activities across community planning partners as a driver for continuous improvement.

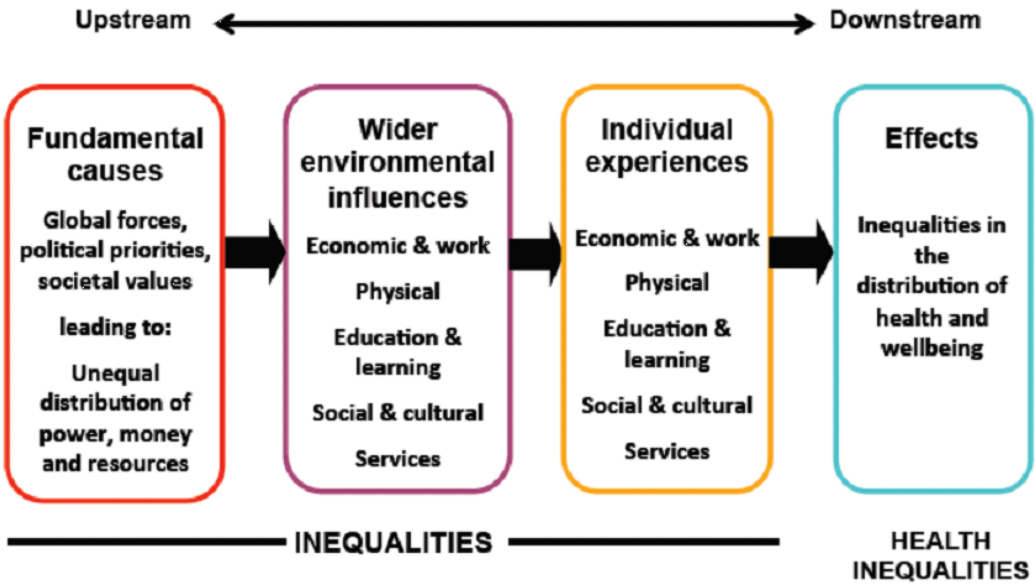
Inequalities

Within West Dunbartonshire – as is true across Scotland - there are significant differences in health, access, experience and outcomes of health care between different groups depending on their age, gender, race, disability, sexual orientation, income and social class. The box plot below summarises West Dunbartonshire's ranks in the overall SIMD 2012 and individual SIMD domains. Boxes show the middle 50% of values and the middle (median) value; whiskers show the minimum and maximum ranks.



The primary determinants of health are well recognised as being economic, social and environmental. One common definition of health inequalities is that they are those systematic and avoidable differences in health between population groups which result from the unequal distribution of resources within populations; and the associated accumulation and interaction of multiple risk factors. Health inequalities are an example of a wicked issue: i.e. one that by definition involves complex, messy and often intractable challenges; where the causes are complicated, ambiguous and often interconnected (as illustrated overleaf); and where there are no clear solutions. The highly regarded Marmot Review (Fair Society, Healthy Lives; 2010) argued that while traditional government policies have focused resources only on some segments of society, in order to improve health for all of us and to reduce unfair and unjust inequalities in health, action is needed across the social gradient.

Figure 1: Health inequalities: theory of causation (summary version)



Within West Dunbartonshire we are formally committed to a determinants-based approach to health inequalities, with our local-term goal being to have tackled population-level health inequalities as a result of our having collectively addressed its root causes through the local Community Planning Partnership – by stimulating sustainable economic growth and employment; promoting educational attainment and aspiration; and supporting community cohesion and self-confidence. The HSCP will continue to provide clear leadership in championing this progressive and evidence-based approach to addressing health inequalities in a streamlined and integrated manner.

An effective and coherent suite of early years interventions is a key element of any serious attempt to tackle (health) inequalities – whilst avoiding placing unrealistic expectations on any given programme to address health inequalities in of itself (particularly in the short-to-medium term). Our Integrated Children's Services Plan expresses our collective commitment to the principles of early intervention and prevention as part of Getting It Right For Every Child (GIRFEC), i.e. that our children and young people are safe, healthy, active, nurtured, achieving, respected, responsible and included. Similarly, neighbourhood-level asset-based initiatives that promote community cohesion are (hopefully) part of a solution – but only if they are energised within a strategic, long-term and determinants-based effort across partners. A good example of this is the successful and award winning West Dunbartonshire Link Up initiative where older people, carers and local services are working jointly to help older people maintain their independence. This service was fostered by the CHCP and local CVS both in response to feedback from older people and their carers; and is an initiative the new HSCP will seek to continue to develop through 2015/16.

SERVICE COMMITMENTS 2015/16

Given that this is the first year of the HSCP and its inaugural Strategic Plan, the commitments set out here predominantly reflect a continuation of the work that was being progressed by the shadow HSCP, both in relation to the key targets identified and actions already approved for 20125/16 by the predecessor Shadow Integration Joint Board.

Adults & Older People

The emphasis of the HSCP current activity for adults and older people revolves around and relates to a range of overlapping and interconnected workstreams first delivered within the Older People's Change Fund Plan and now part of the approved local Integrated Care Fund Plan.

During 2015/16 the HSCP will work with partners to implement the local Integrated Care Fund Plan, delivering upon its key elements as follows:

<u>Anticipatory Care - Long Term Conditions and Frailty</u>

- Improve access to Health Improvement services and to lifestyle support services.
- Develop community based clinical support for patients with long term conditions.
- Develop a House of Care approach across community services linked to Acute Sector specialisms.
- Identify a cohort of clients/patients at high risk of admission or failure of care package and develop alternatives to admission.
- Plan rapid response and alternative choices on behalf of at risk clients.
- Improve coordination and ensure that information is updated and shared.
- Place anticipatory care plans and social care information on e-KIS which will be available to our integrated nursing and social care teams and to the Scottish Ambulance Service and Out of Hours services.
- Introduce Anticipatory Care Planning Nursing team, linked to Out of Hours services.

<u>Developing Services with the Independent Sector</u>

- Improved liaison with independent sector providers.
- Improved care for patients in all care settings.
- Development of capacity in line with changing demand.

- Introduce additional respite and rehabilitation options.

Developing Community Capacity

- Further develop the LinkUp service to streamline referrals from and between the 3rd and Independent sectors and provide access to non statutory provision.
- Develop a Social Prescribing model.
- Increase the number of volunteers including those representing health specific organisations.
- Maintain a dedicated helpline number manned by volunteers.
- Further develop a shared assessment process between key 3rd sector delivery partners.
- Support a shared staff development and training programme.
- Support carers through Carers of West Dunbartonshire and do this in partnership with West Dunbartonshire CVS.
- Identify and support more carers.
- Increase referrals for support by a further 25%.

Respite

- Will extend bureau model for older peoples respite services this to provide equivalent supports for younger adults with a requirement for respite.
- Reduce "failure" rate and costs.
- Increase the number of respite weeks provided by 20% and to maintain that level.
- Increase the level of self directed support for respite by 10%.
- Improve access to out of hours and short break respite.
- Improve access and support for carers.
- Provide respite at home.

Primary Care Dementia Service

- Link to supported discharge team to ensure successful transition.
- Support additional carers in collaboration with Carers of West Dunbartonshire.
- Avoid Admission to EMI and Acute Hospital beds particularly from care homes.
- Improve the health of carers.

Care at Home Provision and Reablement

- Support additional numbers of clients to live as independently as possible.

- Deliver reablement services for home care clients.
- Support more carers in West Dunbartonshire in collaboration with Carers of West Dunbartonshire.
- Increase support for younger adults with complex health conditions to manage their own care at home.
- Contribute to our Anticipatory Care Planning approach.
- Increase appropriate use of Telecare and Step Up, Step Down provision.
- Provide a focus for volunteer input.

Out of Hours Care

- Provide alternatives to admission.
- Provide Rapid Response Out of Hours.
- Develop Neighbourhood Services.
- Integrate Social Work and Health Out of Hours provision.

End of Life Care

- Each patient with Palliative Care needs is held on Palliative Care Register.
- Reduce the proportion of people within West Dunbartonshire known to be at the end of life, dying in hospital.
- Use Supportive and Palliative Action Register (SPAR) to provide a tool to aid the identification of cancer and non-cancer patients entering a palliative phase.
- Enhance training for care home and home care staff.
- Achieve a 20% decrease in the number of palliative care patients dying in hospital.
- Carers will be supported throughout the whole process and referred to appropriate sources of help.

Facilitating Discharge

- Reduce the number of bed days consumed by patients ready for discharge to target.
- Reduction in bed days because of readmission/admission.
- Carers will be involved and supported.

Improving Co-Production

- Increase in the number of patients able to manage their own conditions.

- Support to carers to continue to care.
- Increased peer support and 3rd Sector engagement.
- Better patient information.

The HSCP will also:

- Progress the delivery of its two new replacement Older People's Residential Care Home and Day Care facilities – one in Dumbarton and the other in Clydebank/.
- Expand our capacity to support Access to Funds requests made on behalf of those using our services.
- Develop a Market Facilitation Plan in partnership with care providers currently working in West Dunbartonshire and those who may in the future be providers within the area (Appendix 2 for more details).

Primary Care

Access to primary medical services is a key consideration in improving the delivery of services and ensuring patients are at the heart of how these are designed and provided. Patients should have increased confidence that the care delivered by all parts of primary care is safe, effective and person centred. This requires a culture of ongoing review of decisions taken, and interventions made, as well as encouraging comment and input from patients and the wider public. Agreed care pathways assist both staff and patients understand and achieve the best approaches for care which is safe, person centred and clinically and cost effective. It is recognised that the combination of targeted action within primary care, and both informing and empowering the individual with a condition, will improve their sense of wellbeing and avoid repeated admission to hospital.

The HSCP will work with local primary care contractors and staff to:

- Develop Anticipatory Care as a model of prevention and work with GPs to develop self-care models, and preventative interventions.
- Continue to develop care for patients with long term conditions inc. additional nursing support to patients, GP practices and care homes.
- Further develop use of care planning and management to reduce hospital inpatient care.

- Increase range of urgent access options to advice and appointments for GPs.
- Work with GP practices to monitor their provision of third available appointment, planned appointments and 24 hour access.
- Continue to implement Scottish Patient Safety Programme in the community.
- Bring forward plans for a new Clydebank Health & Care Centre to replace current provision.

Acute Division – Unscheduled/Emergency Care

In February 2012 NHS Greater Glasgow and Clyde established the Clinical Services Fit for the Future Programme to review services in order to prepare a single clinical strategy for NHS GGC for 2015 onwards. This Clinical Services Strategy was approved by the Health Board in January 2015 and is intended to provide a shared vision for the Health Board and the new Integration Joint Boards across the NHSGGC area.

The overarching aim of the clinical strategy is to provide a balanced system of care where people get care in the right place from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services.

Within the context then of the Clinical Services Strategy, the key priority areas for the HSCP in relation to Acute Services during 2015/16 are:

- Reduction in bed days lost to delayed discharge - with the reconfiguration of acute sites in 2015 into a reduced bed base, the impact of delayed discharges on the delivery of acute care becomes even more critical.
- Reduction in the number of A&E presentations - where alternatives to A&E presentation exist, these services need to be maximised and plans developed to increase the scope and number of these services available in the community.
- Reduction in the number of emergency admissions - where alternatives to emergency admission exist for patients whose acuity does not require acute admission, these services need to be maximised and plans developed to increase the scope and number of these services.
- Relationship Building between Primary and Acute Care Services - working to describe clearer pathways and better communication between primary and secondary care.

NHSGGC Musculoskeletal (MSK) Physiotherapy

The MSK Physiotherapy service incorporates 37 sites across NHSGGC. Referrals have risen 27.9% in the past 2 years with the service receiving 88,302 referrals in 2014/15. The current waiting time target to-date is 9 weeks for a routine appointment. Looking forward, the Allied Health Professions (AHP) National Delivery Plan sets a target of 4 weeks by March 2016.

Key changes planned to respond to the 2016 4 week target include implementing:

- Referral Management Centre.
- Netcall - appointment reminder system.
- National GP MSK resource.
- Risk stratification.

NHSGGC Eye Care

The previous CHCP led the development of primary care eye care services across NHSGGC over the last four years, and the HSCP will continue to do this going forward by:

- Continue to develop and maintain a local optometry network.
- Contribute to the development of networks across NHSGGC and facilitate profession-wide leadership.
- Support the development of a quality and governance framework for community optometry.
- Develop the primary – secondary care interface, including referral and after care for serious eye conditions.
- Develop community optometry as the front line service for primary eye care in partnership with general practice.

The HSCP will also host the Diabetic Retinal Screening Service for the Health Board, ensuring that:

- It continues to provide annual reviews for all diabetic patients across the NHSGGC area (approx. 81,000).
- It meets its national quality assurance and performance targets.

Mental Health

The HSCP is committed to the full spectrum of mental health improvement, services and recovery to ensure delivery of effective, quality care and treatment for people with a mental illness, their carers and families.

During 2015/16 the HSCP will work with partners to:

- Relocate older peoples continuing care mental health beds to West Dunbartonshire.
- Support a national campaign to raise awareness of Power of Attorney.
- Deliver and implement a local West Dumbarton Dementia Strategy, including working with partners to develop Dementia Friendly West Dunbartonshire.
- Expand access to therapeutic psychological therapies across West Dunbartonshire.
- Roll out Greater Glasgow and Clyde Mental Health Trauma Services across all West Dunbartonshire.
- Roll out the West of Scotland Perinatal Service to Mental Health Services within Dumbarton and Alexandria.

Learning Disability

People with learning disabilities should be supported to live independently in the community wherever possible. The national Keys to Life Strategy (2013) supports our ability to improving quality of life for people with learning disabilities and informs our local actions.

Key local actions for the HSCP in taking this forward include:

- Work with third sector to relocate local clients with a learning disability diagnosis who are currently living in specialist care facilities out of area back within West Dunbartonshire.
- Work to with people with learning disability and sensory impairment to increase their uptake of the national screening programme.
- Implement improvement actions to reduce discrimination.
- Engender closer operational links across HSCP services to support effective transitions.
- Support continued partnership with Housing Services to maintain effective connectivity with the Local Housing Plan and wider housing services and housing providers.

Alcohol and Drugs

The HSCP convenes, holds the budget for and chairs the Alcohol and Drug Partnership (ADP), which is responsible for developing and leading local strategies to deliver improved outcomes.

During 2015/16 the HSCP will undertake its role in:

- Internal redesign of alcohol and drug services to ensure fit with Recovery Orientated Systems of Care (ROSC) (this will include issues linked to workforce development).
- Quantification of availability and access to New Psychoactive Substances (NPS); within that identification of uptake of services and possible changes to service delivery as a result of this work, and using intelligence to develop appropriate information and training for young people and their families regarding the dangers of new psychoactive substances.
- Work with children and families - Children Affected by Parental Substance Misuse (CAPSM).
- Review and redesign local data systems to enable access to specific information.

Carers

The implementation of Carers Strategy 2012 – 2022 will be led by the HSCP with its partners; with carers, the third and private sector, to ensure actions are realistic, achievable and inextricably linked to the needs of carers – both young carers and adults - in West Dunbartonshire.

Key local actions for the HSCP in taking this forward include:

- Continuing to implement the Carers Information Strategy.
- Articulate and promote the value and benefits of a carer's assessment.
- Undertake targeted work to support sustainable caring, whilst promoting and improving the health and well-being of carers.
- Development of Respite Bureau.
- Work closely with primary health care to support carers with the appropriate information, ensure that they are engaged in the care planning and that the outcomes for the patient and carer are enhanced.

Housing

The Local Housing Strategy sets out the housing issues in West Dunbartonshire for the period 2011 to 2016. The strategy shows how the Council and its partners mean to address these issues. It deals with both private and rented housing. The Strategy goes with a Strategic Housing Investment Plan which details the funding priorities for affordable housing in West Dunbartonshire. It is the Council's main document on: housing, homelessness, housing support services and fuel poverty.

The local Housing Strategy seeks to ensure clear strategic leadership about housing priorities for older people. It aims to ensure appropriate information and advice to make informed choices and that older people are assisted to remain in and make best use of existing housing stock. It seeks to invest in new housing which meets the needs of older people and to provide low level preventative support. We also have a significant cohort of younger adults with complex health conditions who also require a strategic approach to their housing needs and we will extend our activities to this group.

The Council's Housing Section will work with the HSCP to:

- Establish a housing support service enabling long term clients to be supported within West Dunbartonshire.
- Continue to develop plans for new and refurbished Housing.
- Develop Services at Points of Transition.
- Provide preventative interventions and supports.
- Ensure rapid access to assessment, and provision of aids and adaptations.
- Seek to develop supported housing solutions for younger adults with complex needs.

This will contribute to:

- Reduced waits for OT assessment and aids and adaptations
- The development of new models of care at home such as extra care housing
- In conjunction with 3rd Sector and Local Housing Associations develop housing with care options for all care groups.

Children and Young People

The Integrated Children's Services Plan (ICSP) is the vehicle by which the HSCP and other community planning partners will address the new statutory requirements as described within the Children and Young Person Act (Scotland) 2014 and delivering Getting It Right For Every Child (GIRFEC). As the HSCP has well established integrated strategic and service delivery arrangements across children and young people's services the ICSP plan reinforces our commitment to these arrangements and reiterates the agreed priorities across and with partners to ensure that children, young people and families receive the best opportunities through delivery of service as community planning in practice.

The Children and Young Person Act brings about a specific duty on local areas to have an ICSP in place, with new guidance is awaited from Scottish Government - after which the HSCP will lead a review across community planning partners to update our local ICSP accordingly.

During 2015/16 the HSCP will undertake its role and provide leadership to:

- Deliver the UNHCR Rights of the Child.
- Implement its commitments within the Integrated Children's Services Plan.
- Implement the National Early Years Framework and deliver the workstreams of the Early Years Collaborative.
- Lead the delivery of our Child Protection Committee Improvement Action Plan.
- Continue to identify and intervene in the lives of vulnerable children as identified in our joint work with Police Scotland through the Concern Management Hub.
- Deliver Corporate Parenting.
- Deliver a local Parenting Strategy.
- Deliver the Family Nurse Partnership Programme.
- Develop our multi-agency approach to supporting children with regards to their mental health and emotional well being.
- Deliver the Whole Systems Approach to Youth Offending.
- Redesign our Children's Home provision.
- Review and redesign our community based supports and introduce a consistent process for accessing the right service at the right time

Health Improvement

Health improvement is a key function of public health and is pursued through wide-ranging health promotion effort, aimed at promoting good health and preventing ill-health through maximising the population health benefits of treatment of ill-health. This includes helping individuals, in so far as they are able, to take responsibility for their own health and wellbeing and that of others.

Key workstreams that the HSCP will lead include:

- Implement local stop-smoking service action plan targeting intensive support for people from 40% most deprived datazones.
- Pilot intensive support for people with COPD to stop smoking
- Develop and pilot an intervention to support people to change their smoking behaviour to protect children from secondhand smoke
- Continue to test approaches to reduce smoking rates in pregnancy
- Work with West Dunbartonshire Leisure to ensure delivery of nutrition and physical activity programmes across the life-course.
- Work with educational settings to implement "Setting the Table".
- Begin implementation of new teenage pregnancy and young parent strategy
- Ensure implementation of the refreshed sexual health and blood borne virus framework
- In partnership with WDC Educational Services, review and update RSHPE (Relationships, Sexual Health and Parenthood Education) policy and LAC (Looked After Children) sexual health and relationships policy.
- Build capacity to ensure delivery of Alcohol Brief Interventions within priority and wider settings
- Deliver training on alcohol and drugs to a range of staff with identified need. Continue to lead Choose Life suicide prevention programme.
- Support delivery of youth mental health Project 99.
- Continue to implement HSCP Cancer Information Action Plan to ensure delivery of Scottish Government "Detect Cancer Early" campaign.
- Maintain Healthy Working Lives Gold Award for Health and Social Care Partnership and West Dunbartonshire Council.

Public Protection

Public Protection provides a range of measures which can be used together to take steps to decide whether someone is an adult at risk of harm, balancing the need to intervene with an adult's right to live as independently as possible; or where a child needs protection from harm. It also encompasses the effective and robust management of High Risk Offenders (including those subject to Multi-Agency Public Protection Arrangements – MAPPA – and Serious Violent Offenders). It is everyone's business to help protect adults and children who may be at risk - and as such public protection is an integral part of all delivery of adults and children's services within the HSCP.

The Child Protection Committee ensures that agencies, services and organisations work together to protect children and provide support to parents, carers, children and young people. The key priorities of the Child Protection Committee are:

- Child Protection Performance and Demand Analysis.
- Improvement and Workforce Development.
- Communication and Inclusion.
- Planning for Outcomes.
- Practice Guidance and Development.
- Improve the safety of children in West Dunbartonshire.

The work of the Adult Support and Protection Committee is driven by both national governance and accountability and meeting the needs of the local population. The priority work streams identified by the Scottish Government include:

- Financial harm.
- Adult Protection in nursing and care homes.
- Adult Protection in A&E departments.
- Service user and carer involvement.
- Data collection.

Criminal Justice

West Dunbartonshire Council delivers criminal justice services in formal partnership with Argyll and Bute and East Dunbartonshire councils. Criminal Justice services undertake a range of statutory duties concerned with the assessment and supervision of offenders subject to community sentences or subject to supervision following a custodial sentence. This is the fourth Area Plan for the North Strathclyde Community Justice Authority (NSCJA) and is for the three year period April 2014 – March 2017. Locally, the HSCP will work with partners to achieve:

- A continued reduction in the one year reconviction rate in the North Strathclyde Community Justice Authority area
- The effective provision of person centred, evidence led support services and interventions for women offenders as recommended by the Commission on Women Offenders in both community and in-custody settings
- Effective and enhanced support services and interventions for high risk offenders including sex offenders and perpetrators of domestic abuse, whilst ensuring the 'victim's voice' is heard in the North Strathclyde Community Justice Authority area
- An increased focus on alternatives to custody and community sentences where appropriate, including diversion; community payback order (CPO); Drug Treatment and Testing Orders (DTTO); the use of electronic monitoring, where suitable; and alternatives to remand.
- Continue to support a prison culture where the maximisation of opportunities for prisoners to work towards positive destinations is the norm, addressing the cross cutting issues that contribute to offending and re offending.
- A smooth and efficient transition into the new Structure for Community Justice.

KEY PERFORMANCE INDICATORS

As part of the development work in support of the Public Bodies (Joint Working) (Scotland) Act, a range of indicators for health and social care partnerships have been developed in consultation with a wide range of stakeholders across all sectors, and by the Ministerial Steering Group.

These indicators will develop and improve over time - and some of them still require data development. The indicators have been, or will be, developed from national data sources so that the measurement approach is consistent across all areas. They can be grouped into two types of complementary measures:

(1) Outcome indicators based on survey feedback[1], to emphasise the importance of a personal outcomes approach and the key role of user feedback in improving quality:

- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good
- Percentage of people with positive experience of care at their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of adults supported at home who agree they felt safe.
- Percentage of staff who say they would recommend their workplace as a good place to work.

[1] While national user feedback will only be available every 2 years, it is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often.

(2) Indicators derived from organisational/system data primarily collected for other reasons[2]:

- Premature mortality rate.
- Rate of emergency admissions for adults.
- Rate of emergency bed days for adults.
- Readmissions to hospital within 28 days of discharge.
- Proportion of last 6 months of life spent at home or in community setting.
- Falls rate per 1,000 population in over 65s.
- Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
- Percentage of adults with intensive needs receiving care at home.
- Number of days people spend in hospital when they are ready to be discharged.
- Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
- Percentage of people admitted from home to hospital during the year, who are discharged to a care home.
- Percentage of people who are discharged from hospital within 72 hours of being ready.
- Expenditure on end of life care.

Importantly, the above suite of indicators remain to be tested in practice, and Scottish Government has acknowledged that will need to be tested out with new partnerships to understand their usefulness both for reporting progress and identifying areas for improvement to help with strategic planning.

Given the developmental status of the above, the following suite of key performance indicators have been prepared for the HSCP for 2015-16, relating to a combination of routine service activity and transformational initiatives within the context of the national Outcomes and commissioning context set out earlier; and which address many of the nationally sponsored indicators above (overleaf).

Work will be on-going through 2015/16 between the HSCP, the Council and the Health Board to further develop a robust and timeous suite of performance indicators for future years.

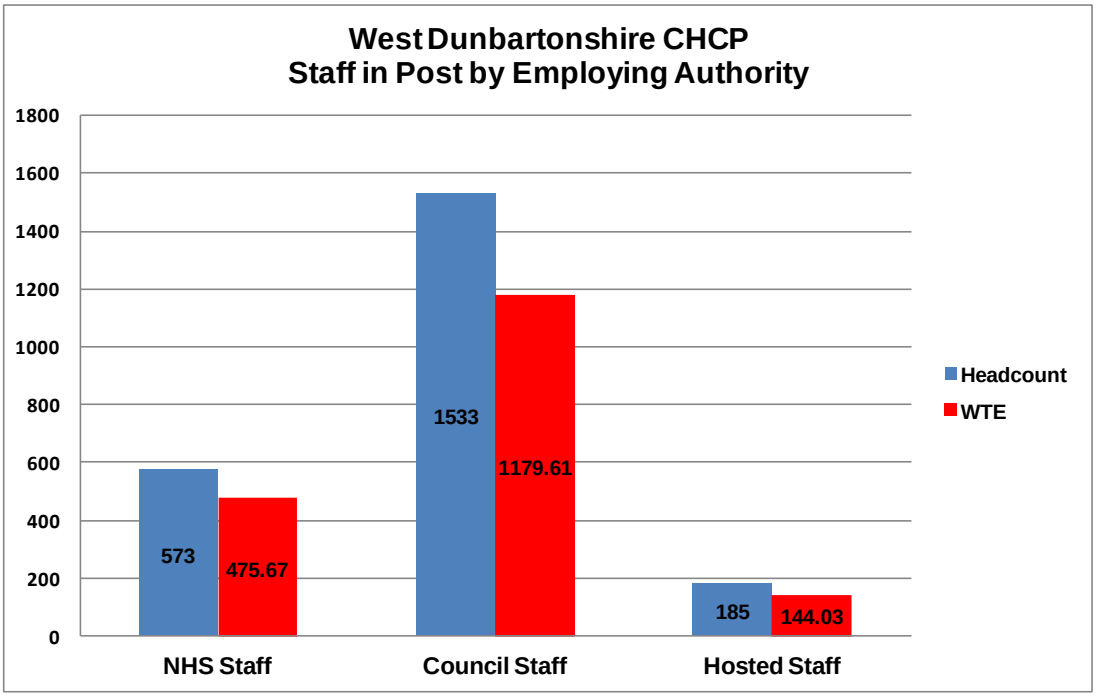
[2] These indicators will be available annually or more often.

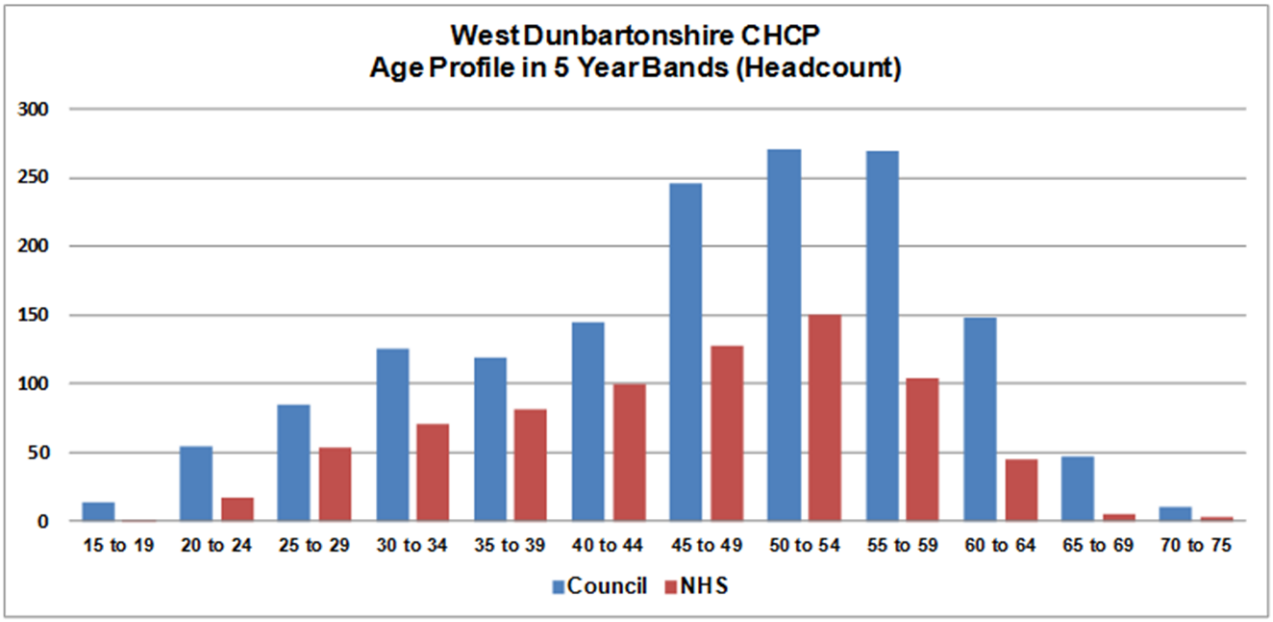
Performance Indicator	Target 2015-16
Rate of stillbirths per 1,000 births	4.3
Rate of infant mortality per 1,000 live births	3.1
Percentage of pregnant women in each SIMD quintile booked for antenatal care by the 12th week gestation	80%
Percentage of all children aged 0-18 years with an identified "named person" as defined within the Children's and Young People's Act	100% (2016 target)
Percentage of children who have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review - Early Years Collaborative Stretch Aim	80%
Percentage of children who have reached all of the expected developmental milestones at the time the child starts primary school - Early Years Collaborative Stretch Aim	80%
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	97%
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	95%
Number of children with or affected by disability participating in sports and leisure activities	172
Number of children completing tailored healthy weight programme	65
Child and Adolescent Mental Health Services (CAMHS) 18 weeks referral to treatment	100%
Number of children with mental health issues (looked after away from home) provided with support	23
Balance of Care for looked after children: Percentage of children being looked after in the Community	89%
Percentage of Council-operated children's residential care homes which are graded 5 or above	100% (2017 target)
Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	69%
Number of successful smoking quits, at 12 weeks post quit, in the 40% most deprived areas	95
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	90%
Number of alcohol brief interventions using setting appropriate screening tool (at least 80% in priority settings and up to 20% in wider settings.)	688
Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	91.50%
Number of Drug-Related deaths	14
No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015	0
Number of acute bed days lost to delayed discharges	3,819
Number of acute bed days lost to delayed discharges for Adults with Incapacity	466
Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	40%

Performance Indicator	Target 2015-16
Number of unplanned admissions for people 65+ as a rate per 1000	240
Percentage of patients achieved 48 hour access to appropriate GP practice team	95%
Percentage of patients advanced booking to an appropriate member of GP Practice Teams	90%
Number of adults 65+ who access tailored physical activity programme in a range of community settings	150
Percentage of homecare clients aged 65+ receiving personal care	83%
Percentage of people receiving free personal or nursing care within 6 weeks of confirmation of 'Critical' or 'Substantial' need	100%
Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	97%
Percentage of people aged 65 or over with intensive needs receiving care at home	40%
Percentage of adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes	65%
Percentage of Care Plans reviewed within agreed timescale	74%
Total number of homecare hours provided as a rate per 1,000 population aged 65+	600
Percentage of Council Home Care services which are graded 5 or above	100% (2017 target)
Percentage of Council-operated older people's residential care homes which are graded 5 or above	100% (2017 target)
Total number of respite weeks provided to all client groups	6,540
Total number of clients aged 65 years+ with a respite package	50
Percentage of people newly diagnosed with dementia who receive a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.	100% (by end 2015/16)
Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	88%
Rate per 1,000 of children/young people aged 8-18 who are referred to the Reporter on offence-related grounds	6
Rate per 1,000 of children/young people aged 0-18 who are referred to the Reporter on non-offence grounds	33.15
Percentage of child protection investigations to case conference within 21 days	95%
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%
Percentage of Adult Support and Protection clients who have current risk assessments and care plan	100%
Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling	98%
Percentage of Community Payback Orders attending an induction session within 5 working days of sentence	80%
Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence	90%
Sickness absence rate amongst WD HSCP NHS employees	4%
Number of days lost to sickness per WD HSCP Council employee	8

WORKFORCE

As at 31st March 2015 just short of 1800 whole time equivalent staff were employed within the then CHCP by its two employing authorities.





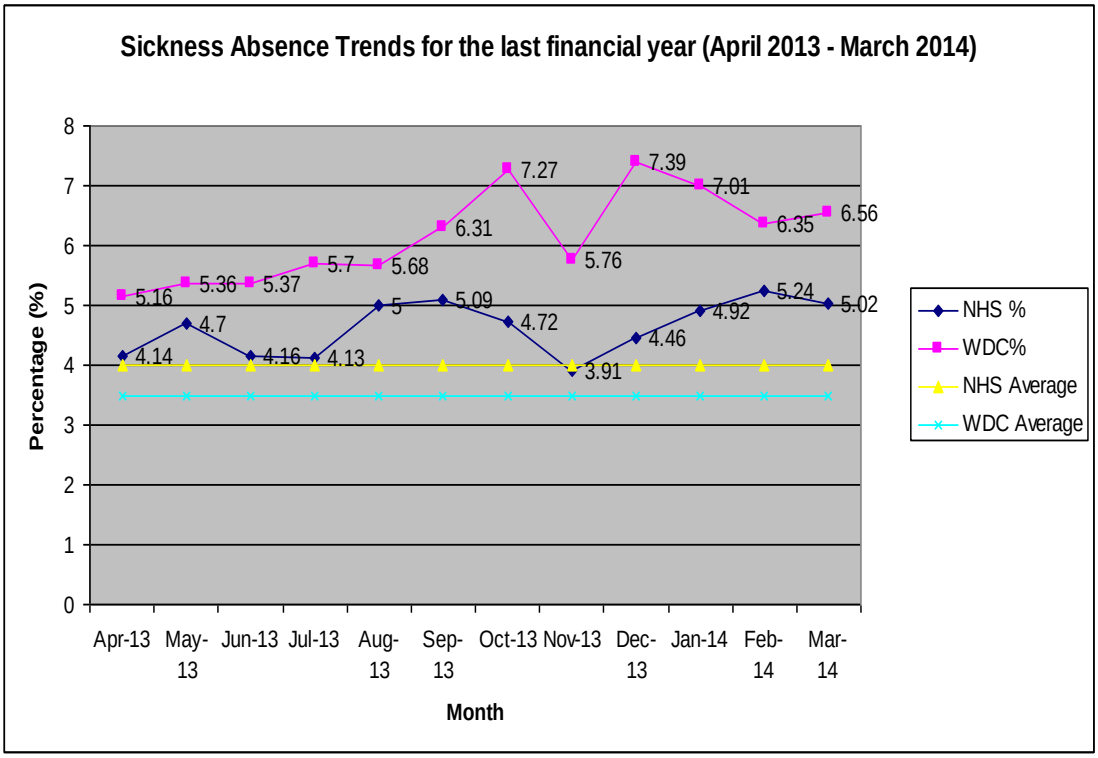
Staff governance is a system of corporate accountability for the fair and effective management of all staff, i.e. that staff should be well informed; appropriately trained; involved in decisions which affect them; treated fairly and consistently; and provided with an improved and safe working environment. The Chief Officer will convene a refreshed local joint Staff Partnership Forum, with formal linkages to their respective corporate trade union partnership forums.

In 2014 the then CHCPs Senior Management Team identified a number of key priorities for the workforce to be addressed across the short and medium term (i.e. the next 1-5 years). These were:

- To assess the implication of workforce structures which arise from the new HSCP structure.
- The development of a robust out of hours/unscheduled care services.
- Talent Management and Succession Planning within the workforce to mitigate the impact of future skills loss associated with an ageing workforce profile.
- The use of agile technologies to assist the workforce, improve productivity and free up additional capacity from existing resources.
- Building on existing capacity within the volunteer and third sector workforce while ensuring the maintenance of quality and standards of service.
- Creating career pathways to encourage retention among key staff groups (e.g. Occupational Therapy, Community Specialist Nurses).
- Increasing levels of Mental Health Officer Qualification among social care staff;
- Assessing workforce training needs in dementia care and engaging educational partners regarding appropriate mechanisms for provision.
- Improve staff wellbeing and staff absence management.

The HSCP will develop a joint Workforce Development and Support Plan and Organisational Development strategy in relation to staff delivering integrated services (except for NHS acute hospitals services), taking account of existing workforce development policies and procedures of both NHSGGC and the Council. These will be prepared within and put in place by 31st March 2016.

The chart below shows the whole CHCP sickness absence trends for the last financial year April 2013 to March 2014, across both NHS-employed and Council-employed staff.



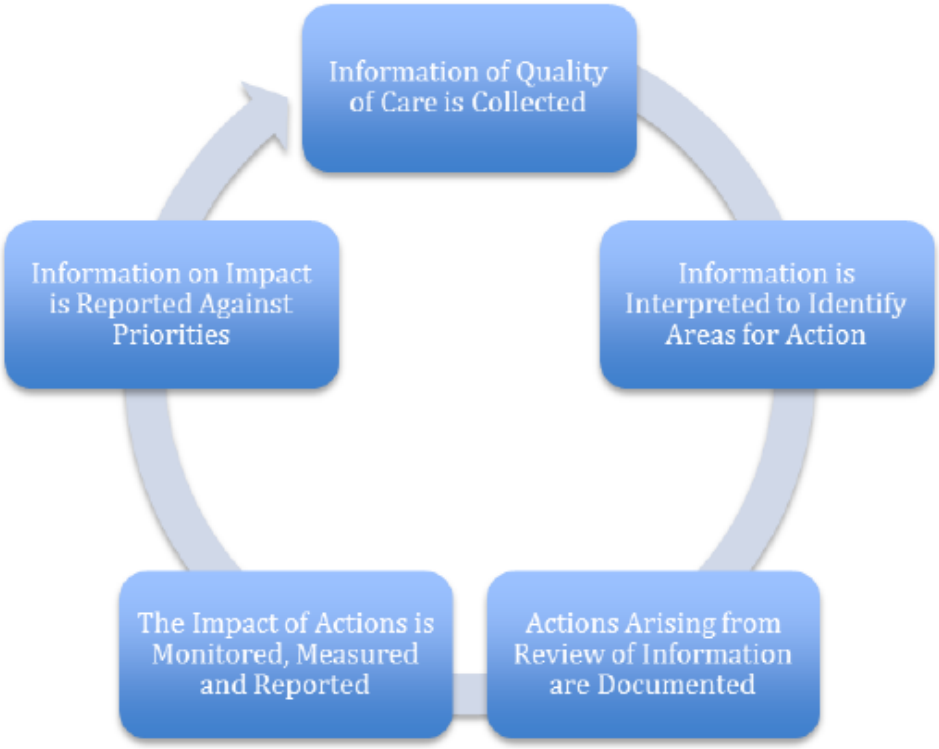
The main causes of sickness absence amongst NHS-employed staff were anxiety/stress related reasons; other musculoskeletal problems; and back problems. The main causes of sickness absence amongst Council-employed staff were acute medical conditions; other musculoskeletal problems; and anxiety/stress related reasons.

The HSCP will implement the following as identified within its Absence Action Plan 2015/16:

- Day one stress Notification to HR team.
- Day one musculoskeletal notification to HR team.
- Managers Stress Workshops.
- Stress Action Plan developed.
- Revised policy update sessions to all Managers.
- In depth absence analysis to be undertaken and routinely presented to the HSCP Senior Management Team.
- Maintain Healthy Working Lives Gold Award.

CLINICAL AND CARE GOVERNANCE

Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured, supporting staff in continuously improving the quality and safety of care and ensuring that wherever possible poor performance is identified and addressed. Effective clinical and care governance arrangements need to be in place to support the delivery of safe, effective and person-centred health and social care services within integrated services.
The Scottish Government's Clinical and Care Governance Framework states that all aspects of the work of Integration Authorities, Health Boards and local authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care. The Framework identifies a number of process steps to support clinical and care governance as illustrated below.



Many clinical and care governance issues will relate to the organisation and management of services rather than to individual clinical decisions. Clinical and care governance, however, is principally concerned with those activities which directly affect the care, treatment and support people receive.

The Clinical and Care Governance Framework also stresses that effective clinical and care governance should support staff in continuously improving the quality and safety of care; and ensure that wherever possible poor performance is identified and addressed. All health and social care professionals will remain accountable for their individual clinical and care decisions.

Clinical and care governance within the HSCP will be achieved by co-ordinating three interlinking strands of work:

- Robust national and local systems and structures that help identify, implement and report on quality improvement.
- Quality improvement work involving staff, service users and the public.
- Establishing a supportive, inclusive learning culture for improvement based on self-evaluation and critical reflection.

The Chief Officer has delegated responsibilities, through the Chief Executives of the Council and the Health Board, for the professional standards of staff working in integrated services. The Chief Officer, relevant lead health professionals and the Council Chief Social Work Officer will work together to ensure appropriate professional standards and leadership. Partnership managers will manage teams of Health Board employed staff, Council employed staff or a combination of both; and will promote best practice, cohesive working and provide guidance and development to their team. This will include effective staff supervision and implementation of staff support policies. Where groups of staff require professional leadership, this will be provided by the relevant Health Board professional lead or the Council's Chief Social Work Officer as appropriate.

The HSCP will establish a local Clinical and Care Governance Group for integrated services managed within the Partnership. This will be chaired by the Chief Officer, and its membership will include the Partnership's Senior Management Team; Clinical Director; Lead Nurse; Allied Health Professions Lead; and Council's Chief Social Work Officer. Through its representative membership, the Clinical and Care Governance Group will interface with the Health Board Clinical Governance Forum; Health Board professional committees; the Area Clinical Forum; Managed Care Networks; and local Multi-Agency Public Protection Arrangement, Adult Support & Protection and Child Protection Committees as appropriate.

LOCALITY PLANNING

The Public Bodies (Joint Working) (Scotland) Act and explanatory notes places a requirement on Health and Social Care Partnerships to establish effective locality planning arrangements, with the stated expectations that:

- Local clinicians and care professionals will play a greater role in locality planning, which will inform the partnerships' strategic plans.
- Carers, patients, service users and their families will also inform locality planning arrangements.

The Public Bodies (Joint Working) (Scotland) Act 2014 Section 29 specifically requires the partnership to include in its Strategic Plan information on:

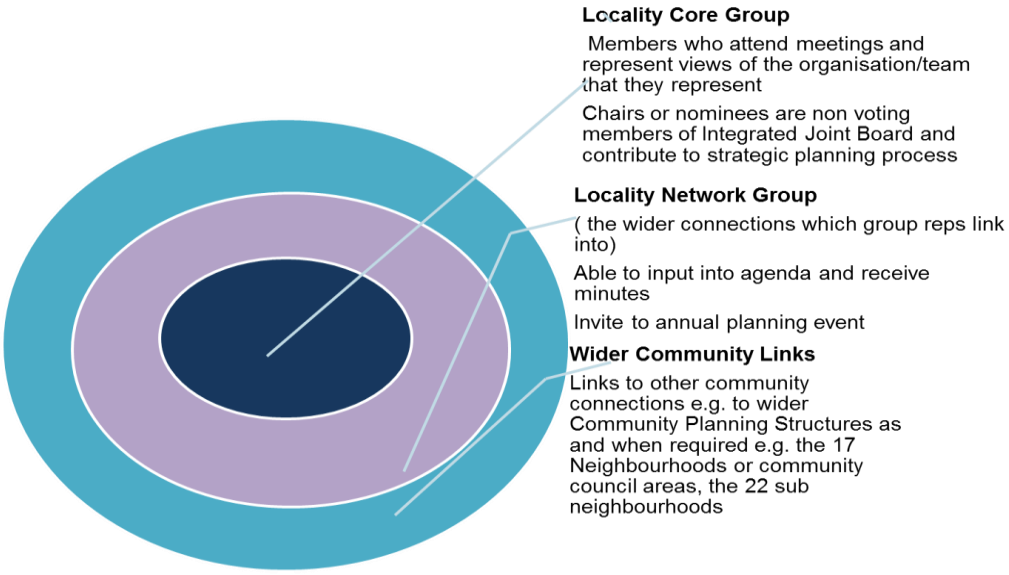
- How it will divide the area of the local authority into two or more localities.
- How it will set out arrangements for the carrying out of the integration functions in relation to each locality.

For West Dunbartonshire two localities have been identified: *Alexandria/Dumbarton* and *Clydebank*. These take account into account:

- The existing good partnership working across each locality which has been developed over a number of years.
- The fact that the populations are of similar size.
- The natural geographical boundaries of the two parts of the local authority.
- Current links into different parts of hospital NHSGGC services.

While the CHCP's locality group arrangements provided a reasonable platform for addressing the requirements of the Act, they required updating to fully comply with the necessary requirements of the Act, notably in relation to the wider range of stakeholders who should be engaged at that level; and to respond to locality-level feedback that meetings should be kept to a minimum but structured to make the best use of everyone's time and commitment.

So, it is proposed to have a *locality core group* for each locality which is involved in the locality plan with a *locality network group* structure where the representatives on the core group involve the wider networks, teams or services in locality programmes and specifically through an annual planning meeting. Additional links with wider community planning partnership services and mechanisms will also be available to support locality work as and when required.

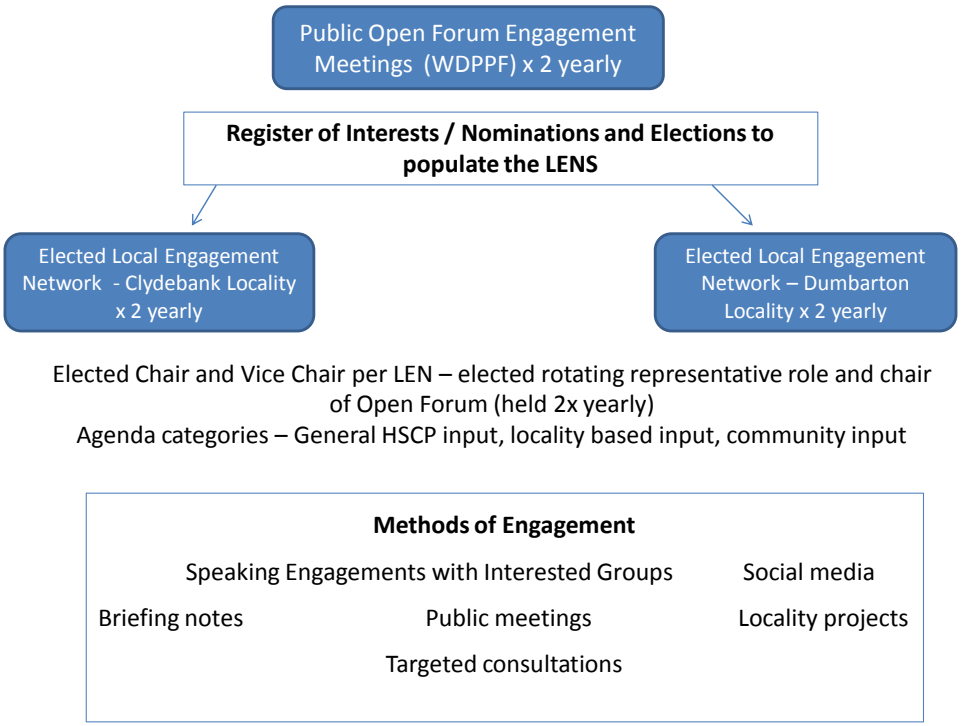


The above proposals have been consulted upon locally, been positively received and further refined in response to constructive feedback. In further developing these arrangements, the HSCP will collaborate with partners to:

- Provide information on current performance and expenditure on a locality basis.
- Work with locality stakeholders to identify two or three issues to prioritise that are of particular concern within their "patch" from a long-list of issues highlighted by profile and performance data; and to develop and then implement a work plan to effect improvements.
- Developing a common structure for the engagement of secondary care and improving the interface between community and secondary care, implementing appropriate elements of the NHSGGC Clinical Services Strategy.
- Supporting locality professional engagement, particularly with the seventeen GP practices and other primary care contractors.
- Having structured engagement with locality community organisations, community members and the public, most notably to develop more supported self-care and provide feedback to providers (including NHS external contractors).

COMMUNITY ENGAGEMENT

Following the completion of our comprehensive Community Engagement Review, we are now looking to update our Public Partnership Forum arrangements in line with its recommendations. The intent is to maintain a West Dunbartonshire-wide forum, strengthened with the introduction of a stronger locality "voice" and a renewed emphasis on increasing the representation and diversity of those involved. The Local Engagement Network is to be a re-development of the previous Public Partnership Forum structure and aims to positively further develop community engagement across Health and Social Care in West Dunbartonshire. The model is the result of extensive consultation with existing and potential stakeholders and allows for evolutionary change over time as the HSCP and its locality planning arrangements also develop (as below).



As required by the new legislation, the HSCP will seek to co-produce a local participation and engagement strategy, which will be delivered by 31 March 2016. In developing these arrangements, the HSCP will work with partners and local communities to apply the principles and practices endorsed by the Scottish Health Council and those set out in the National Standards for Community Engagement. Through the HSCP's processes for community engagement we will ensure that we engage and consult with services users and the wider community routinely, building feedback into all of our interactions. The feedback we receive will be fed into our continuous quality improvement processes to shape further planning and delivery of services.

EQUALITIES FRAMEWORK

The Equality Act 2010 strengthens, harmonises and streamlines 40 years of equalities law in relation to the nine "protected characteristics" of age, disability, gender, race, religion and belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment. The intent of the Equality Act to protect groups from discrimination, harassment or victimisation readily fits with the over-arching priorities and commitments set out within this Strategic Plan to the delivery of quality person centred supports and services - not least because the requirements of this legislation have been considered in preparing it. Given its legal status, the HSCP Board (alongside the Council and the Health Board) will require to play its part in addressing the general duties outlined in the Equality Act 2010 to:

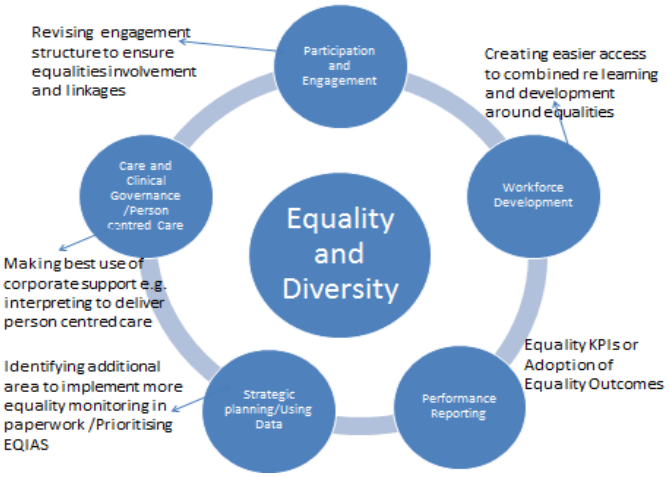
- Eliminate discrimination, harassment and victimisation.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Additionally the Scottish Parliament's Equal Opportunities Committee (February 2015[3]) has indicated that Integration Authorities will be added to the listed bodies[4] under the Equality Act 2010 (Specification of Public Authorities) (Scotland) Order 2015 - which will mean that they will be subject to some of the additional public sector specific duties for functions which have been delegated to them. Whilst more guidance on the detail of this is expected from the Equalities and Human Rights Commission, it is likely that the HSCP Board will have additional responsibilities in relation to the specific duties to publish equality outcomes and report progress; and assess and review policies and practices (where policies and practices are locally decided and relate to responsibilities around the delegated functions of the HSCP Board).

With respect to integrated health and social care services in West Dunbartonshire, the former CHCP had already adopted a focus on streamlining processes around equalities responsibilities - such as standardising Equality Impact Assessments processes; actively contributing to both the NHSGGC and Council Equality Outcomes; and mainstreaming reporting as a key community planning partner

[3] http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/87166.aspx
[4] http://www.equalityhumanrights.com/about-us/devolved-authorities/commission-scotland/public-sector-equality-duty-scotland/public-authorities-scotland-who-covered-specific-duties-0

in West Dunbartonshire. This integrated and streamlined approach to considering equality fits well with the intentions of the Equality Act whereby equality should be taken into account in all the day to day organisational functions; and also the Equality & Human Rights Commission Measuring Up report on public bodies performance against the Equality Act 2010(Specific Duties) (Scotland) Regulations 2012 where the importance of considering equality outcomes on a community planning basis was reinforced. Further integrating of equalities responsibilities into on-going planning, delivery and reporting of the HSCP activities is illustrated as below.



As guidance becomes available and the position is clarified, then these matters will be addressed and brought forward to the HSCP Board for consideration. In the meantime, the HSCP will look to continue work with corporate equalities support services within the Health Board and the Council to develop a locally streamlined approach which combines:

- A continued focused approach to the general equalities duties.
- A move to having a stronger organisational response by taking more ownership of the specific equalities duties and equality outcomes in a integrated manner.
- Introduce greater local scrutiny in relation to progress.

Given that the remaining specific duties concern areas (such as procurement and employment) will remain the overall responsibility of the Health Board and the Council, the HSCP will continue to meet its obligations around these areas by implementing the relevant policies and practices as appropriate related to these areas. Similarly where appropriate, the HSCP will continue to contribute to wider corporate equalities programmes of the Council and the Health Board.

FINANCIAL FRAMEWORK

Budget Allocation - West Dunbartonshire Council

Revenue (recurring)

Amounts to be paid by the Council to the Health & Social Care Partnership Board in respect of all of the functions delegated by it to the Health & Social Care Partnership Board is as follows.

	£million	
	2015/16 Full Year	**9 months from July 2015**
Older Persons	15.341	11.506
Adults with physical or sensory disabilities	1.969	1.477
Adults with learning disabilities	11.211	8.408
Adults with mental health needs	2.066	1.550
Service Strategy	1.178	0.884
Children's Panel	0.002	0.002
Children & Families	14.869	11.152
Criminal Justice ***	-	-
Adults with other needs	1.231	0.923
Homecare	9.349	7.012
Housing Adaptations and gardens	0.756	0.567
Other Social Care Services	3.349	2.512
Total	**61.321**	**45.991**

***Criminal Justice cost of 0.371M is funded by Scottish Govt grant giving net cost to HSCP of nil.

Capital

Capital and assets and the associated running costs will continue to sit with the Council.

- Recurrent

	£million	
	2015/16 Full Year	**9 months from July 2015**
Aids and Adaptations – HSCP	0.655	0.491
Aids and Adaptations – Housing Revenue Account (HRA)	0.300	0.225

- Non-recurrent

Replacement of all older people's residential care and day care facilities with two new facilities – one in Dumbarton and the other in Clydebank): £22.652m (full project cost)

Budget Allocation – NHS Greater Glasgow & Clyde

Revenue (recurring)

Amounts to be paid by NHSGGC to the Health & Social Care Partnership Board in respect of all of the functions delegated by it to the Health & Social Care Partnership Board is as follows.

	£million	
	2015/16 Full Year	**9 months from July 2015**
Community		
District Nursing	2.032	1.524
Health Visiting	1.498	1.124
Child Health	1.743	1.307
Specialist Nursing	0.393	0.295
Hospital Inpatient Services	2.073	1.555
Community Mental Health Teams	4.541	3.406
Community Learning Difficulties Team	0.282	0.212
Addiction Services	1.871	1.403
Community AHP	1.139	0.854
Health Promotion	0.914	0.686
Other (includes hosted services – MSK & Eye Care)	11.897	8.923
Family Health Services		
GMS	11.533	8.650
Pharmaceutical Services - GP Prescribing	17.255	12.941
Pharmaceutical Services – Other	3.072	2.304
General Dental Services	4.973	3.730
General Ophthalmic Services	2.166	1.625
Resource Transfer	7.588	5.691
Total	**74.970**	**56.228**

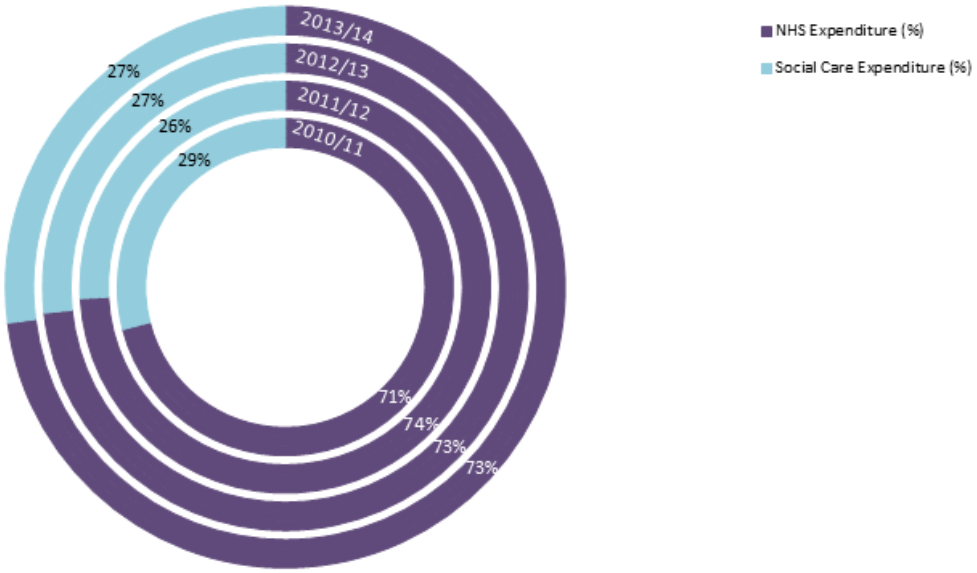
Capital

Capital and assets and the associated running costs will continue to sit with the Health Board. On 23rd June 2015 the Scottish Government announced that a new £19 million Clydebank Health & Care Centre will be funded through its non-profit distributing (NPD) programme.

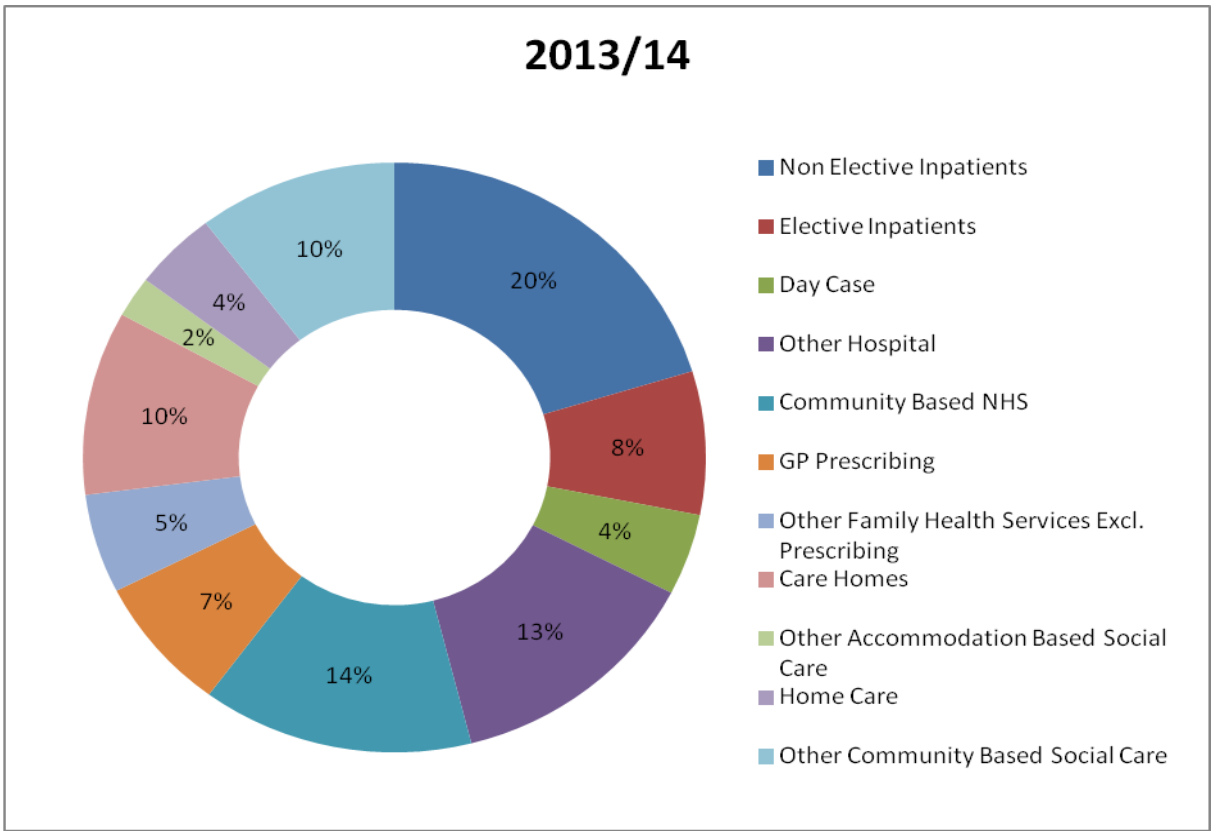
Acute Hospital Budget

During 2015/16 the Health Board Director of Finance will work with HSCPs within the NHSGGC area to develop an agreed methodology to calculate the appropriate budget to represent consumption of unscheduled care services by Integration Joint Boards. Set aside budgets will be then be proposed to each Integration Joint Board with a view to their being available to all those Integration Joint Boards from 1 April 2016.

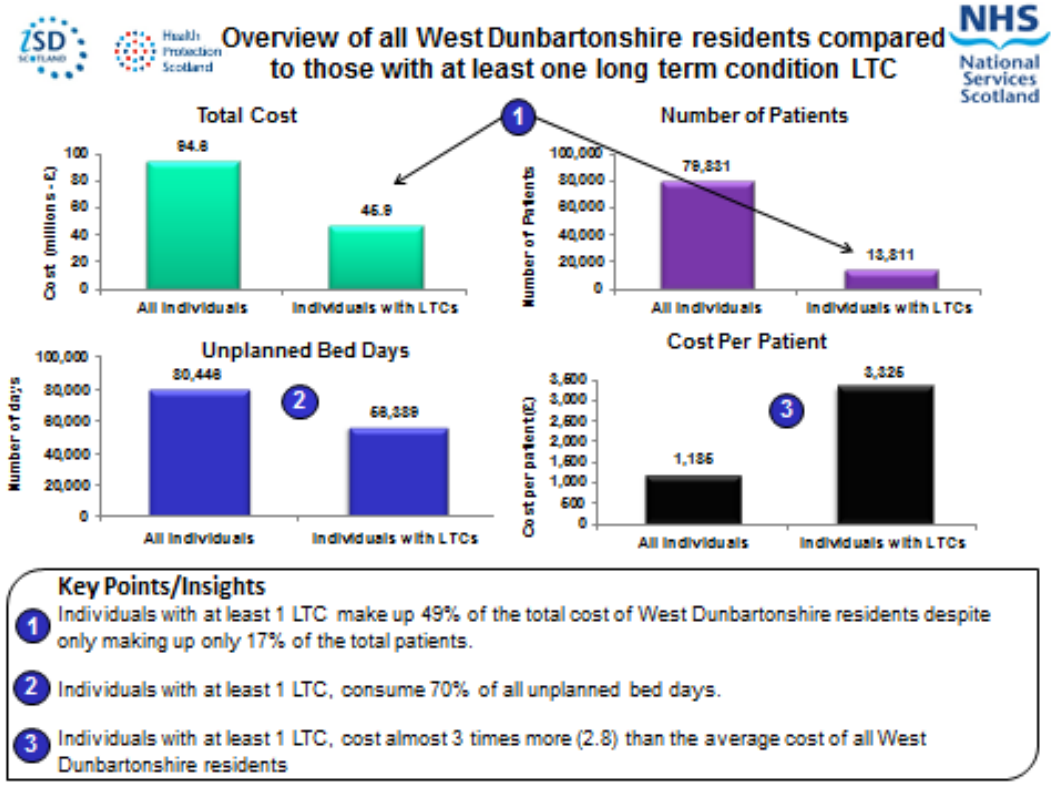
In anticipation of this and to support the broader planning and delivery of services within West Dunbartonshire, working has been undertaken with the national Information Services Division (ISD); with analysis using the Integrated Resource Framework for the financial year ending 31st March 2014 used to highlight the proportion of total NHS and Council social care expenditure.

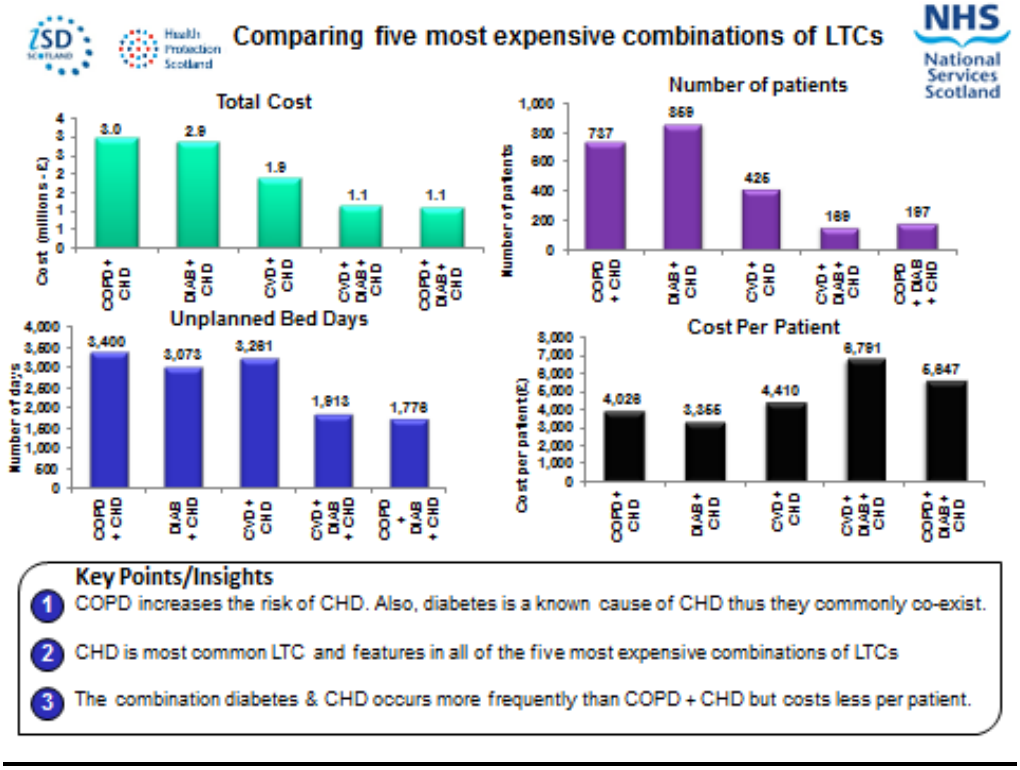


The indicative analysis of that spending for 2013/14 can be seen per sector as:

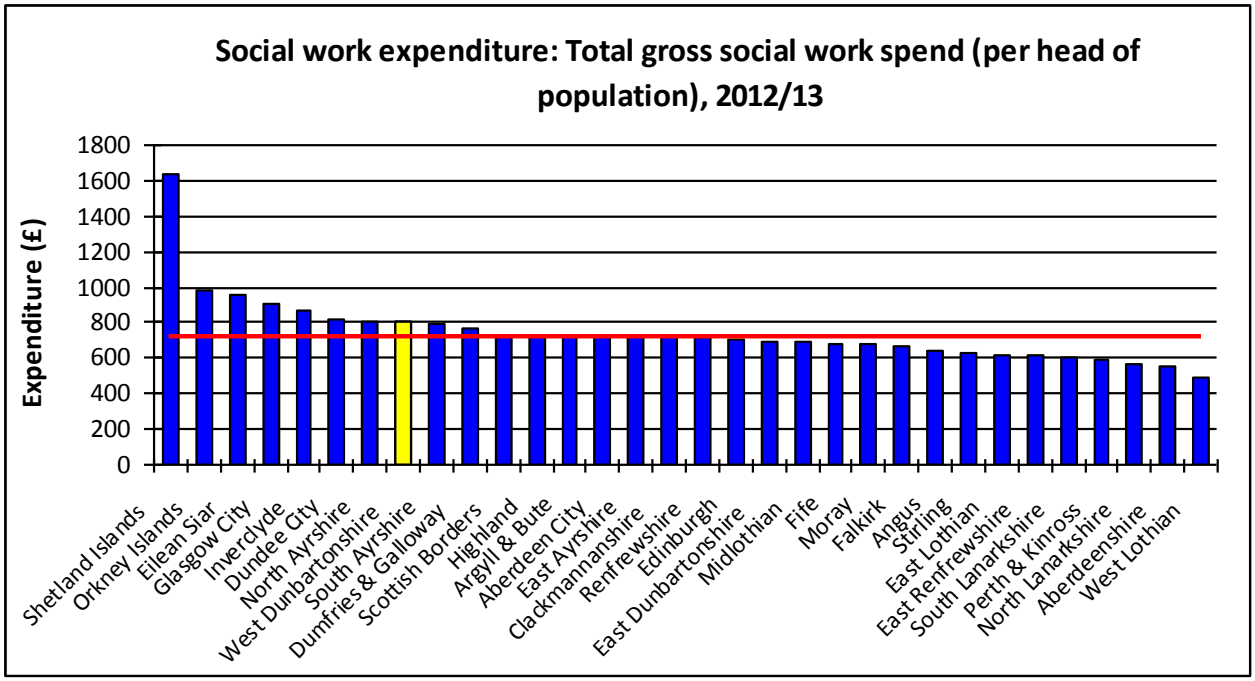


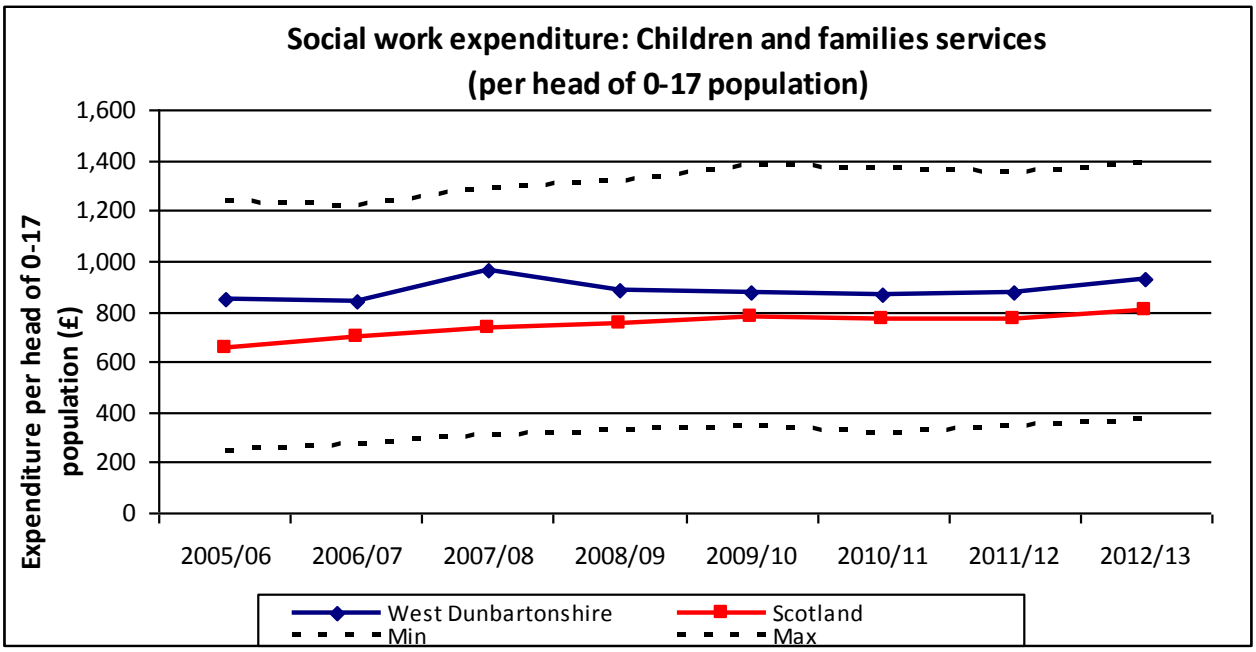
In terms of gauging the financial implication of demands on services, further work has been undertaken with ISD to review and analyse management information relating to Long Term Conditions. The following charts are provided for information and based on SMR01 data for the 12 months ended 31st March 2013 - this work is at an early stage and requires to be treated with caution, particularly costs as these are "NHS" only at this point.

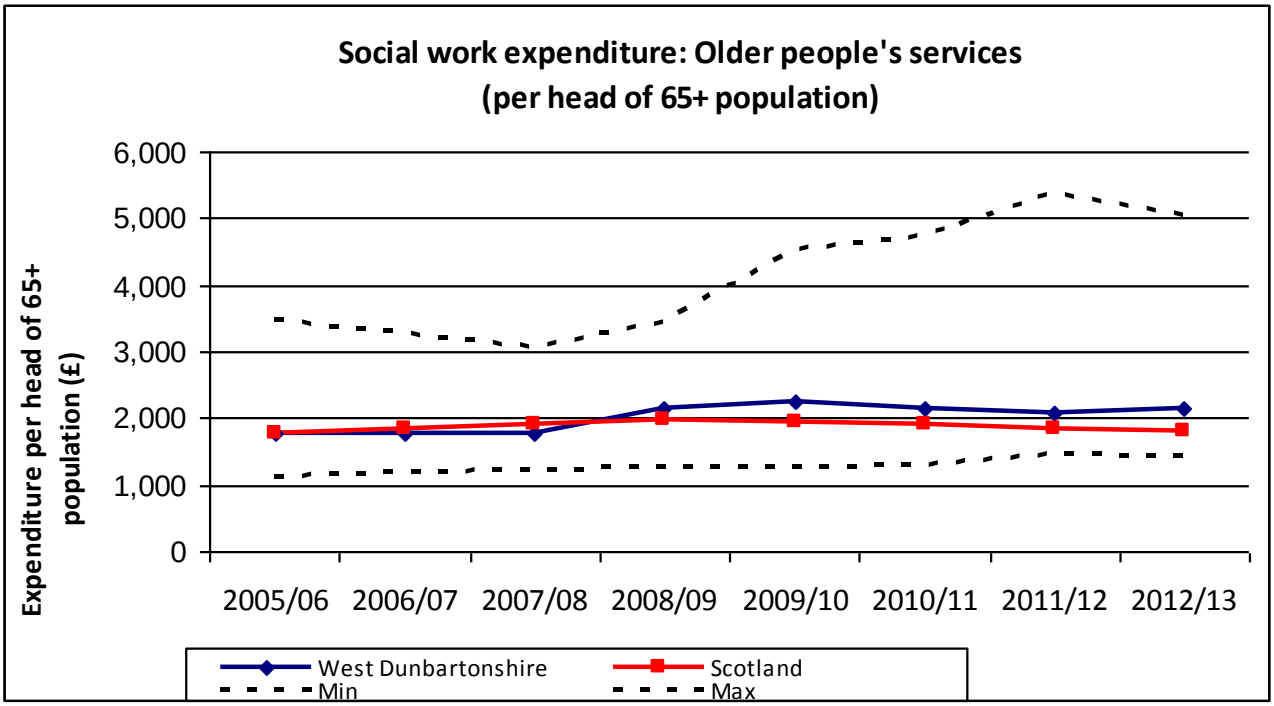




The most recent report on Social Work Spend and Activity 2005/06 - 2012/13 from the Scottish Government presents the following picture in relation to West Dunbartonshire.







Based on prevalence data and analysis of service usage, it is likely that the current level of demand for services is going to increase over the coming years. Local analysis of IORN (Indicators of Relative Need) data has confirmed that we can anticipate a significant increase in the number of people in high needs categories in particular. This is also going to be accompanied by further changes in the nature of the needs within the population, the types of demands that are expressed, the expectations concerning how best to meet them and the reduced finances available to resource them. Fortunately West Dunbartonshire has the benefit of a strong local track record for improvement across health and social care services; and as such provide a solid foundation for the further developments necessary for the new WD HSCP through 2015 and beyond.

APPENDIX 1: HEALTH & SOCIAL CARE PARTNERSHIP BOARD DELEGATIONS

Services delegated by the Health Board

- Accident and Emergency services provided in a hospital.
- Inpatient hospital services relating to the following branches of medicine: general medicine; geriatric medicine; rehabilitation medicine; respiratory medicine; psychiatry of learning disability.
- Palliative care services provided in a hospital.
- Services provided in a hospital in relation to an addiction or dependence on any substance.
- Mental health services provided in a hospital, except secure forensic mental health services.
- Services provided by AHPs in an outpatient department, clinic, or outwith a hospital.
- Health Visiting services.
- School Nursing.
- Speech and Language Therapy.
- Specialist Health Improvement.
- Community Children's Services.
- Child and Adolescent Mental Health Services
- District Nursing services.
- The public dental service.
- Primary care services provided under a general medical services contract.
- General dental services.
- Ophthalmic services.
- Pharmaceutical services.
- Services providing primary medical services to patients during the out-of-hours period.
- Services provided outwith a hospital in relation to geriatric medicine.
- Palliative care services provided outwith a hospital.
- Community learning disability services.
- Rehabilitative Services provided in the community.
- Mental health services provided outwith a hospital.
- Continence services provided outwith a hospital.
- Kidney dialysis services provided outwith a hospital.
- Services provided by health professionals that aim to promote public health.

Services delegated by the Council

- 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.
- The legislative minimum delegation of housing support, including aids and adaptations.
- Day services.
- Local area co-ordination.
- Self-Directed Support.
- Occupational therapy services.
- Re-ablement services, equipment and telecare.
- Residential and non-residential care charging.
- Respite provision for adults and young people.
- Social work services for children and young people:
    - Child Care Assessment and Care Management.
    - Looked After and Accommodated Children.
    - Child Protection.
    - Adoption and Fostering.
    - Child Care.
    - Special Needs/Additional Support.
    - Early intervention.
    - Throughcare Services.
- Social work criminal justice services, including Youth Justice Services.

APPENDIX 2: MARKET ANALYSIS AND FACILITATION

The health and social care marketplace in West Dunbartonshire represents a mixed economy approach to service delivery, bringing together differing elements of service delivery agreed shared client outcomes. Within this landscape, the Health and Social Care Partnership (HSCP) provides leadership both in service planning and mapping and in ensuring service quality compliance within an agreed standard of quality assurance of services. This requirement serves to protect people who use health and social care services as well as promoting quality across all statutory services and within the third and independent sectors. As such within our commissioning approach, there is a requirement for analysis of our current position, a description of the agreed direction of travel and the restatement of the underlying philosophy of care across all services within our partnership.

Such a robust market analysis and commissioning approach across the partnership requires an effective dynamic with communities and individuals to understand their needs, their assets and their aspirations; in order to fund and guarantee effective, meaningful and efficient support.

Quality assurance

A cornerstone of this approach to commissioning is our commitment to quality assurance which is already applied to a range of community services. Quality assurance articulates delivery against contract specifications, service users and carers needs as well as appropriate inspection and regulation compliance requirements.

Within the HSCP and wider partners this is expressed as a collection of processes focused on achieving the agreed quality objectives i.e. what the service user has as an assessed need. It is articulated within the HSCP organisational structure through policies, procedures, processes and resources needed to implement quality management. Representing for the HSCP and partners the convergence of inspection processes and customer satisfaction analysis.

Assessing quality is a process by which partners can review the quality of all factors involved in service delivery, placing an emphasis on three aspects:

- Service management - defined and well managed processes, performance information and eligibility thresholds and identification of individuals.

- Competence within service delivery - such as being assured of the knowledge, skills, experience, and qualifications of all staff involved.
- "Soft" elements with organisations such as organisational integrity, confidence in providers, organisational culture, service motivation, team spirit, and quality relationships.

In order to measure effectiveness of service and outcomes for service users; controls include service inspection, where the service is assessed based on the Care Inspectorates Care Standards; where inspectors have a set of agreed standards to support the inspection of quality and care and descriptions of unacceptable service deficiencies. The quality of the service is at risk if any of these three aspects outlined above is deficient in any way.

Recognising that not all services are regulated in this way, the assurance framework within the HSCP relies on robust quality assurance and contract compliance across all services within health, social care, third and independent sector. Current provision by the independent and third sectors is currently clustered around a number of regional/national provider agencies, serviced by a range of smaller more locally based, specialism focussed organisations. However, changing client need and the desire to move to a clearer co-production focus has signalled the need for a review of the market and the opportunities it holds, both for individual organisation and for potential Consortium service arrangements.

Consortium

West Dunbartonshire uses co-production as a keystone in developing effective commissioning systems which use an asset based care *consortia* approach across all partners – public sector, independent sector, third sector and service users – to maximise and contribute to the long term viability of services.

The third sector describes itself as individual organisations within the following categories; charity, voluntary organisation, community group, social enterprise and community business. In addition to the universal support services provided in West Dunbartonshire, the Third Sector provides a range of services and interventions including:

- Residential Services and Supported Accommodation.
- Home Care Support.

- Access to Respite opportunities.
- Care and Repair services.
- Befriending services.
- Carer Support services.
- Peer Support services.
- Sensory impairment services.
- Dementia services.

The third sector play a key role in facilitating the necessary interventions both in building community capacity and supporting co-production through positive service collaboration, development and planning. Both the third and independent sector deliver a wide range of services for older people and those with long term conditions, learning disabilities, physical disabilities, dementia or mental health problems as well as supporting.

The independent sector aims to offer choice and value for money, by creating an environment in which care providers can continue to deliver and develop the high quality care that communities require and deserve. The independent sector described as a being a range of small, medium and large providers of health and social care; including single providers, small and medium sized groups, national providers and not-for-profit voluntary organisations and associations; providing residential services, supported accommodation, home care support and access to respite opportunities.

Within the Consortium, there is a need to support a market approach that offers diverse opportunities for the delivery of care to people across West Dunbartonshire who can be active consumers of care and who can direct the service they require. The services may be delivered by existing providers, from partners or indeed from new start-up independent and third sector businesses.

Philosophy of Care

By creating an agreed philosophy of care, partners within the Consortium are agreeing how we measure the quality of service, what is expected of partners and the ongoing impact of the changing policy and legislation landscape. This continuous review of quality will highlight good practice as well as identifying where there are requirements for improvement; supporting a timeous and

focused approach. Overall an approach that refers to the administrative and procedural activities implemented across the partnership so that requirements and goals for all of our services or activity will be fulfilled.

The need to ensure the provision of high quality services across both registered and non-registered service provision is a priority. A tiered approach will be taken to quality monitoring spanning the requisite inspection and reporting duties of Care Inspectorate Registered Providers, through vigorous contract management approaches undertaken through HSCP to self-assessment and proportionate risk-assessment scrutiny for small non-commissioned providers. With the support of partners from the Third Sector Interface and Scottish Care, a suite of consistent quality standards will be created reflecting the agreed Philosophy of Care.

Community capacity building

Building community capacity to support the locality remains a key priority within the West Dunbartonshire partnership. All partners recognise that the significant scale of change needed to shift the balance of care to more community based provision can only be achieved through positive engagement and capacity building activity. Annual sector mapping undertaken by West Dunbartonshire CVS, identifies a considerable provision of low-level, non-commissioned engagement and support activity (145 active organisations) spanning social and physical activity, domestic support and community activity.

These organisations are principally volunteer-led and neighbourhood based and have been identified as requiring ongoing support to maintain sustainability; an activity on which the Third Sector Interface will continue to lead. Building on the groundwork undertaken in developing the LinkUp one-call telephone service for older people and carers, work is progressing to the development of structured neighbourhood asset maps and corresponding development plans to ensure equity of sustainable and appropriate service provisions and clear community pathways across the full local authority area in line with the priorities of older people. The replicability of the LinkUp model facilitates the development of clear pathways which will both connect and harness the services available from organisations and from individual voluntary efforts.

Ongoing dialogue and consultation with older people and representative groups is a key element in all aspects of this activity; maximising the value of their views, experience, abilities and expertise.

Co-production

Co-production is a critical element of the West Dunbartonshire way forward, reflecting its ability to improve well-being through building and supporting social networks; to narrow health inequalities and rebuild traditions of 'mutuality' - all crucial to meeting the aims of Reshaping Care for Older people and helping to bring about an overall reduction in demand for acute health services.

In order to shape the market for the next three years, a full market analysis has been undertaken across the third and independent sectors, highlighting existing and potential providers and signalling the need for service provision to be aligned to the outcomes of the reshaping care agenda and explicitly highlighting co-production as the expected method of working going forward. To facilitate this, third and independent sector partners will continue to work proactively with the provider based in the area to develop capacity via a pipeline approach. This will be taken forward both within and outside of any existing commissioning relationships.

Resource and Leverage

The resources available across the Consortium will become increasingly pertinent; commissioning partners will identify the areas which they see as requiring priority and therefore also more likely to be sustainable for providers to operate within. Where funding pressures may require a re-shaping of service provision and priorities, discussions with the providers can facilitate change to models of delivery which are purposeful in relation to areas which will be vulnerable to reductions in funding or decommissioning of services.

The move to a Consortium approach allows West Dunbartonshire's population to benefit from any funding streams and opportunities which may be developed for both the statutory and third sector over the period. This strengthening of an outcomes focussed approach will increase both service opportunities and sustainability for the population served.

Market Facilitation

The starting point for Market Facilitation will be the development of a Market Position Statement (MPS) for West Dunbartonshire. The MPS will require information in four distinct areas as below.

1. Supply & Demand
   Supply and demand presently and for the future, reviewing current population with 5-10 year projections and the impact of population changes on demand and consequently supply needs. Review of current spend on services coupled with present supply in relation what is being provided, to whom, where and volume of the provision. Review of how the present supply meets anticipated future need and how to support providers adjust to changes in service delivery whether that is a change to how services are delivered or changes to the client profile.
2. Customer Base
   Confirm who the "customers" of the services currently are and who will they be in the future. Going forward we may see more individuals purchasing their own services - so how can we make the market more transparent for them and also support them with the information which will empower them to make the best decisions for their and their families needs.
3. Philosophy of Care
   Consortium partners are agreeing how we measure the quality of service, what is expected of partners and the ongoing impact of the changing policy and legislation landscape.
4. Resources
   The Consortium will lay out what are the totality of resources available to be used, not just what statutory sector can provide but what is available from the community and how are you working in partnership with the available services. In addition, community benefit clauses will also support the best-fit for partners in the delivery of care.

The Consortium partners will ensure and support all partners within the agreed commissioning model to have effective and appropriate systems of:

- Quality control.
- Compliance to regulation and inspection regimes.
- Readiness to deliver.
- Provide alternatives and choices for citizens.

West Dunbartonshire
Health & Social Care Partnership