

Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board

Date: Wednesday, 8 August 2018

Time: 14:00

Venue: Civic Space, Council Offices, 16 Church Street, Dumbarton

Contact: Nuala Quinn-Ross, Committee Officer
Tel: 01389 737210 Email: nuala.quinn-ross@west-dunbarton.gov.uk

Dear Member

ITEMS TO FOLLOW

I refer to the agenda for the above meeting which was issued on 26 July 2018 and enclose a copy of the undernoted reports which were not available for issue at that time.

Yours faithfully

BETH CULSHAW

Chief Officer of the
Health & Social Care Partnership

Note referred to:-

6 ANNUAL PUBLIC PERFORMANCE REPORT 2017/18 420 - 485

Submit report by the Interim Head of Strategy, Planning & Health Improvement presenting the third Annual Public Performance Report for the Health & Social Care Partnership, including a complaints management overview for the full year.

7 STRATEGIC PLAN 2016 – 2019; ANNUAL REVIEW 486 - 529
2018 – 2019

Submit report by the Interim Head of Strategy, Planning & Health Improvement presenting an annual review of the Strategic Plan 2016 - 2019 in preparation for the development of a new Strategic Plan 2019 - 2022.

Distribution:-**Voting Members**

Marie McNair (Chair)
Denis Agnew
Allan Macleod
John Mooney
Rona Sweeney
Audrey Thompson

Non-Voting Members

Barbara Barnes
Beth Culshaw
Wilma Hepburn
Carron O'Byrne
Chris Jones
John Kerr
Neil Mackay
Diana McCrone
Anne MacDougall
Kim McNabb
Janice Miller
Peter O'Neill
Selina Ross
Julie Slavin
Alison Wilding

Senior Management Team – Health & Social Care Partnership

Date of issue: 27 July 2018

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 8th August 2018

Subject: Annual Public Performance Report 2017/18

1. Purpose

- 1.1** To present the Partnership Board with the third Annual Public Performance Report for the Health & Social Care Partnership, including a complaints management overview for that full year.

2. Recommendations

- 2.1** The Partnership Board is recommended to approve the Annual Public Performance Report for publication.

3. Background

- 3.1** As required by legislation, the appended Annual Public Performance Report has been produced to enable scrutiny of the delivery of the second year of the HSCP's Strategic Plan 2016 – 19. As has been the custom in previous years, it is accompanied by a complaints management overview for the corresponding period.

4. Main issues

- 4.1** The preparation and presentation of the Annual Performance Report has been informed by the national Guidance for Health and Social Care Integration Partnership Performance Reports. It has also been informed by local experience of integrated performance reporting, alongside feedback from other sources - including formal feedback from the Accounts Commission Best Value Assurance Report of June 2018 where the HSCP was praised for making progress in delivery new models of care; as a result of more integrated working between district nursing and care at home the HSCP is responding more effectively to risks and unnecessary hospital admissions.
- 4.2** Once considered by the Partnership Board, this Annual Public Performance Report will be published on the Health & Social Care Partnership's website; submitted to the Health Board, the Council, the local Community Planning Partnership Management Group and Scottish Government.

5. People Implications

- 5.1** There are no people implications specifically associated with this report.

6. Financial Implications

- 6.1** The Annual Public Performance Report includes a summary of the Health & Social Care Partnership's year end financial position, as agreed by the Chief Financial Officer and previously reported by them to the Partnership Board.

7. Professional Implications

- 7.1** The content of the Annual Public Performance Report will overlap with the substance of the next Chief Social Work Officer's Annual Report (which will be presented to a future meeting of the Partnership Board and the Clinical and Care Governance Meeting as well as to full Council).

8. Locality Implications

- 8.1** The Annual Public Performance Report confirms the continuing development of the arrangements for both the two locality areas and the three GP Clusters as well as the ongoing development of the Primary Care Improvement Plan which will be presented to this committee.

9. Risk Analysis

- 9.1** Section 42 of the Public Bodies (Joint Working) Act obliges integration authorities to prepare and publish an annual performance report setting out an assessment of performance in planning and carrying out the integration functions for which they are responsible.

10. Impact Assessments

- 10.1** None required.

11. Consultation

- 11.1** Appropriate complaints management – including lessons learnt – is an important element of service user feedback.

12. Strategic Assessment

- 12.1** The Annual Public Performance Report has been produced to enable scrutiny of the delivery of the Strategic Plan in an open and accountable manner.

Author: Wendy Jack – Interim Head of Strategy, Planning & Health Improvement, West Dunbartonshire Health & Social Care Partnership

Date: 11th July 2018

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Attached: West Dunbartonshire Health & Social Care Partnership Annual Public Performance Report 2017/18

Background Papers: HSCP Board Report (August 2018): Strategic Plan 2016-19; Annual Review 2018 –2019

HSCP Strategic Plan 2016 – 2019; Annual Review 2018 – 2019

Guidance for Health and Social Care Integration Partnership Performance Reports:
<http://www.gov.scot/Publications/2016/03/4544>

Wards Affected: All

public performance report 2017/18

www.wdhscp.org.uk



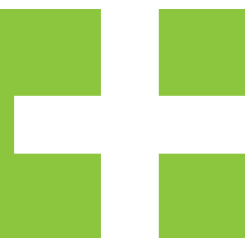
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The year in figures 2017/18

81%

OF PEOPLE RATED THEIR CARE
OR SUPPORT AS GOOD OR EXCELLENT



756

LESS BED DAYS SPENT IN HOSPITAL BY PEOPLE
AGED 65 AND OVER WHO WERE READY FOR DISCHARGE

98%

OF PEOPLE AGED 65 AND OVER WITH COMPLEX
NEEDS LIVING AT HOME OR IN A HOMELY SETTING

85%

OF PEOPLE HAD A POSITIVE EXPERIENCE OF THE
CARE PROVIDED BY THEIR GP PRACTICE

92%

OF CARE SERVICES GRADED
GOOD OR BETTER IN CARE INSPECTORATE
INSPECTIONS: 3rd BEST PERFORMING
IN SCOTLAND



4,344

EMERGENCY ADMISSIONS TO
HOSPITAL FOR PEOPLE AGED
65 AND OVER

49,304

UNPLANNED HOSPITAL
BED DAYS
FOR PEOPLE
AGED 65 AND
OVER



79%

OF PEOPLE AGREED THEIR
HEALTH AND CARE SERVICES
SEEM TO BE WELL CO-ORDINATED



90.4%

OF LOOKED AFTER
CHILDREN WERE
LOOKED AFTER IN
THE COMMUNITY

79.2%

OF CHILD PROTECTION
CASE CONFERENCES
WERE CARRIED
OUT WITHIN 21 DAYS

89%

OF PEOPLE AGREED
THEY FELT SAFE



80%

OF PEOPLE FELT THEY HAD A
SAY IN HOW THEIR HELP, CARE
OR SUPPORT WAS PROVIDED

941

PEOPLE SUPPORTED TO
MANAGE THEIR MEDICATION

628

CARERS RECEIVED 4,449
WEEKS OF RESPITE

91%

OF PEOPLE HAD A POSITIVE
EXPERIENCE OF THE CARE
PROVIDED BY THEIR
GP PRACTICE



1,921

PEOPLE HAVE
AN ANTICIPATORY
CARE PLAN
IN PLACE



632

PEOPLE RECEIVED A
REABLEMENT SERVICE
RE-LEARNING DAILY SKILLS
TO LIVE AS INDEPENDENTLY
AS POSSIBLE



92.4%

OF PEOPLE RECEIVED APPROPRIATE DRUG
OR ALCOHOL TREATMENT TO SUPPORT THEIR
RECOVERY WITHIN 3 WEEKS OF REFERRAL

81%

AGREED THAT THEY ARE SUPPORTED TO LIVE
AS INDEPENDENTLY AS POSSIBLE

79%

OF PEOPLE AGREED THEIR SERVICES AND
SUPPORT HAD AN IMPACT ON IMPROVING
OR MAINTAINING THEIR QUALITY OF LIFE

10,632

HOURS OF HOME CARE
PROVIDED EACH WEEK TO
SUPPORT PEOPLE AT HOME



96.4%

OF PEOPLE STARTED
PSYCHOLOGICAL
THERAPIES
WITHIN 18
WEEKS OF
REFERRAL



2,436

PEOPLE SUPPORTED AT
HOME BY A COMMUNITY/ALARM
TELECARE SERVICE



introduction



Welcome to our third annual Public Performance Report which covers the period April 2017 to March 2018.

I am delighted to present a flavour of the wide ranging supports and interventions provided by West Dunbartonshire Health and Social Care Partnership across our communities to meet the needs and personal outcomes of those using our services.

I would also like to take this opportunity to thank all staff across the range of our services who went 'above and beyond' to ensure that services were maintained for vulnerable people in our community during 'The Beast from the East' winter weather. Our integrated Older People and Adult teams, Hospital Discharge, Learning Disability, Mental Health, Addictions, Criminal Justice and Children's services worked hard to co-ordinate and deliver services in spite of the widespread transport and infrastructure problems which affected the whole of West Dunbartonshire.

From people walking to work in hazardous conditions; opening up and staffing buildings not their usual place of work; offering lifts and ensuring colleagues arrived home safely; to clearing entryways and car parks; making unscheduled home visits to check on particularly

vulnerable clients; shopping for food and essentials and collecting vital medications; covering duty work and shifts at short notice; working additional hours and sleepovers; and a range of community staff offering support within wards and care homes.

Our local communities also made an invaluable contribution; helping out vulnerable neighbours and even providing their 4x4 vehicles and driving services to transport staff to and from work, as well as delivering important blood and specimen samples to laboratories. I would like to add my personal thanks to the thanks of those whom they assisted.

Finally I would like to recognise the hard work and commitment of all our staff year round to deliver high quality person-centred and outcome-focused services within our communities.

Beth Culshaw
Chief Officer

supporting children and young people



- active
- achieving
- safe
- healthy
- responsible
- respected
- included
- nurtured

Our children have the best possible start in life and are ready to succeed

‘Children and young people were benefitting from warm nurturing care provided by well supported and committed foster carers. For many children purposeful activity such as drama and musical pursuits was part of their daily routines. This meant that children had the opportunity to participate in local community resources, and establish meaningful friendships. As a result, children and young people were having their needs met and were achieving good outcomes.’

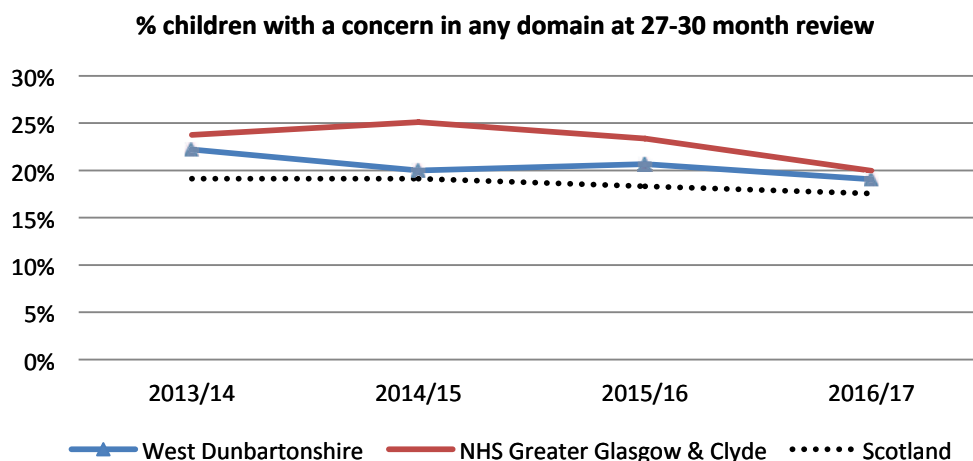
Care Inspectorate Report Fostering Service
April 2018

West Dunbartonshire Health and Social Care Partnership (HSCP) is committed to improving outcomes and supporting the wellbeing of our children and young people, aiming to give every child the best possible start in life.

We have embedded the principles of the Scottish Government’s Getting It Right for Every Child (GIRFEC) into all aspects of children’s services across community and specialist health and social work and care services: working to ensure that all children are safe, healthy, achieving, nurtured, active, respected, responsible and included. In implementing GIRFEC, we have continued to focus on preventing crisis and reducing risk for children and families through using timely assessment and the right supports. This reflects our shared community planning objective to focus on early intervention and prevention in the lives of children, young people and their parents and carers.

NHS Scotland’s Child Health Programme promotes proactive care and support to help children attain their health and development potential. A key milestone of the programme is that 85% of our children have reached all expected developmental milestones by their 27-30 month child health review, meaning that developmental delay is identified at an early stage.

Within West Dunbartonshire the proportion of children with a concern identified in any developmental domain in their 27-30 month review has improved from 22.2% in 2013/14 to 19.1% in 2016/17. This is also slightly lower than the figure across NHS Greater Glasgow and Clyde which was 19.9%, but higher than the Scotland-wide figure of 17.6%.



966 children were eligible for their 27-30 month child health review during 2016/17 and of these 91.8% of reviews were carried out. This compares favourably with the proportion of eligible reviews carried out by NHS Greater Glasgow and Clyde and the Scotland figure, both 89.3%.

94.9%

of children aged 2 years
received their MMR
vaccination

97.7%

of children aged 5 years
received their MMR
vaccination



1,302

referrals to
Specialist
Community
Paediatrics



Specialist Community Paediatrics

West Dunbartonshire Specialist Community Paediatric Team (SCPT) provide services to children and young people who require assessment, medical management and therapeutic interventions which cannot be provided by universal and primary care services.

There are multi-disciplinary pathways: for example, the Disability Pathway and Autism Spectrum Disorder Assessment Pathway, the latter being an example of excellent integrated practice with Child and Adolescent Mental Health Services (CAMHS) and Social Work involvement.

- deliver person-centred care which includes the voice of the young person and their family
- reduce the need for families to tell their story multiple times
- problem solve in collaboration
- set mutual goals to meet an individual's needs
- Provide a quality assessment

Disability Joint Assessment Clinics or Autism Spectrum Disorder Assessments are carried out, with communication and discussion across disciplines.

Children and their families are at the centre of the process and leave the assessment with an outcome, a clear plan and the resources available to support them.

Scottish Government's Health and Social Care Delivery Plan reinforces the equal importance of mental and physical health. It is estimated that in Scotland 10% of children and young people have a clinically diagnosable mental health problem: this rises to 45% for looked after children.

Poor mental health can disproportionately affect children from lower income households and areas of deprivation and can also have significant impact on life chances, personally, socially and economically. Moreover the life expectancy of people with serious mental health problems is 15 to 20 years lower than the general population.

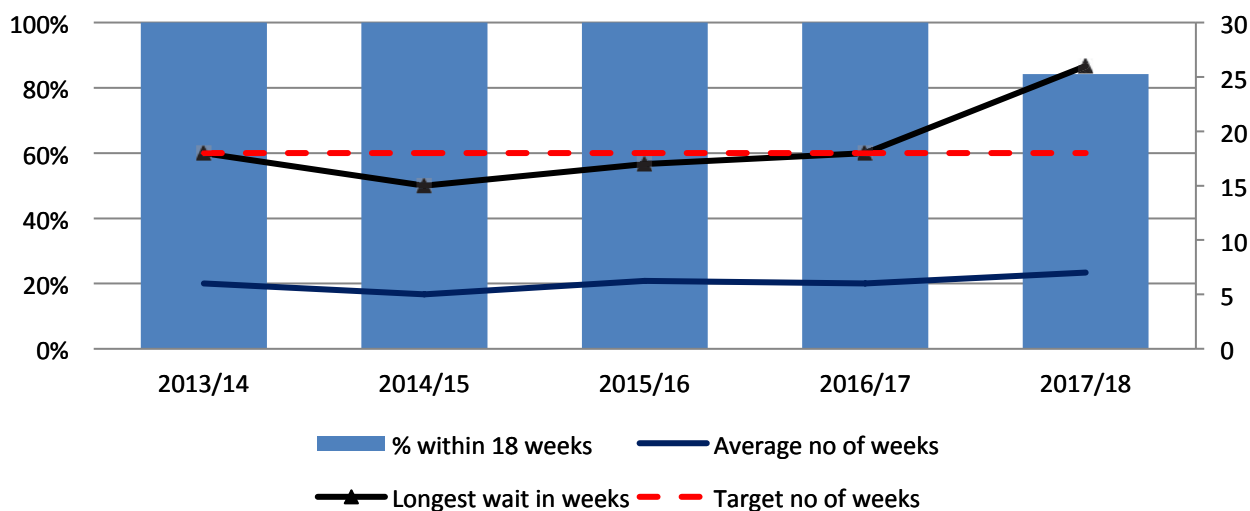
The HSCP continues to develop a strong multi-agency approach to supporting vulnerable children and young people with mental health and emotional wellbeing issues. Robust and early planning systems have also been implemented to support transitions from children's services to specialist adult services.

Child and Adolescent Mental Health Services (CAMHS) embrace the range of services that contribute to the mental healthcare of children and young people and their families and carers.

367
referrals to Child and
Adolescent Mental Health
Services



Child and Adolescent Mental Health Services (CAMHS) - Referral to treatment



Performance against the target of 90% of children receiving treatment within 18 weeks of referral to CAMHS had been consistently high since the target's introduction in April 2013 however, during 2017/18 performance declined. At March 2018, less than 90% of children and young people received treatment within the timescale for the first time (84%) and the longest waiting time was 26 weeks.

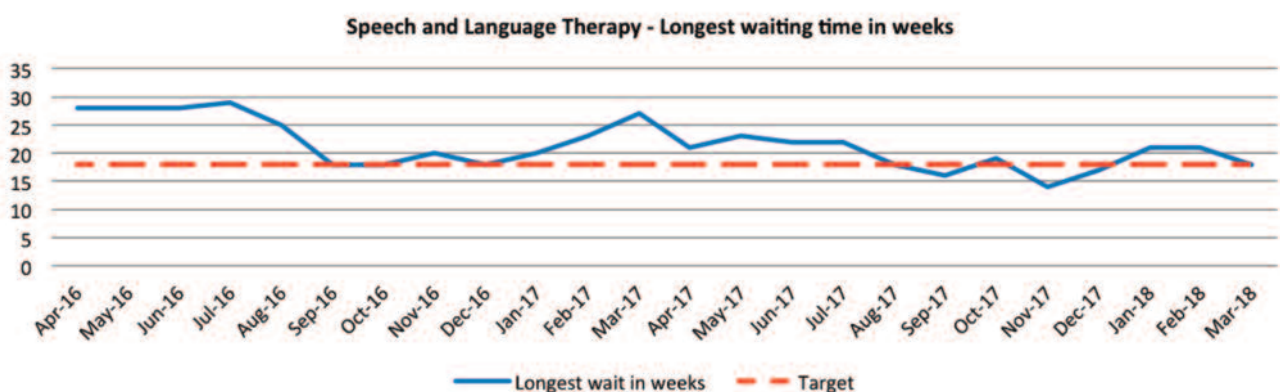
This dip in performance is reflected across NHS Greater Glasgow and Clyde. Within West Dunbartonshire and across the Health Board area staff vacancies, along with an increase in the number of urgent referrals to the service, are the main reasons for some children and young people experiencing longer waits.

Meeting our local target times for the longest wait for Speech and Language Therapy has also proved challenging, however the trend in 2017/18 is an improvement on 2016/17 performance.

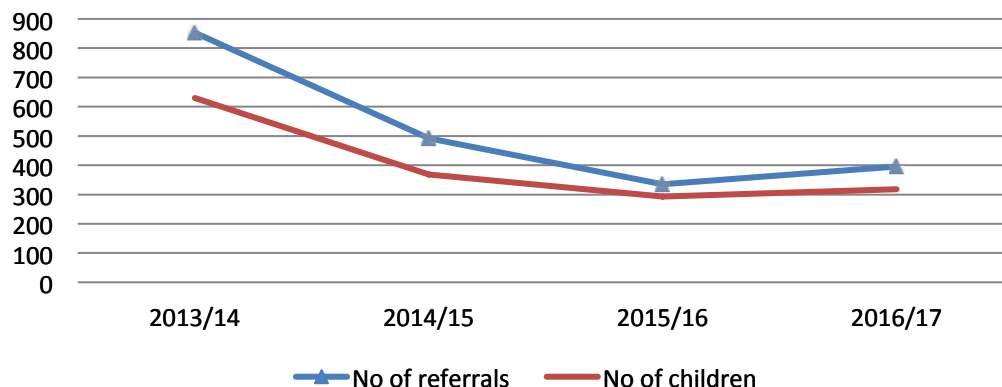
We have improved the life chances for children, young people and families at risk

The HSCP and our community planning partners have a strong commitment to early intervention and we have invested in approaches and services to prevent problems escalating for children and their families. We continue to provide a range of interventions to support vulnerable young people who may be experiencing difficulties, including our school counselling service and our range of mainstream parenting opportunities for all parents within our communities.

347
referrals to Speech
and Language
Therapy



Referrals to the Scottish Children's Reporter on care and welfare grounds



The number of referrals to the Scottish Children's Reporter on care and welfare grounds has fallen by 54% from 853 in 2013/14 to 396 in 2016/17. After a slight increase in 2016/17, initial figures suggest the number of referrals will fall again for 2017/18. Publication of 2017/18 figures is due towards the end of July, too late for inclusion in this report, but can be found at https://www.scra.gov.uk/resources_articles_category/official-statistics/

The HSCP is committed to ensuring that children affected by parental substance misuse (CAPSM) receive the best opportunities from both adult and children's services, built on a shared understanding of the risks for families where parents are misusing alcohol and/or drugs.

Adult and Children's services have worked together in developing our 'Parental Capacity Assessment', enabling our community addiction services to better identify parenting needs and potential risks whilst building on existing strengths. This recognises the impact of parental substance misuse in West Dunbartonshire along with our strong commitment to have the same life chances for all children, young people and families at risk.

**All children in
West Dunbartonshire
have a 'named person'**



407

looked after children

368

children looked after
in the community

Children and young people who become looked after are among the most disadvantaged children in society and in general experience poorer outcomes than their peers. Reasons for becoming looked after vary for each child but in every case children will have been through difficult or traumatic life experiences which can result in poor emotional and physical health, distress, a lack of stability and often a lack of social and educational development.

The HSCP supports children and families through effective early intervention, prevention and providing families with the support they need, when they need it. We strive to increase the proportion of looked after children and young people who are looked after in the community, to help them maintain relationships and community links which may result in better outcomes.

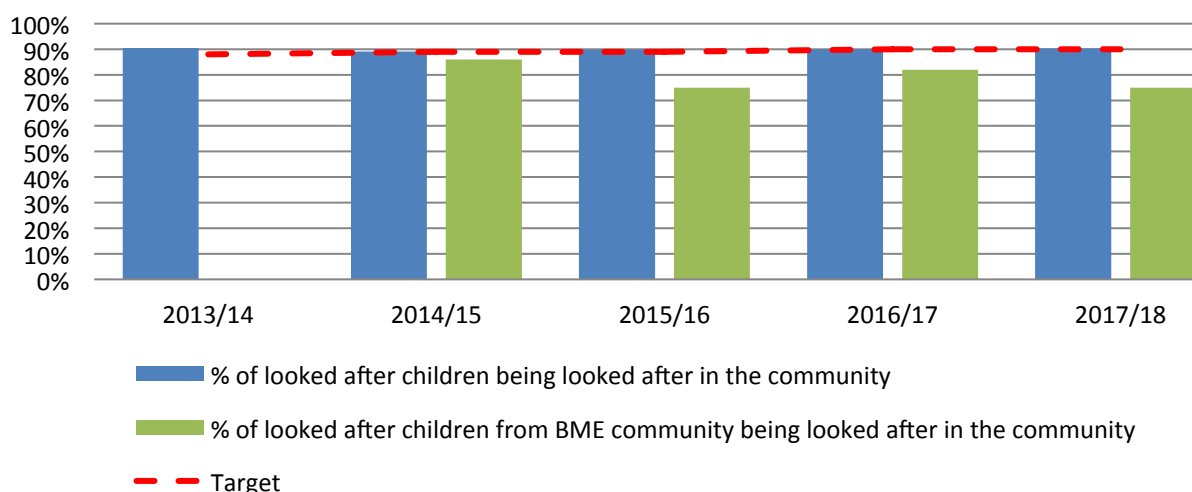
The number of looked after children has increased by 12% since 2015/16 in West Dunbartonshire. The proportion of looked after children being looked after in the community has exceeded our target of 90% throughout most of 2017/18.

of March 2017/18 against 90.4% for all looked after children, the numbers of BME children are very low therefore small changes in numbers will see percentages fluctuate more significantly.

Changes in care placement can be distressing for children and young people and research suggests that multiple placement moves can be linked to a greater likelihood of these looked after children having some form of psychiatric diagnosis compared with other looked after children. The proportion of children in West Dunbartonshire who had more than one care placement in the previous year was the fifth lowest in Scotland in 2016/17 at 17%: across Scotland 21.2% of children had more than one placement.

In 2016 the Scottish Government announced an independent root and branch review of the children's care system. [The Independent Care Review](#) is now under-way and across Scotland has listened to the voices of 854 children, young people and adults with care experience, including those from West Dunbartonshire, and 789 people who work with and for vulnerable children and families, with the aim of identifying and delivering lasting change in the care system.

Percentage of children being looked after in the community

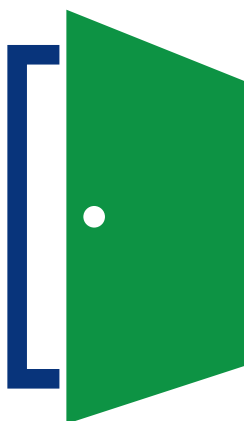


In line with our equalities monitoring, we also monitor the proportion of children from a Black Minority Ethnic (BME) community who are looked after in the community. Although there is a slight variance against the overall figure, 75% at the end

Our young people are successful learners, confident individuals, effective contributors and responsible citizens

Young people leaving care are less likely to go on to education, employment or training compared to young people in the general population. The HSCP's Throughcare and Aftercare service work with young people through the process of leaving care and support them with access to accommodation, financial help and entering further/higher education, employment or training.

78%
of young people
aged 16 or 17 years
of age who left
care entered
further/higher
education,
training or
employment



Their Supported Lodgings service provides an environment which helps young people to learn the skills needed to maintain their own tenancy. The team work with many care experienced young people and support them to live independently within the community. Over the past few years the Throughcare Team has worked closely with West Dunbartonshire Council Housing colleagues developing a Care Leavers' Housing Protocol, with care experienced young people now being a recognised priority.

Throughcare has two registered services under the Care Inspectorate: the Adult Placement Service and Housing Support and both of these services received the highest possible grading of 6 across all areas inspected in their most recent Care Inspectorate inspections.

'The staff...provided an excellent quality of care and support to vulnerable individuals to prevent homelessness and to establish stable independent lives. Young people we met with spoke highly of the excellent support they received and of the very positive working relationships they enjoyed with staff members...'

'At first I was resistant to working with them. Since I got to know my keyworker I've built up a good bond. I trust her, she's always fighting my corner (young person).' Staff were committed to supporting and advocating for the young people to achieve the best possible outcomes.'

Care Inspectorate Inspection
WDC Throughcare/Aftercare Housing Support
March 2018

Champions' Board

West Dunbartonshire's Champions' Board allows care experienced young people to be involved in shaping policy and practice based on their care experiences; to become active citizens through participation; and to develop and build positive relationships with service providers and corporate parents. Providers and corporate parents gain better understanding of the lives and experiences of our care experienced young people.

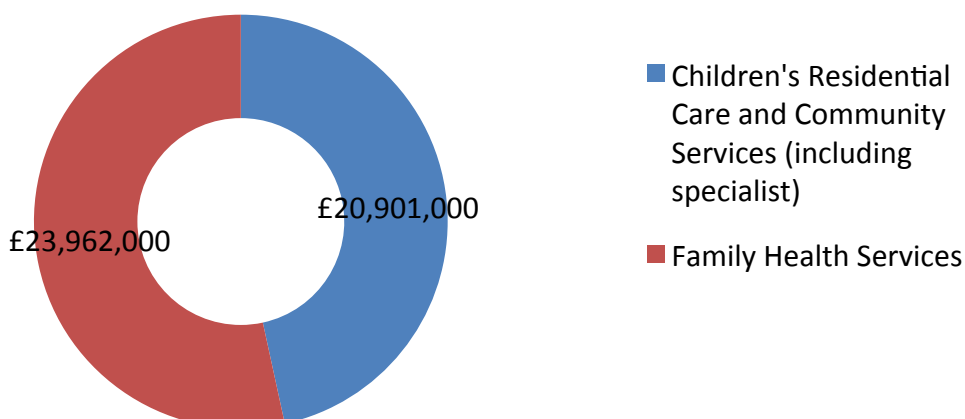
The Champions' Board is creating exciting and innovative opportunities for changes to be made to the futures of care experienced young people. West Dunbartonshire Council, and in particular the HSCP, have a very focused outlook on areas affecting care experienced young people, such as leading healthy lifestyles, having increased access to education, training and employment, having access to safe and settled accommodation, and to have the knowledge that they are loved, respected, valued and listened to.

In March 2018, some of our care experienced young people presented their 'Dear Parent' letter to the Council's Chief Executive, Joyce White OBE. This letter was on the same basis as the 'Dear Parent' letter which our young people received at school, but this time it was intended for 'Corporate Parents' rather than 'biological' parents. This was greatly received by the Chief Executive who committed to achieving the signatures of around 50 Corporate Parents, who would agree to their commitment to engage with our young people.

On our Corporate Parenting Day 2018, the Champions Board launch event was held in Clydebank Town Hall and was attended by around 80 Corporate Parents and 20 young people.

The event was hugely successful and our 3 newly employed lead young people to the Champions' Board will be in post from early June 2018. They are really excited about the coming weeks and months and the 'journey of change' which will begin for them then.

Net Expenditure 2017/18



2

supporting older people



“Last year I had an accident and broke my shoulder and hip. After a spell in hospital I had carers attending to me twice a day, a physiotherapist came several times to my home. An occupational therapist ensured that I had all the equipment necessary for my recovery. A community nurse came to attend to my wounds. I couldn't fault the care I received. It was excellent.”

The HSCP leads on the Community Planning strategic priority of Supporting Older People across Community Planning Partners, primarily through the vehicle of the Independent Delivery and Improvement Group which reflects our commitment to avoiding unnecessary hospital admissions and supporting people to live as independently as possible and safely within a homely setting for as long as possible.

98%
**of people aged 65
or over with complex
needs supported
to live at home or in
a homely setting**



To achieve this we work with communities to build community capacity. This means working together to avoid unnecessary admissions to, and delay in discharge from, hospital through strong partnerships of statutory, third and independent sector providers of health and social care provision in the community.

In line with the National Health and Wellbeing Outcomes, improved co-ordination of health and social care services should help to ensure that ‘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.’

Improving emergency or unscheduled care within hospitals across Scotland is a key ministerial priority for the Scottish Government. Through the National Unscheduled Care - 6 Essential Actions Improvement Programme the Government aims to improve the timeliness and quality of patient care, from arrival to discharge from hospital and back into the community.

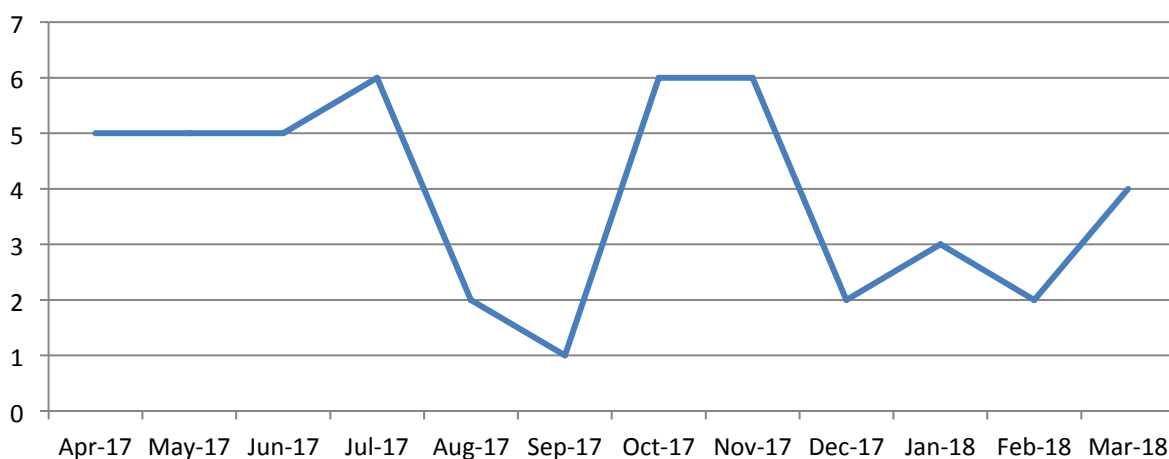
The Ministerial Steering Group (MSG) for Health and Community Care is closely monitoring the progress of HSCPs across Scotland, in light of the integration of health and social care services, in delivering reductions in: delays in hospital discharge; unnecessary hospital admissions; and attendances at accident and emergency (A&E). They are also monitoring the shift in the balance of care from hospital to community settings and the proportion of people supported within the community in the last six months of their life.

Detailed monthly trend data relating to these objectives can be found at Appendix 4.

Avoid unnecessary delays in hospital discharge

The national target is that no person should wait more than 3 days for discharge from hospital once they have been assessed as medically fit for discharge home or to a care home.

Number of delayed discharges more than 3 days (non-complex cases)



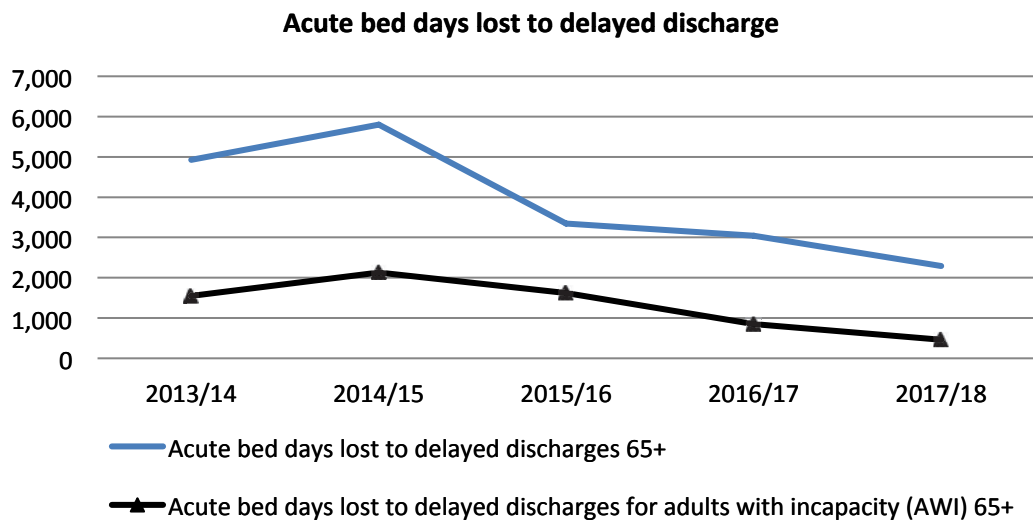
Meeting this target during 2017/18 has proved challenging but the design of our integrated health and social care teams has helped to keep lengthy delays to a minimum. Early Assessors are present on hospital wards to pick up and encourage early referrals and to begin assessments in advance of an individual being fit for discharge. Community-based teams and Care at Home services also notify of recent admissions and a dedicated Mental Health Officer provides support in relation to adults with incapacity and where Guardianship is relevant.

In 2017/18 we were ranked 6th best in Scotland for the number of days people aged 75 and over spent in hospital when they had been assessed as being medically fit to be discharged: as a rate per 1,000 population this was 335 days. We were also substantially lower than the overall figure across Scotland which was 772 days per 1,000 population. Numbers are often converted to rates per 1,000 population to allow for comparisons across partnerships and nationally as this effectively compensates for variation in population sizes.

1,018

new Power of Attorneys
registered for people who live
in West Dunbartonshire





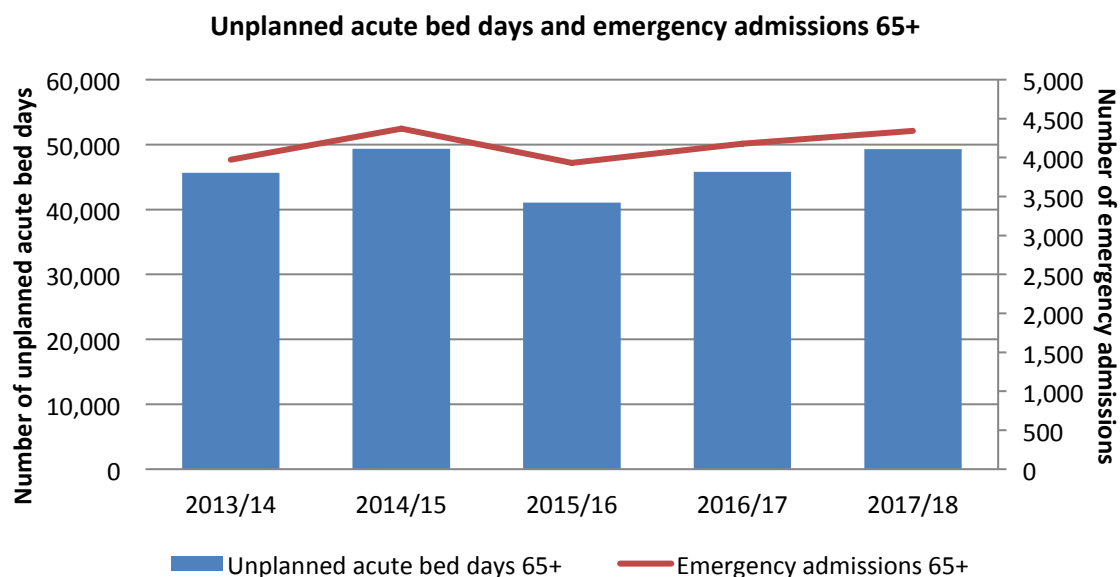
The number of acute hospital bed days lost due to delays in discharge for people aged 65 and over peaked in 2014/15 and has since reduced by 61% overall and by 78% for adults with incapacity. Progress has improved year on year with a 25% reduction overall between 2016/17 and 2017/18 and a significant drop of 46% for adults with incapacity during the same period.

Significantly, bed days lost to delayed discharges during the winter months of 2017/18 were improved on the previous year. Between November 2017 and February 2018 there was a 33% reduction in bed days on the same period in 2016/17: 40% in relation to adults with incapacity.

This would suggest that our planning and delivery of services had a more pronounced impact in 2017/18. By ensuring effective levels of capacity were in place to meet the additional demand and pressures of a particularly harsh winter, the HSCP improved outcomes for more people within West Dunbartonshire, allowing them to be discharged to an appropriate setting when they were ready.

Reduce emergency admissions to hospital

Between 2016/17 and 2017/18 there was an increase of 4% in emergency admissions and of almost 8% in unplanned acute hospital bed days used for people aged 65 and over. This increase was most significant between September 2017 and March 2018. Attendances at Accident and Emergency (A&E) peaked in December 2017, with a marked increase in 999 and self-referrals. We will continue to monitor levels and trends of A&E attendance in partnership with our primary care and acute colleagues.



During 2017/18 we have increased efforts to help people avoid unnecessary admission to hospital: improving co-ordination and communication across our integrated teams. We have worked to streamline services, reducing duplication and delivering services using inter-disciplinary approaches. Early intervention is key and we use local intelligence and assessment tools, such as frailty indicators, to identify people at risk of hospital admission: offering them assessment; the support they need to remain as safely and independently as possible at home; and the development of an Anticipatory Care Plan.

1,921
people have an
Anticipatory Care Plan
in place



Anticipatory Care Planning (ACP) is a fundamental component of our comprehensive assessment for those identified at risk of admission to hospital, and plays a vital role in communicating with all relevant stakeholders to ensure we deliver person-centred care. We are working to increase visibility of ACPs across services as well as ensuring acute hospital staff can access a patient's Single Shared Assessment.

Anticipatory Care Planning

Mrs F has a high risk of falls and has been admitted to hospital in the past.

Mrs F and her son, who holds Power of Attorney, were both present for discussions about the development of an Anticipatory Care Plan (ACP) for Mrs F.

These discussions helped Mrs F clarify her wishes for her future care ensuring she had sufficient knowledge of her condition, which allowed her to agree priorities in relation to that condition.

Options available and desired outcomes were talked through and Mrs F's personal preferences were identified.

An action plan was developed to work towards Mrs F's desired outcome of preventing further falls. She had just completed input from physiotherapy services and was currently receiving strength and balance training for a twelve week period.

Referrals were agreed for a community alarm, a keysafe and a referral to Link Up services.

Mrs F was satisfied with her existing Care at Home package and the chairlift and bathroom adaptations already in place, however she was open to further adaptations and services if her condition deteriorated.

This conversation allowed Mrs F and her son the chance to have a discussion which they otherwise may not have had and while challenging, they valued this opportunity.

Also, knowing that ACP is an ongoing process provided reassurance that Mrs F could reconsider her future care at any point should her health deteriorate.

The agreed ACP assessment was uploaded to e-KIS (electronic Key Information Summary) which is visible to all staff who have access to Clinical Portal's Emergency Care Summary, which includes acute hospital and out of hours staff.

Should Mrs F have a crisis or deterioration of her condition, her ACP will therefore be available to identify her personal preferences for her care and help her avoid an unnecessary hospital admission.

Community Nursing, Care at Home service and our Community Older People's team work together to support people within their own homes and to prevent the need for unnecessary hospital admissions: identifying people at risk and putting in additional supports when required. These include additional homecare, respite, nurse-led beds in local care homes and step up/step down placements.

2,930

out of hours district
nursing visits in
Clydebank

2,741

out of hours district
nursing visits in
Dumbarton and
Alexandria



Along with our focus on prevention, effective discharge from hospital is also important in reducing the risk of readmission. In 2017/18 we had the 7th lowest readmission rate in Scotland with 83 people per 1,000 population readmitted within 28 days: the Scotland figure was 97.

Care at Home services are in place as close to discharge from hospital as possible and the Care at Home Pharmacy service supports people to manage often complex medication, increasing confidence and providing reassurance. Where a person has been referred for a restart of existing Care at Home services as part of a hospital discharge more than twice in a 6 month period, they are immediately given a full assessment to identify and meet their probable change in needs.

Key initiatives have been developed to tackle the impact of frailty and falls upon vulnerable people within the community. In West Dunbartonshire 390 emergency admissions of people aged 65 and over in 2016/17 were directly as a result of a fall and in West Dunbartonshire fractured femur is one of the top 6 diagnoses for admission to hospital.

The HSCP's Frailty Priority Project is underway in the Dumbarton and Alexandria Locality and

provides a common language for practitioners in identifying frailty. As part of the assessment and review process an individual's frailty is being assessed and recorded using the Rockwood Clinical Frailty Scale. Clydebank Locality agreed in October 2017 to also begin roll out of the use of this scale. Recording of Rockwood Clinical Frailty scores allow an individual's frailty to be monitored over time and to flag up any deterioration or risk of hospital admission, allowing appropriate supports and preventative measures to be put in place. At the end of March 2018, the Rockwood Clinical Frailty Scale had been used to assess the frailty of 1,542 people.

1,821

falls screenings carried out

1,007

falls assessments
completed



Our local established Falls Collaborative delivers local agreed actions prompted by the Scottish Government's national framework [The Prevention and Management of Falls in the Community](#). A two tier falls assessment process has been adopted: a falls screening tool has been added to all assessment documentation and implemented across our integrated health and social care teams; and a more in-depth falls assessment has been developed and has also been incorporated into our Occupational Therapy and Physiotherapy specialist assessments. A key action resulting from a falls assessment is strength and balance training

to help regain and/or improve mobility to prevent future falls.

Training has been delivered to wider community services such as Scottish Fire and Rescue and Community Volunteering Services, introducing the falls screening tool and providing improved pathways to our services.

Support independent living

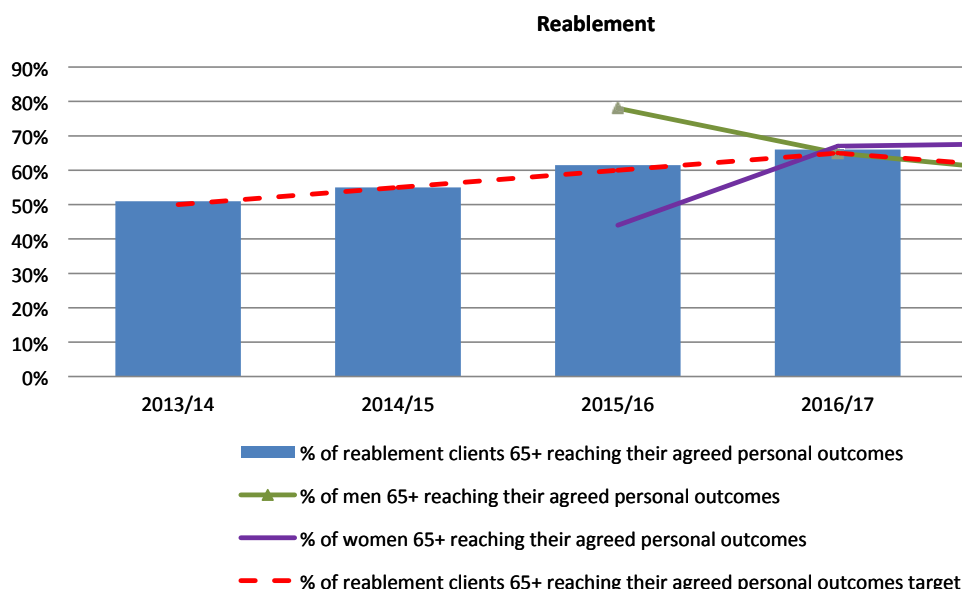
West Dunbartonshire had the highest proportion in Scotland of people aged 75 and over being supported at home in 2016/17 at 14.5%. Reablement services focus on helping people to relearn daily skills they may have lost due to a deterioration, crisis or hospital admission: allowing them to regain confidence, independence and to live safely at home for as long as possible. Care at home and focused occupational therapist services support people to achieve their agreed personal outcomes such as preparing their own meals, resuming their personal care, or being able to access community resources they previously enjoyed.

women receiving a reablement service. Roughly 59% of men achieved their outcomes and 68% of women during 2017/18. Looking back to 2015/16 there is no discernible trend in experiences across gender and we will continue to monitor this with a view to improving the reablement process for all.

632
people received a
reablement service

1,274
people aged 65 and
over received 7,968
hours of homecare per week

941
people supported
by the Care at Home
Pharmacy service



In 2017/18 almost 65% of people receiving a reablement service achieved their personal outcomes. As part of our equalities monitoring we look at the different experiences of men and

Care at Home Pharmacy Service

Mr A was referred to the Care at Home Pharmacy Service (CAPS) following discharge from hospital.

The Pharmacy Technician visited Mr A at home. Mr A advised that he was blind in one eye and could barely see with the other, which was resulting in him struggling to take his medicines properly.

On further discussion it became clear that Mr A was experiencing several problems such as not being able to identify different boxes of medicines as they were similar in size and shape and also around dropping tablets; this was identified by loose tablets lying on the kitchen work surface.

The technician contacted Mr A's community pharmacy asking if some of his medicines could be dispensed in different packaging to help identify one from the other. This was especially important for one of his medicines where he was prescribed two different strengths to be taken at different times of the day.

The pharmacy agreed to dispense one in a plastic amber tablet bottle and the other in its original pack, a box, to allow him to differentiate between different strengths. To help with the tendency to drop tablets the technician suggested that Mr A should pop them out over a dish or tray so that if any are dropped they could be easily retrieved.

During the technician's visit Mr A mentioned other non-medicine related issues he was experiencing. The technician directly referred him to the Sensory Impairment Team who not only supplied a talking clock, but organised a benefits check and referral to the Low Vision Clinic to be assessed for a magnifier.

The combination of the above supports and communication across teams and services has helped Mr A to self manage his medication; has had a positive impact on his quality of life; and supported him to maintain his independence at home.

1,865

people aged 65 and over
have a Community
Alarm / Telecare service



Within West Dunbartonshire the prevalence of people with Chronic Obstructive Pulmonary Disease (COPD) is 3.02% compared to 2.57% in Greater Glasgow and Clyde and numbers continue to increase. The HSCP's COPD Nursing Service is a targeted approach to reducing the impact of COPD. Patients assessed by the service have anticipatory care plans and self-management plans put in place along with anticipatory medicine where appropriate. This supports patients to self-manage their condition proactively.

The COPD Nursing Service also provide training, advice and support to Care at Home staff and staff within care homes. This model of training provides staff with the skills and confidence to support their clients to live as independently as possible in their home/ homely setting and prevent unplanned admissions to hospital where possible.

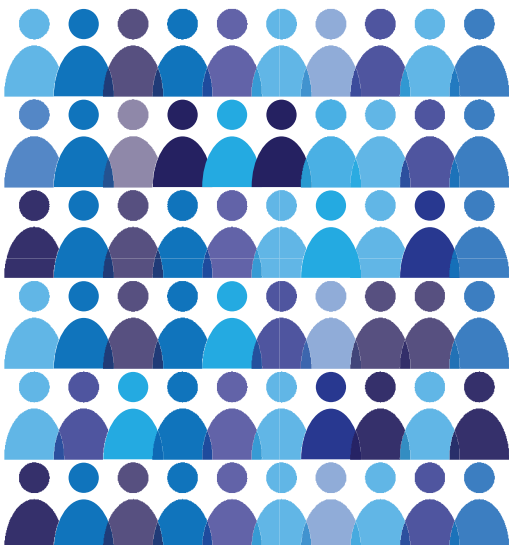
The HSCP is also combining the use of telehealth with telecare (community alarm) for patients with COPD.

Using the Florence system in combination with a community alarm, COPD patients test and text their oxygen levels on a daily basis to specifically trained staff. These staff are equipped with knowledge of the individual's usual pattern of oxygen levels and can then proactively identify where a person may require the early intervention of medication or a more serious intervention where appropriate. This supports starting treatment without delay and assists with better symptom management. The community alarm provides extra support and reassurance, particularly during evenings and weekends, helping to maintain COPD patients safely at home with a variety of support options at any time of day or night.

The HSCP recognises the invaluable contribution made by unpaid carers in supporting vulnerable people within our community. In the 2011 UK Census 9,637 people in West Dunbartonshire identified as carers and 18.2% of these carers were aged 65 and over, many of whom will have their own health problems.

60

**people supported by the
COPD telecare/telehealth
service**



97.4%

**of carers asked as part of
their Carer Support Plan
felt supported to continue
in their caring role**



The Carers (Scotland) Act came into force on 1st April 2018 and is designed to promote, defend and extend the rights of all carers, both adult carers and young carers. It aims to better support all carers with their health and wellbeing and help make caring roles more sustainable.

A 2015 report by the Scottish Government, Scotland's Carers highlighted that while caring can be a positive and rewarding experience and can have a positive impact on wellbeing, caring can be associated with poor psychological wellbeing and physical health; with those in the most demanding care situations, providing higher levels of caring over an extended period, experiencing the most negative impact on their health and wellbeing.

The HSCP works in partnership with Carers of West Dunbartonshire to offer a range of supports to carers from signposting to financial advice, community groups and other support organisations, to providing carer assessments and respite or short break services. There were 192 carer assessments carried out in 2017/18 and individual plans developed to provide carers with the supports they need to sustain their caring role. This will be reviewed alongside the new mandatory datasets prescribed by the new Act.

In total 4,449 weeks of respite were provided to give carers a break from their caring role: 1,739 nights of residential respite and the remainder in less traditional, more innovative forms of respite such as short breaks, day care and day opportunities where the cared for person also benefits from the change in environment and social interactions that these afford.

During 2017/18 we have been developing our Carer Support Plan to accommodate two levels of assessment: a tier 1 to meet the needs of those carers who do not feel they require a full carer's assessment but are recognised as having a formal role and relationship to the cared for person; and a comprehensive tier 2 Adult Carer Support Plan.

This approach was developed through our work with carers and in November 2017 the HSCP hosted a Carers' Co-Production Event alongside partners from the multi-agency Carers' Development Group. Attendees included carers, young carers, third sector partners and HSCP staff coming together to hear and learn from carers about their own experiences of caring in West Dunbartonshire. Feedback from the event will be used to develop our local Carer's Strategy and eligibility criteria.

The HSCP hosts the Musculoskeletal (MSK) Physiotherapy Service and Diabetic Retinopathy Screening Service for the Greater Glasgow and Clyde area.

MSK conditions account for the largest cause of disability and time off work in the UK: therefore demand for MSK Physiotherapy remains high and waiting times continue to be a challenge. Work is ongoing to ensure the service is as efficient and effective as possible. In 2017/18 there were 6,222 referrals to the MSK Physiotherapy services provided within West Dunbartonshire and 43% of people were seen within the target time of 4 weeks from referral.

Diabetic Retinopathy Screening

NHS Greater Glasgow and Clyde Diabetic Retinopathy Screening provides a comprehensive diabetic retinopathy screening service to approximately 60,000 patients with diabetes in Greater Glasgow and Clyde. Diabetic retinopathy is a complication of diabetes and, if undetected, can ultimately lead to sight loss and blindness.

All diabetics are usually invited to a screening appointment once a year. Screening is usually performed by taking photographs of the retina. These photographs are then examined by experienced staff. If abnormalities are detected in the photographs, the patient will be referred to ophthalmology for further assessment and treatment, if necessary.

Photographs are unsuitable for some people, for example if they have cataracts or if they have difficulty in positioning at the camera.

These people are examined by optometrists using slit lamp biomicroscopy.

Screening takes place at many locations in Greater Glasgow and Clyde, including the Vale Centre for Health and Care, Dumbarton Health Centre and Clydebank Health Centre. 56,391 people in Greater Glasgow and Clyde were invited for a screening in 2017/18 and 45,626 people attended for screening.

Support more people at end of life

The HSCP's integrated palliative care services care for the increasing number of people with complex long term conditions and palliative care needs: giving people the choice of being supported in the place most appropriate to them when it comes to the end of their life. All palliative and end of life care patients have an Anticipatory Care Plan and an electronic palliative care summary which is shared with hospital acute services and the Scottish Ambulance Service.

The new Carers (Scotland) Act requires us to focus on carers of those with palliative care needs in 2018/2019 and we will be able to provide more detail in the coming year.

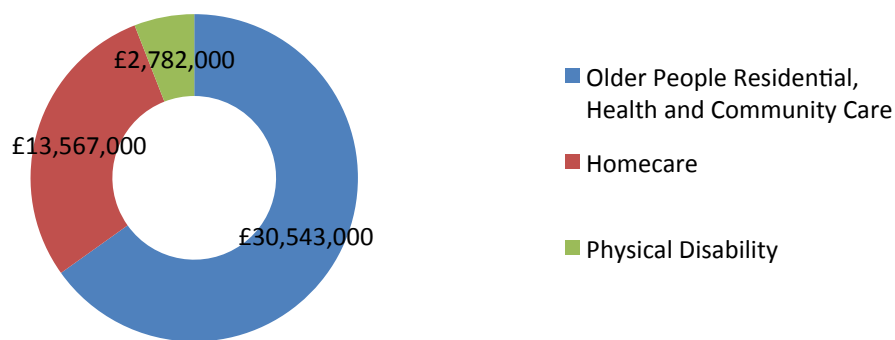
76%
of people on the
Palliative Care Register
were supported
to die at home
or in a homely
setting



The HSCP's Palliative Care Team also provide support to Care Homes to manage patients with complex needs during palliative and end of life care. Additional support is provided from specialist nursing e.g. Diabetic Specialist Nurses, COPD Nurses and Pharmacy teams as requested.

89.3% of West Dunbartonshire residents who died in 2017/18 spent the last 6 months of their life at home or in a community setting rather than in a hospital setting.

Net Expenditure 2017/18



supporting safe, strong and involved communities

3



The creation of opportunities for people with learning disabilities to be supported to live independently in the community wherever possible

- active citizen
- healthy life
- keys to life
- choice and control
- independence

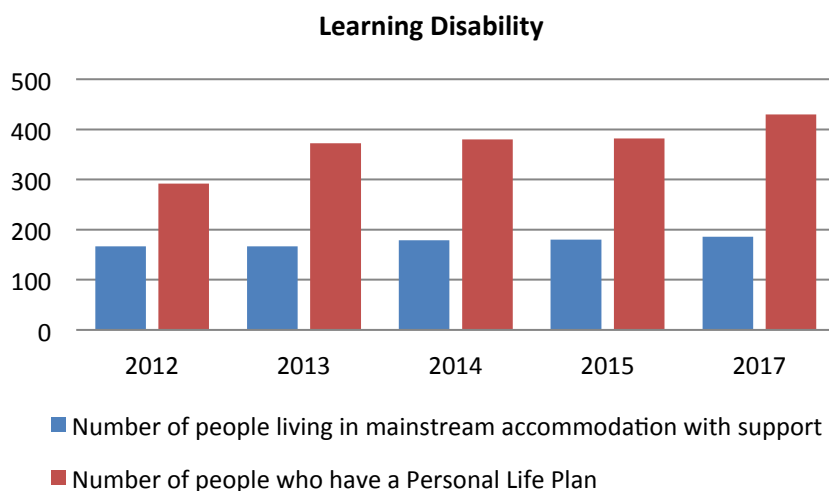
The HSCP's commitment to continuously improving the quality of life for people with learning disabilities reflects the national Keys to Life Strategy. Our integrated approach to service delivery across community health and care, as well as third sector providers, supports the delivery of effective and targeted specialist services, and is prioritised around key aims of people with a learning disability. Our outcomes focused approach promotes person centred assessment and planning.

People with a learning disability and their carers are actively involved in planning their care and support. Their Personal Life Plans reflect differing levels of understanding and awareness, whilst striving to involve them as much as possible.

The number of people with a learning disability living in mainstream accommodation with support has increased by 11% between 2012 and 2017 and the number of people with a Personal Life Plan has increased by 47% to 430 during the same period.

The HSCP's Learning Disability Housing Support Service support adults who have learning disabilities and communication difficulties to live as independently as they can and to ensure their day to day health and social care needs are met and positive outcomes achieved. Most of the people supported by the service are unable to read and in 2017/18, service users, support staff and a third sector provider worked together to develop digital passports as an alternative to the existing written paper files produced by support staff.

Digital passports embody the principles of the Keys to Life Strategy: promoting individual choice and control, independence and active involvement. The passports allow individuals to explain to staff how they wish to have their support provided and also what they are able to do for themselves by demonstrating this in their own support plan videos.



The passports are saved on the service user's own i-Pad and can accompany them on hospital visits or admissions and can be seen by primary care professionals to show them how each individual presents when well. Anyone providing care and support can also see how the person communicates, learn about their likes and dislikes and generally have an improved understanding of the person who they may have just met, and who may have limited or no verbal communication.

Feedback from service users and their families has been very positive, with service users enjoying making and watching their videos and gaining a sense of empowerment and ownership of their information which had not been the case with their paper files. New staff have also benefited from watching individuals' support plan videos which give a better understanding of how to support that individual than written notes, and increase confidence both for the support worker and the individual.

“I think the digital passport my brother has is absolutely wonderful! It's fantastic the way I can see what my brother can do and it's so different from support being explained or shown photographs. I was so touched watching my brother on his tablet. I can't praise his staff team enough.”



The Good Life Group

The Good Life Group is a COSLA award-winning group of adults with learning disabilities from West Dunbartonshire who came together to take action to make life better for themselves and their peers. It has undertaken research, consultancy services and campaigning and awareness-raising activities. They have produced a training DVD and website. The group has evolved into a focused, user-driven Action Group, delivering innovative, ongoing training programmes for health and social care professionals, service providers, service users and carers all over Scotland.

The training uses a variety of methods including Forum Theatre: a technique incorporating lively scenarios which allow participants to practice solving service problems and gain instant, supportive feedback from the service users themselves.

Uniquely the training is delivered by learning disabled people themselves and is regarded as industry-leading.

The group charges a professional fee for the training it provides and in 2017/18 earned £5,629, reaching 130 professionals and 220 people with a learning disability.

Programmes in 2017/18

For professionals: Rolling programmes of training in Adults with Incapacity (AWI) with NHS Education Scotland; Reducing Health Inequalities for Tayside Public Dental Service; Adult Support and Protections workshops for East Renfrewshire HSCP.

For service users: Violence Against Women awareness-raising workshops for Glasgow City HSCP/VAW partnership; Cancer-screening awareness sessions as part of the Keys to a Healthy Life Project across Greater Glasgow and Clyde.

The group also worked with Glasgow University to produce a training video for behavioural therapists working in learning disability.

“One of the best workshops I’ve attended in 28 years in General Practice.”

Practice Manager

“Really made me think about my attitude, the way I say things, the barriers service users face.”

Support worker

“Because it’s very important to talk about cancer it helped to understand.”

Service user

“In over 20 years working to reduce inequalities in health for people with a learning disability this was far and away the most clear, and the most powerful, description of the issue I have seen. In my opinion every health professional should see this and take on the messages.”

Professor Mike Kerr, Cardiff University

182

people attend
day opportunities

87

people attend
day centre



The HSCP commissions a range of services from third sector providers to support and improve opportunities for people with a learning disability. To improve processes and efficiency, during 2017/18 we have developed the financial functionality of our CareFirst information management system to allow automatic payments to these providers and will continue to roll this out through 2018/19.

To deliver effective care and treatment for people with a mental illness, their carers and families

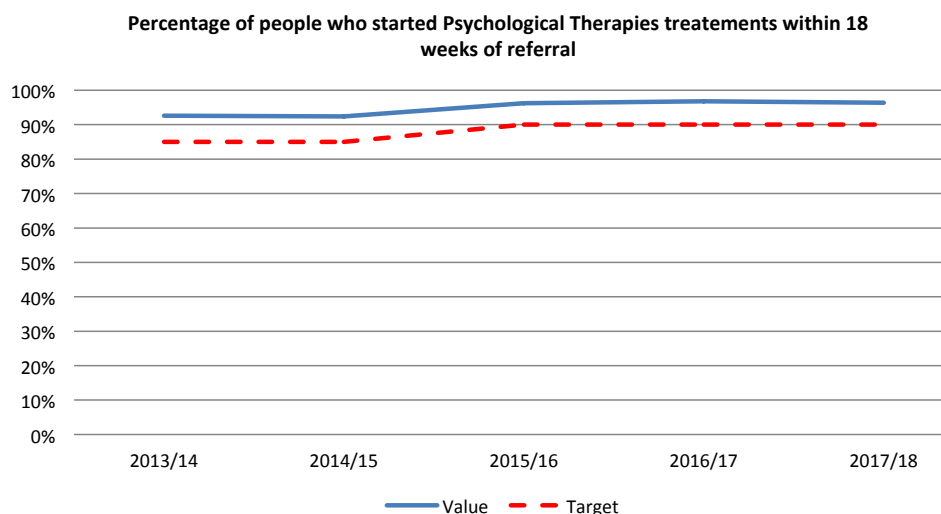
Scotland's Mental Health Strategy: 2017-2027 emphasises the need to prevent and treat mental health problems with the same commitment, passion and drive as physical health problems. In line with this, the HSCP works to improve:

- prevention and early intervention
- access to treatment
- the physical wellbeing of people with mental health problems
- rights, information use and planning around mental health services

Health inequalities for people with a mental health problem are stark: it is estimated that only a third of people in Scotland who would benefit from treatment for a mental illness actually receive it; and, as stated earlier, life expectancy for people with serious mental health problems is 15 to 20 years lower than the general population.

To promote positive mental health and early intervention, the HSCP has worked with Community Voluntary Services colleagues during 2017/18 to develop 'Looking After Your Mental Health' leaflets for Clydebank and Dumbarton/Alexandria, signposting the public to the range of HSCP and third sector supports available within West Dunbartonshire.

Enhanced access to Psychological Therapy programmes across the HSCP's Mental Health community-based services has led to clinically significant improved symptoms for local patients. By implementing a strategic approach to integrating resources across teams and supporting staff skills development through peer mentoring; service users with anxiety, stress and depression have been supported to improve their mental health. Access to Psychological Therapies within 18 weeks of referral continues to be well above the 90% target at 96.4%.



Over the last two years the HSCP's Occupational Therapy Mental Health Service has developed a groupwork programme which includes a creative activity group, an activity building confidence group and a branching out group run in partnership with the Forestry Commission. These groups run across both resource centres in Clydebank and Dumbarton ensuring equal access to services and Occupational Therapy groupwork in mental health is very well supported by the evidence base.

The creative activity group allows people the opportunity to experience different forms of activity such as glass painting, colouring, card making and jewellery while in a therapeutically supportive peer-based environment. This type of activity allows individuals to explore and express their feelings in a healthy, constructive and often non-verbal manner. As a result people are able to build their skills base in self-soothing and distraction techniques while experiencing activity that has personal meaning and value.

The peer element of the group helps with normalisation of mental health difficulties and raises confidence around social interactions which help individuals make the transition from NHS to more community-based and third sector-based projects and organisations. As well as showing improvements in self-esteem and Occupational Self-Assessment outcome measures, people often report that this

group improves mood, confidence and structure and has allowed them to carry on with many of the creative activities in their own time.

In 2017 there were approximately 90,000 people living with dementia in Scotland. By 2020 it is estimated that there will be around 20,000 new cases diagnosed each year. One of the key outcomes of Scotland's [National Dementia Strategy 2017-2020](#) is that there are more dementia-friendly and dementia-enabled communities, organisations, institutions and initiatives. Dementia Friendly West Dunbartonshire is a community-led and multi-agency initiative involving statutory, independent and third sector organisations that has improved dementia awareness and support to people living with dementia in local communities. During the 3 years since the initiative began, 263 training sessions have been delivered and 2,607 pledges of support and action collected following awareness training. The initiative has also engaged with 209 groups and organisations.

Cognitive Stimulation Therapy Group

A relaxed, fun and educational group providing an opportunity for individuals to: explore changes in their memory; meet other people with similar experiences; and to engage in some exercises to help improve their memory and concentration.

Small group sessions of 45 minutes, held once a week for 12 weeks. The group is based on research evidence and is suitable for anyone with a diagnosis of any type of dementia.

Each session has a different theme in a relaxed group environment. Topics include word games, present day and famous faces; childhood, being creative, food, money, current affairs and music.

Person-centred care treating people as unique individuals with their own personality and preferences.

An opportunity to learn about how others cope and manage and to appreciate different perspectives on memory changes.

Due to the nature of progressive illness, no difference in outcome measures before and after the 12 week groups, however feedback from participants suggests positive experiences and benefits for wellbeing.

"I enjoyed the company and talking to people."

"It was an upbeat and pleasant group."

"Never felt uncomfortable."

"It brought happiness to me."

Feedback from carers:

"My Mum was more content, stimulated and chatty on a Thursday afternoon."

"The company and regularity was beneficial."

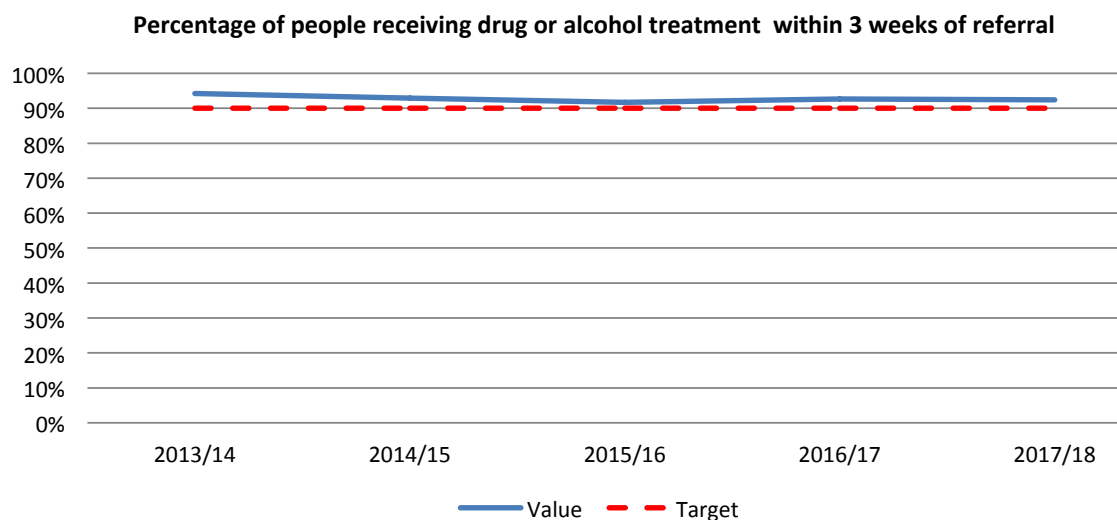
"Good recall of events, other people and mentioned looking forward to going back."

"Gave me a short break from caring for my wife."

Through efficient and effective partnership working with key stakeholders, to reduce the harmful effects of alcohol and drugs and promote recovery in local communities

HSCP Addiction Services support people to regain and sustain a stable lifestyle. They support individuals to access education, training and employment services enabling them to participate in meaningful

activities as members of their community; to improve family and other relationships and access counselling services; and provide parental support for families and children. The national Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services underpin the development of HSCP Addiction Services, supported by The Road to Recovery Drugs Strategy and Getting Our Priorities Right guidance.



Performance against the target of 90% of people receiving treatment to support their recovery within 3 weeks dipped slightly to 88.9% in April to June 2017 but reverted to over 90% for the remainder of the year with an annual figure of 92.4%. This is slightly lower than both Scotland at 93.8% and 95.7% across Greater Glasgow and Clyde.

660
alcohol brief
interventions



During 2017/18, a total of 209 Alcohol Brief Interventions (ABIs) were carried out within a GP practice setting and 451 within wider community settings. An Alcohol Brief Intervention (ABI) is a short, evidence-based, structured conversation about alcohol consumption that seeks in a non-confrontational way to motivate and support the individual to think about and plan a change in their drinking behaviour, in order to reduce their consumption and their risk of harm. Higher numbers of ABIs being carried out in wider community settings reflect the broadening of ABI delivery and may potentially cover harder to reach groups, especially in communities where deprivation is greatest.

The Future of Addiction Services Team (FAST) is an example of our commitment to peer recovery support services; ensuring that the voices and experiences of people, and their families, in recovery are included in the planning and delivery of services. In addition to the successful café in St Augustine's Church, Dumbarton, FAST opened a new Recovery Café in Dalmuir Park. This has been well received and attended since the launch and allows local people to access Recovery Orientated Systems of care to support them with their substance misuse issues and make positive lifestyle changes. The cafés offer an opportunity to socialise, expand culinary skills and to participate in activities such as art, arts and crafts or sample

alternative therapies. Many individuals build on the social and technical skills they have developed to go on to support others who may be at a different stage of their recovery journey providing hope and inspiration that change is always possible.

The SEARCH Project, Support and Education for Alcohol Related Challenges led by Carers of West Dunbartonshire, is an apparently unique project in Scotland and the UK and was nominated for NHS Greater Glasgow and Clyde's Chairman's Awards 2017 in the Improving Health category. The HSCP's Addiction teams in Dumbarton and Clydebank in partnership with Carers of West Dunbartonshire, have been able to help identify not only carers looking after someone who is misusing alcohol, but also carers who may be using alcohol to cope with their stressful and challenging caring responsibilities.

Carers are made aware of their rights to assessment and support, thereby opening up access to services that could help sustain them in their caring role. The service has also helped to break through some of the barriers that prevent people from asking for help by having conversations with service users and, where appropriate, with their carer or family member.

The project evidences implementation of the Quality Principle that 'services should be family inclusive as part of their practice': giving individuals the opportunity to involve other people, and particularly those close to them, who can support their recovery.

Blood Borne Virus (BBV) Service

A dedicated team of nurses, specialising in blood-borne viruses are helping patients in West Dunbartonshire to access treatment for their condition nearer to home.

Before the specialist team was set up locally 6 years ago, patients had to travel to Gartnavel General in Glasgow for treatment for Hepatitis C and only about 10% of patients actually attended their appointment. These patients have very complex needs and were not always able to make the journey.

The BBV team have now successfully treated over 200 patients. Over a third of these patients had a diagnosis of advanced liver disease. These are often people who historically do not attend appointments or sustain treatment.

It is down to the commitment of the staff and their flexible model of care, reaching out into the community where traditional methods have failed, that this unique team are having such a positive impact on the health of an especially vulnerable and ill group of people.

In light of this drive and approach, the BBV team's data was recognised at the International Liver Congress in Amsterdam where the BBV Nurse Specialist was invited to deliver the data in person.

Further to this the BBV team were awarded NHS Greater Glasgow and Clyde's Chairman's Award for Clinical Excellence 2017.

The team were also selected to be showcased at NHS Greater Glasgow and Clyde's Celebrating Success 2017 event for demonstrating an innovative change in the delivery of good practice.

One patient said: "It made a big difference and actually made me go through with my treatment. If I couldn't make it for any reason they would come to my home. It's basically made me want to live again."

public protection

4



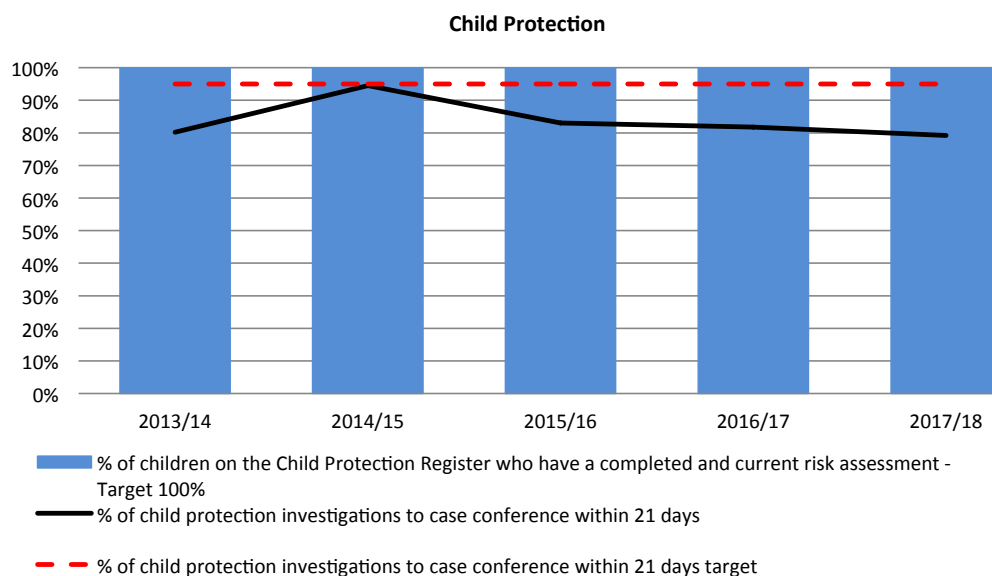
Public Protection

Public Protection provides a range of measures which can be used together to 'protect our people'. This includes protection from harm for children and young people, vulnerable adults and the effective and robust management of High Risk Offenders through our Multi-Agency Public Protection Arrangements (MAPPA). As such Public Protection is integral to the delivery of all adult and children's services within the HSCP.

The HSCP has a significant role within the Public Protection Chief Officers Group (PPCOG), with both the Chief Officer and Chief Social Work Officer providing the necessary leadership, scrutiny and accountability. This includes the management of high risk offenders; and in assuring that each of the services in place for child and adult protection are performing well and keeping the citizens of West Dunbartonshire safe.

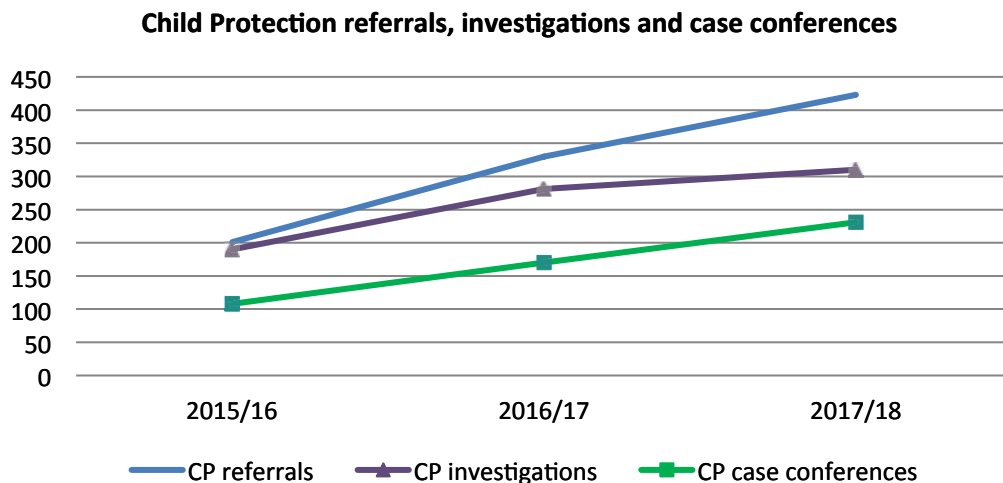
Child Protection

As at the 31st of March 2018 there were 70 children on the Child Protection Register in West Dunbartonshire. As the chart below illustrates, all children on the Register have a completed and current risk assessment.



Performance against the 90% target for case conferences being held within 21 days of an investigation dipped in April - June 2017 but has recovered somewhat throughout the rest of the year giving an annual figure of 79.2%.

There has been a significant increase in Child Protection activity over the past 3 years: reflected in a 12% rise in the number of looked after children during the same period.



The local HSCP-led and multi-agency Child Protection Committee continues to monitor activity and registrations and the variance over the course of the year.

Adult Protection

Within our communities there are adults who are at more risk of harm than others because of illness, disability or some other factor. The Adult Protection Committee continues to meet on a quarterly basis and attendees include a representative from the HSCP, Police Scotland, Council Trading Standards, the Care Inspectorate, the Office of Public Guardian, the Mental Welfare Commission, Scottish Care, advocacy services and Scottish Fire and Rescue Service.

West Dunbartonshire has set more stringent targets for timescales for Adult at Risk investigations than the West of Scotland Guidelines: no less than 80% within 6 working days rather than 8 working days. Performance against this has been challenging with 74% meeting the 6 day target.

100%

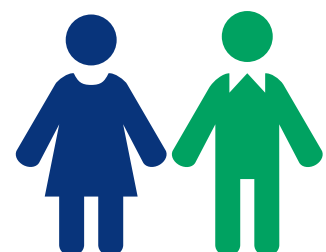
of adult support and protection clients have a current risk assessment and care plan

347

Adult at Risk referrals

54

Adult at Risk investigations



Multi Agency Public Protection Arrangements

Multi Agency Public Protection Arrangements (MAPPA) bring together Police Scotland, local authorities, the Scottish Prison Service and territorial NHS health boards, as the Responsible Authorities, to jointly establish arrangements to assess and manage the risk posed by sex offenders and mentally disordered restricted patients.

All level 2 MAPPA cases were reviewed no less than every 12 weeks



In addition to registered sex offenders and restricted patients, since April 2016 MAPPA arrangements have also applied to offenders who through the nature of their conviction are assessed as presenting a high or very high risk of serious harm to the public, referred to as category 3. It is important to note that the threshold for inclusion in MAPPA is set at a high level and is based upon the application and interpretation of formal risk assessment.

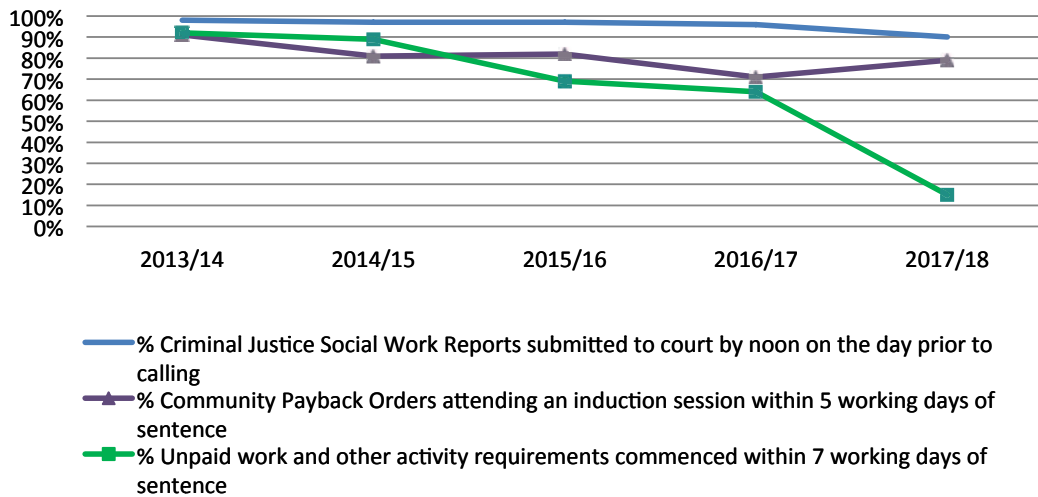
Criminal Justice

The Community Justice (Scotland) Act 2016 identified Community Planning Partnerships as the vehicle to bring partner organisations together to plan and deliver community justice outcomes. It transferred the responsibility for the local strategic planning and delivery of community justice from Community Justice Authorities to Community Planning Partnerships; with full responsibility being conferred from 1st April 2017 following the disestablishment of Community Justice Authorities on 31st March 2017. The new arrangements rely on Community Planning Partnerships being the vehicle to bring partner organisations together to plan and deliver community justice outcomes.

Community Justice relates to the whole journey that a person can travel through, including the risk factors that can underpin a person's offending behaviour; to the factors supporting desistance and the milestones people often experience on this journey. The HSCP is crucial in supporting people and their families and carers through statutory criminal justice services, and importantly through HSCP and third sector partnership provision: reflecting the often poor physical and mental health of people involved in offending behaviour.

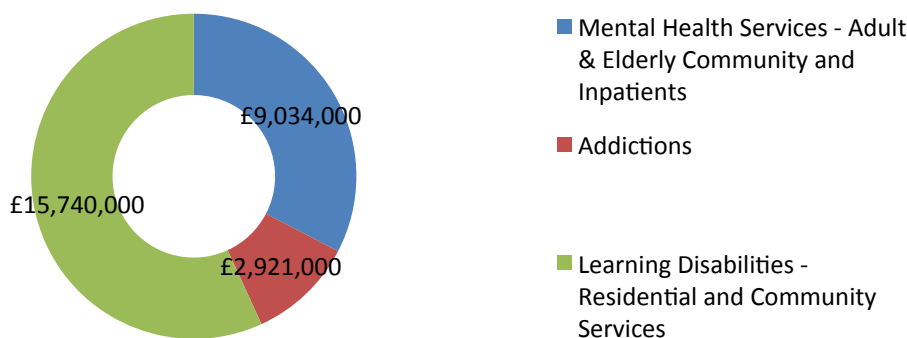
As shown opposite, performance within Criminal Justice services has proved challenging during 2017/18 particularly in relation to meeting timescales for the commencement of unpaid work requirements.

Criminal Justice



A high volume of new unpaid work orders and 2 vacant posts may have been contributing factors however performance is being closely monitored and improvements are expected in 2018/19.

Net Expenditure 2017/18



best value and financial performance



The key messages for the financial year 2017/18 are:

- On a total budget allocation of £167.295m from our funding partners West Dunbartonshire Council (WDC) and NHS Greater Glasgow and Clyde (NHSGGC), we have ended the year with a surplus of £0.574m (subject to external audit review) after taking account of planned additions to reserves
- The surplus will be added to HSCP Board Reserves brought forward from 2016/17. The general reserve is categorised into earmarked for specific projects and unearmarked which are available to help manage the financial risk of any future unanticipated events that may materially impact on the financial position of the partnership
- The earmarked reserves balance has had a net increase of £0.949m, mainly due to Scottish Government Primary Care Transformation Funding, Integrated Care Fund (supporting the shift in the balance of care to a community setting) and Musculoskeletal (MSK) Orthopaedic Project, bringing the closing balance to £4.437m
- The unearmarked reserves balance has closed 2017/18 with a net decrease of £0.375m, mainly due to the application of reserves to offset the additional costs within social care linked to demographic pressures in our older people population and supporting children and families within their community. However there was a significant addition of £0.725m from unallocated Social Care Fund which was to fund the new Frailty Project, which will be rolled out in 2018/19.

The HSCP Board is required to make arrangements for the proper administration of its financial affairs and to ensure that the proper officer of the board has responsibility for the administration of those affairs (Section 95 of the Local Government (Scotland) Act 1973). In this partnership, that officer is the Chief Financial Officer (CFO).

The financial reporting responsibilities of the CFO include preparing financial statements and performance reports. Financial performance is an integral element of the HSCP Board's overall performance management framework, with regular reporting and scrutiny of HSCP Board and its Audit Committee. The 2017/18 financial performance reports demonstrate that in challenging economic times coupled with significant demographic pressures, the requirement to achieve best value in the delivery of services is paramount, in tandem with maintaining quality and securing continuous improvement.

The table on the next page sets out the consolidated financial performance (subject to final audit approval) of all our services and whilst the overall position is favourable, it is clear to see that health and social care services are under pressure due to increasing demand across our population.

West Dunbartonshire Integrated Joint Board Health & Social Care Partnership	2017/18 Annual Budget £000	2017/18 Net Expenditure £000	2017/18 Underspend/ (Overspend) £000
Consolidated Health & Social Care			
Older People Residential, Health and Community Care	29,801	30,543	(742)
Homecare	13,137	13,567	(430)
Physical Disability	2,872	2,782	90
Children's Residential Care and Community Services (including specialist)	19,008	20,901	(1,893)
Strategy Planning and Health Improvement	1,882	1,597	285
Mental Health Services -			
Adult & Elderly Community and Inpatients	9,300	9,034	266
Addictions	2,955	2,921	34
Learning Disabilities -			
Residential and Community Services	16,303	15,740	563
Family Health Services (FHS)	23,962	23,962	0
GP Prescribing	19,887	19,887	0
Hosted Services - MSK Physio	5,975	5,777	198
Hosted Services - Retinal Screening	824	741	83
HSCP Corporate and Other Services - includes drawdown from Reserves	3,113	993	2,120
IJB Operational Costs	283	283	0

**Cost of Services Directly Managed
by West Dunbartonshire HSCP**

	149,302	148,728	574
Set aside for delegated services provided in large hospitals - notional figure	17,066	17,066	0
Assisted garden maintenance and Aids and Adaptions	927	927	0
Services hosted by other Integrated Joint Boards within Greater Glasgow & Clyde	11,997	11,997	0
Services hosted by West Dunbartonshire IJB for other IJBs	6,337	6,337	0

**Total Cost of Services to
West Dunbartonshire HSCP**

185,629	185,055	574
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The 2017/18 outturn position (agreed by the 20 June 2018 HSCP Audit Committee), before the application of general (unearmarked) reserves reported an overspend of £1.231m (-0.85%), funded by general reserves of £1.052m and £0.179m to cover the overspends within social care and health care services respectively. The main points to note are:

- Community placements for children including kinship care and fostering placements accounts for £0.709m of the overspend, due to an unprecedented increase in numbers. The number of kinship placements increased by 43 and the number of fostering placements 17. Ongoing difficulties across Scotland in attracting foster carers to sign with local authorities meant that the majority of these new places had to be arranged with external fostering agencies at a higher cost;
- Children placed within residential schools due to emotional, behavioural or physical disabilities exceeded the budget by £0.736m. This is an extremely volatile budget and secure placements can cost in excess of £0.200m per child. Childcare managers review these packages on a weekly basis for alternative, appropriate community-based support;
- Older people supported through care at home services or in residential or nursing care exceeded the budget by £0.430m and £0.626m respectively and can be attributed to demographic demand and continued improved performance on anticipatory care planning and reduction to bed days lost through delayed discharge; and
- All other adult services including learning and physical disability and mental health and addiction services collectively underspent by £0.953m, due to many factors including a reduction in a small number of high tariff, complex mental health and learning disability clients in receipt of high cost packages and the cost of rolling out the living wage being less than anticipated as it does not require to be applied to the cost of sleepovers until the end of 2018.

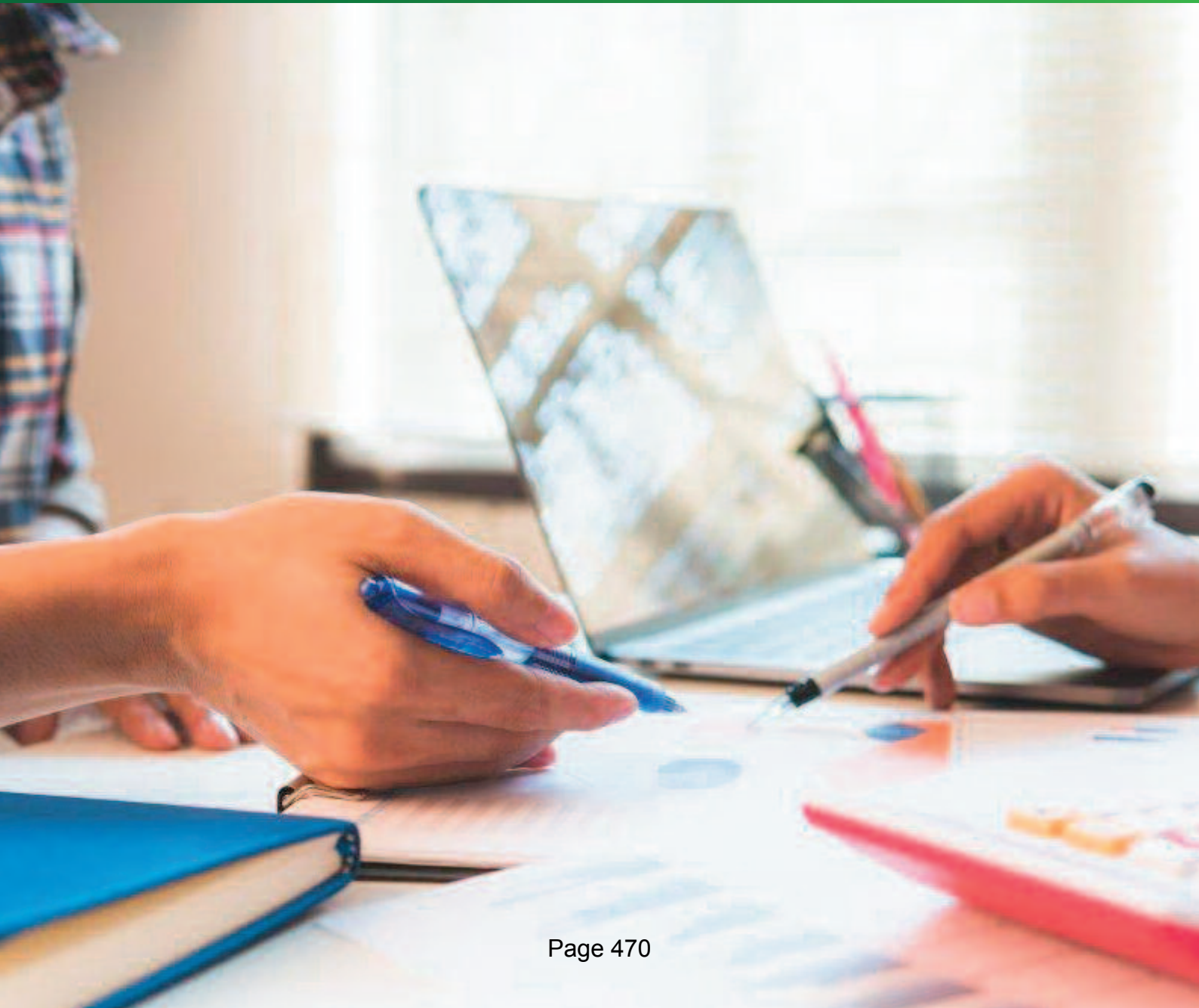
The Scottish Government continued to support Health and Social Care Services across Scotland in 2017/18 through the continuation of the Social Care Fund. An additional £107m was allocated in addition to the £250m available in 2016/17. For West Dunbartonshire HSCP Board our share of the 2017/18 fund was £2.087m to support the continuation of the rollout of the Scottish Living Wage (£8.45/hr) to all adult social care workers, preparation for the implementation of the Carers Act 2016 (effective from 1st April 2018) and the development of new ways of working to support the shift in the balance of care to a community setting, wherever possible.

The set aside budget for large hospital services is related to the HSCP Board's responsibility for the strategic planning for unscheduled care with respect to the population of West Dunbartonshire. For 2017/18 the reported budget is regarded as 'notional' with a corresponding equal 'notional' spend. However the Scottish Government have made it clear to Health Boards and Integrated Joint Boards that by the end of 2018/19 the set aside budget must be a true reflection of activity and be able to demonstrate positive improvements in shifting the balance of care from hospital to community care settings. Good quality community care should mean less unscheduled care in hospitals, and people staying in hospitals only for as long as they need specific treatment.

While the outlook may be financially challenging the HSCP Board through the delivery of its Strategic and Financial Plans will continue to develop, transform and deliver high quality health and social care services to the people of West Dunbartonshire.

good governance

6



The HSCP Board is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively. To secure best value, the Strategic Plan 2016-19 commits to continuous quality improvement in performance across all areas of activity.

To meet this responsibility the HSCP Board continues to have in place robust arrangements for governance of its affairs and effectiveness of its functions, including the identification, prioritisation and the management of risk.

In discharging this responsibility, the Chief Officer has put in place arrangements for governance which includes a system of internal control. The system is intended to manage risk, to a reasonable level, to support the delivery of the HSCP Board's policies, aims and objectives. Reliance is also placed on Greater Glasgow and Clyde Health Board and West Dunbartonshire Council's systems of internal control that support compliance with both partner organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the HSCP Board.

The Chief Internal Auditor reports directly to the HSCP Board's Audit Committee on all audit matters, with the right of access to the Chief Officer, Chief Financial Officer and Chair of the Audit Committee on any matter.

The HSCP Board is committed to continuous improvement and is responsible for conducting at least annually, a review of its governance framework including the system of internal control. The review of the effectiveness of the framework is informed by the work of the Chief Officer and the Senior Management Team who have the responsibility for development and maintenance of the governance environment; the work of the Internal and External Auditors and inspections and reports of other review agencies, including the Care Inspectorate.

The HSCP Board adopted "The Code of Practice for Local Authority Accounting", recommendation that the local code is reviewed each year, in order that it can inform the Governance Statement. This review was carried out and approved by the Audit Committee in June 2018 and can be found on the HSCP website.

In summary there was some improvement in the sub-principles deemed fully compliant, the September Action Plan was updated and some new improvement actions were identified.

Other reviews to improve effectiveness include:

- Refresh of the HSCP Board's Financial Regulations
- Review of remit and membership of the Clinical and Care Governance Group
- Formation of local Prescribing Group to support the work of the Prescribing Efficiency Group
- Approval of the Strategic Planning Group - a sub-committee of the HSCP Board.

Also supporting the review of the HSCP Board's governance framework are the processes of West Dunbartonshire Council and Greater Glasgow and Clyde Health Board.

Within the council each member of the Corporate Management Team presents an annual statement on the adequacy and effectiveness of control (including financial control), governance and risk management arrangements within their service area. Through the delegation of operational responsibility for the delivery of all social care services these statements were provided by the HSCP's Chief Officer, Chief Financial Officer and Senior Management Team. The responses to these are considered as part of the review of the HSCP Board's and Council's governance arrangements and inform the Chief Internal Auditor's Annual Reports.

Some of the key improvements noted in 2017/18 are:

- Legislative compliance in relation to child protection through the local Child Protection Committee
- Introduction of Be the Best Conversations across Community Care staff
- Actioned Public Service Improvement Framework (PSIF) process in both Mental Health and Learning Disability Services
- Update of Business Continuity Plan in partnership with the council and the health board.

Within the health board a similar process is in operation where service managers and Chief Officers complete a “Self Assessment Checklist” covering all the key areas of the internal control framework.

appendices

Appendix 1: Core Integration Indicators

	WEST DUNBARTONSHIRE					SCOTLAND	COMPARISON WEST DUNBARTONSHIRE AND SCOTLAND LATEST DATA
	2014/15	2015/16	2016/17	2017/18	Direction of travel	2017/18	
Premature mortality rate per 100,000 persons*	556.8	569.5	512.1	513.6	↑	425.2	●
Emergency admission rate per 100,000 population	14,254	13,612	13,695	12,720	↓	11,959	●
Emergency bed day rate per 100,000 population	146,024	131,480	142,221	128,474	↓	115,518	●
Readmission to hospital within 28 days per 1,000 population	79	78	87	83	↓	97	✓
Proportion of last 6 months of life spent at home or in a community setting	86.6%	86.7%	87.9%	89.3%	↑	88.3%	✓
Falls rate per 1,000 population aged 65+	21.5	22.9	24.1	22.9	↓	21.7	●
Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	89.5%	92.5%	80.5%	92%	↑	85%	✓
Percentage of adults with intensive care needs receiving care at home	67%	67.7%	70%	N/A	↑	61%*	✓
Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	880	530	479	335	↓	772	✓
Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	22.4%	22%	24.6%	22.5%	↓	23%	✓
Percentage of adults able to look after their health very well or quite well	94% [^]	93%	N/A	91%	↓	91%	✓
Percentage of adults supported at home who agree that they are supported to live as independently as possible	85% [^]	88%	N/A	81%	↓	81%	✓
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	80% [^]	82%	N/A	80%	↓	76%	✓
Percentage of adults supported at home who agree that their health and care services seem to be well co-ordinated	79% [^]	83%	N/A	79%	↓	74%	✓
Percentage of adults receiving any care or support who rate it as excellent or good	85% [^]	86%	N/A	81%	↓	80%	✓
Percentage of people with positive experience of the care provided by their GP practice	82% [^]	87%	N/A	85%	↓	83%	✓
Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	87% [^]	85%	N/A	79%	↓	80%	●
Percentage of carers who feel supported to continue in their caring role	43% [^]	40%	N/A	40%	↔	37%	✓
Percentage of adults supported at home who agree that they felt safe	86% [^]	86%	N/A	89%	↑	83%	✓

↑ increasing

↓ decreasing

↔ unchanged

✓ performing better or as well as Scotland figure

● performing poorer than Scotland figure

* calendar year

[^] 2013/14 figure

Appendix 2: Care Inspectorate Inspections of HSCP Registered Services

This Appendix details the grades achieved for WDHSCP services which were inspected and had reports published by the Care Inspectorate between 1 April 2017 and 31 March 2018.

Gradings:

- 1 - Unsatisfactory
- 2 - Weak
- 3 - Adequate
- 4 - Good
- 5 - Very Good
- 6 - Excellent

SERVICE	DATE INSPECTED	GRADE	QUALITY THEME
Blairvadach Children's House	21 Jun 2017	4 N/A N/A 4	Care and Support Environment Staffing Management and Leadership
			Requirements: None Recommendations: None
Burnside	20 Mar 2018	5 N/A N/A 5	Care and Support Environment Staffing Management and Leadership
			Requirements: None Recommendations: None
Craigellachie Children's House	22 Sep 2018	4 N/A 4 N/A	Care and Support Environment Staffing Management and Leadership
			Requirements: The provider must ensure that the Care Inspectorate is notified when it breaches the conditions of registration for the service. Recommendations: The provider should ensure that staff receive regular supervision, in line with the provider's policy and should take steps to promote an outward looking approach to staff development.
Throughcare/Aftercare Team	27 Mar 2018	6 6 N/A	Care and Support Staffing Management and Leadership
			Requirements: None Recommendations: None

SERVICE	DATE INSPECTED	GRADE	QUALITY THEME
Boquhanran House	29 Sep 2017	5 N/A 4 N/A	Care and Support Environment Staffing Management and Leadership
		Requirements: None Recommendations: Staff should adopt best practice when monitoring residents who may be at risk of developing dehydration and malnourishment. Associated monitoring charts should be fully completed, targets identified as regards as food and fluid intake and recording amounts taken by each resident. The service provider should ensure that staff is given regular opportunities to meet with their supervisors and that appropriate records of these meetings are maintained. The service provider should provide staff with first aid training to ensure the wellbeing of residents both in the care home and when on outings. The service provider should produce a training plan which details how they will roll out further dementia training to staff. The service provider should ensure that there are regular staffing meetings to enable staff to contribute to the on-going development of the service.	

SERVICE	DATE INSPECTED	GRADE	QUALITY THEME
Care at Home Services	15 Mar 2018	5 5 N/A	Care and Support Staffing Management and Leadership
		Requirements: None Recommendations: Dementia training at the skilled level should be completed by all staff. The service should ensure that service users and relatives know how they can access care plans and also provide clear information about the time bands used for support visits.	

SERVICE	DATE INSPECTED	GRADE	QUALITY THEME
Frank Downie Day Care	28 Feb 2018	5 N/A N/A 5	Care and Support Environment Staffing Management and Leadership
		Requirements: None Recommendations: None	

SERVICE	DATE INSPECTED	GRADE	QUALITY THEME
Frank Downie House	11 Oct 2017	5 4 4 N/A	Care and Support Environment Staffing Management and Leadership
		Requirements: None Recommendations: Staff should adopt best practice when monitoring residents who may be at risk of developing dehydration and malnourishment. Monitoring charts should be fully completed, appropriate targets identified as regards food and fluid intake and recording amounts taken by each resident. The provider should ensure that staff training plans are up-to-date so that staff receive appropriate training to meet residents' needs. The service provider should ensure that staff are given regular opportunities to meet with their supervisors and that appropriate records of these meetings are maintained. The service provider should produce a training plan that includes details of how they will roll out further dementia training to staff. The service provider should provide staff with first aid training to ensure the wellbeing of residents both in the care home and when on outings.	

SERVICE	DATE INSPECTED	GRADE	QUALITY THEME
Learning Disability Service	24 Nov 2017	5	Care and Support Environment Staffing Management and Leadership
		N/A 4 5	
Requirements: None Recommendations: None			
SERVICE	DATE INSPECTED	GRADE	QUALITY THEME
Learning Disability Service - Community Connections	9 Mar 2018	5	Care and Support Environment Staffing Management and Leadership
		N/A 5 N/A	
Requirements: None Recommendations: Staff should be able to access historical information about accidents and incidents without the need for 'workaround' systems being used. The provider should take appropriate action to address this.			
SERVICE	DATE INSPECTED	GRADE	QUALITY THEME
Mount Pleasant House	21 Dec 2017	4	Care and Support Environment Staffing Management and Leadership
		4 4 4 4	
Requirements: The provider must ensure that all care plans and related documentation is accurate, up-to-date, signed and dated, and reflective of the care needs and outcomes to be achieved for each resident. Recommendations: Where it is recognised that a resident is in need of dietary support, the care plan should include strategies and practice guidance for staff. Systems such as food and fluid intake charts should be in place to enable monitoring and evaluating how the plan is working.			
SERVICE	DATE INSPECTED	GRADE	QUALITY THEME
Queen Mary Day Care	11 Apr 2017	5	Care and Support Environment Staffing Management and Leadership
		N/A N/A 5	
Requirements: None Recommendations: Staff should have training in delivering meaningful activities and should also be trained at skilled level in dementia.			
SERVICE	DATE INSPECTED	GRADE	QUALITY THEME
Sheltered Housing	15 Mar 2018	5	Care and Support Staffing Management and Leadership
		N/A 5 N/A	
Requirements: None Recommendations: Dementia training at skilled level should be completed by all staff.			

Appendix 3: West Dunbartonshire HSCP Key Performance Indicator Summary 2017/18

The Ministerial Steering Group (MSG) for Health and Community Care is closely monitoring the progress of HSCPs across Scotland in delivering reductions in: delays in hospital discharge; unnecessary hospital admissions; attendances at accident and emergency (A&E); and shifting the balance of care from hospital to community settings. In light of the integration of health and social care services significant improvements in ways of working and efficiencies are expected.

During 2017/18 West Dunbartonshire HSCP has been working with colleagues across NHS Greater Glasgow and Clyde to develop targets for these reductions and these will be applied from 2018/19. The first set of key performance indicators below fall within the MSG objectives and performance status has been set on the basis of a comparison with our performance in 2016/17.

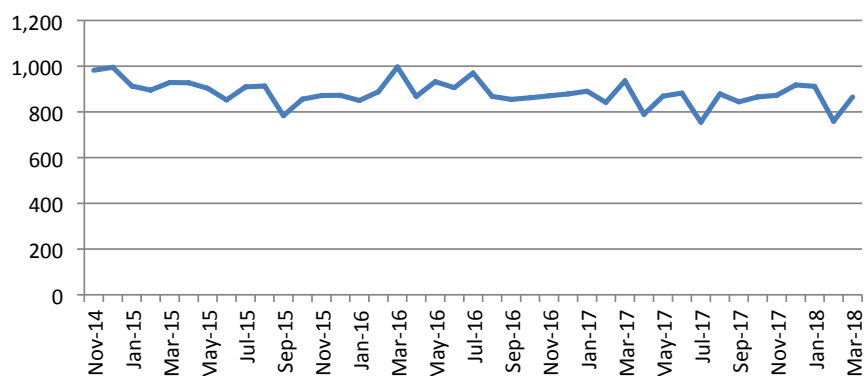
PERFORMANCE INDICATOR	2016/17	2017/18	
	VALUE	VALUE	STATUS
Number of acute bed days lost to delayed discharges (inc Adults with Incapacity) age 65 years and over	3,047	2,291	✓
Number of acute bed days lost to delayed discharges for Adults with Incapacity, age 65 and over	849	461	✓
Emergency admissions aged 65+ as a rate per 1,000 population	263	273	▲
Unplanned acute bed days (aged 65+) as a rate per 1,000 population	2,883	3,102	▲
Number of emergency admissions (all ages)	10,680	9,984	✓
Number of attendances at Accident and Emergency (Emergency Departments and Minor Injuries Units)	30,788	30,422	✓

PERFORMANCE INDICATOR	2016/17	2017/18		
	VALUE	VALUE	TARGET	STATUS
Child & Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	100%	84.2%	90%	▲
Mean number of weeks for referral to treatment for specialist Child & Adolescent Mental Health Services	6	7	18	✓
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	95.6%	94.9%	95%	▲
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	97.6%	97.7%	95%	✓
Balance of care for looked after children: % of children being looked after in the community	90.4%	90.4%	90%	✓
Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	62%	78%	75%	✓
Percentage of all children aged 0-18 years with an identified 'named person' as defined within the Children's and Young People's Act 2014	62%	78%	75%	▲
Number of delayed discharges over 3 days (72 hours) non-complex cases	14	4	0	⬢
Percentage of total deaths which occur in hospital 65+	41.1%	42.6%	45.9%	✓
Percentage of total deaths which occur in hospital 75+	40.2%	41.7%	45.9%	✓
Number of clients 65+ receiving a reablement intervention	610	632	575	✓
Percentage of adults with assessed Care at Home needs and a reablement package who have reached their agreed personal outcomes	66%	64.7%	60%	✓
Number of patients in anticipatory care programmes	1,678	1,921	1,400	✓
Number of patients aged 75+ in receipt of Telecare - Crude rate per 100,000 population	23,058	23,139	23,230	▲
Total number of homecare hours provided as a rate per 1,000 population aged 65+	517.9	488	518	▲
Percentage of people aged 65 and over who receive 20 or more interventions per week	28.9%	34.2%	30%	✓

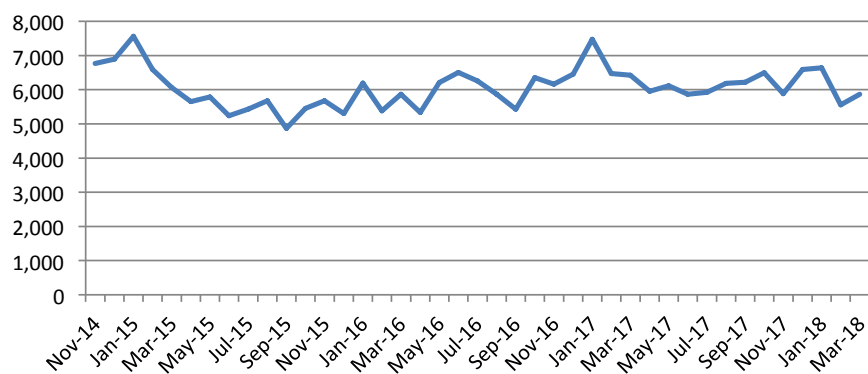
PERFORMANCE INDICATOR	2016/17	2017/18		
	VALUE	VALUE	TARGET	STATUS
Percentage of people aged 65 or over with intensive needs receiving care at home	33.5%	32.2%	35%	▲
Percentage of homecare clients aged 65+ receiving personal care	93.7%	92.1%	90%	✓
Percentage of people aged 65 and over assessed with complex needs living at home or in a homely setting	98.1%	98%	98%	✓
Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	29%	26.9%	30%	✓
Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)	22.3%	24.4%	90%	✓
Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	39.2%	42.5%	35%	●
Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	51.2%	43%	90%	●
Number of clients receiving Home Care Pharmacy Team support	1,048	941	900	✓
Prescribing cost per weighted patient	£181.10	£173.07	£178.32	✓
Compliance with Formulary Preferred List	80.2%	80.2%	78%	✓
Total number of respite weeks provided to all client groups	4,795.1	4,449.25	4,110	✓
Percentage of carers who feel supported to continue in their caring role	99%	97.4%	90%	✓
Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	92.7%	92.4%	90%	✓
Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling	96%	90%	98%	▲
Percentage of Community Payback Orders attending an induction session within 5 working days of sentence	71%	79%	80%	▲
Percentage of unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence	64%	15%	80%	●
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%	100%	✓
Percentage of child protection investigations to case conference within 21 days	81.8%	79.2%	95%	●
Percentage of Adult Support and Protection clients who have current risk assessments and care plan	100%	100%	100%	✓
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	96.8%	96.4%	90%	✓

Appendix 4: Ministerial Steering group - Measuring Performance Under Integration (Provisional Figures)

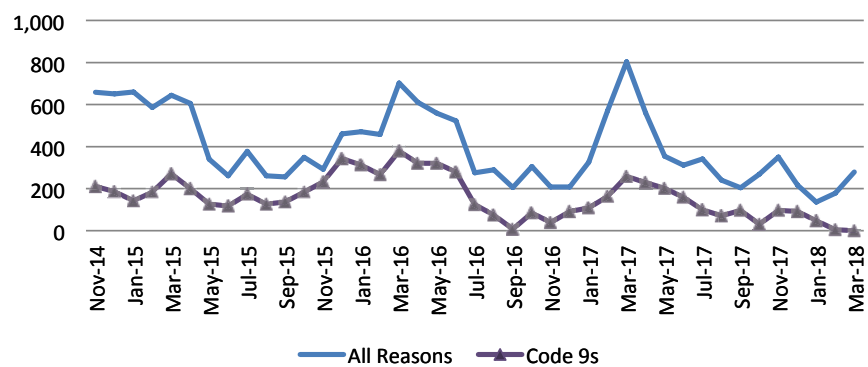
Emergency Admissions - All Ages



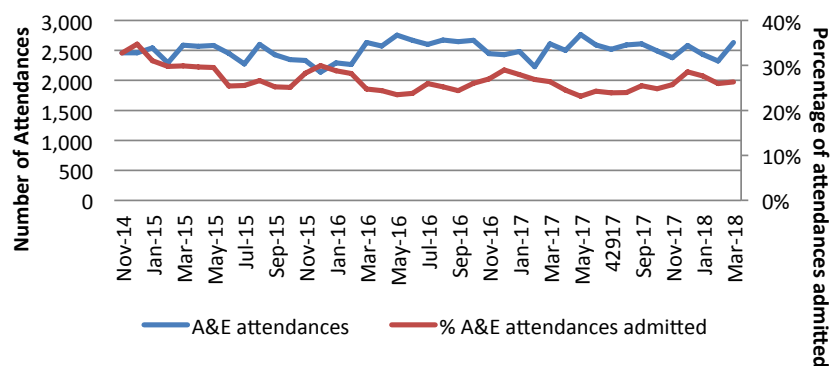
Unscheduled Acute Hospital Bed Days - All Ages



Bed Days Lost to Delayed Discharges - All Ages



Accident and Emergency (A&E) Attendances and Admissions - All Ages



Appendix 5: HSCP Local Government Benchmarking Framework Indicators

PERFORMANCE INDICATOR	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	
	VALUE	VALUE	VALUE	VALUE	VALUE	VALUE	NOTE
The gross cost of 'children looked after' in residential based services per child per week £	£3,008.94	£1,994.98	£2,946.15	£2,374.54	£2,292.62	£2,022.36	We are ranked 2nd in Scotland for this measure and our cost per week is substantially lower than the Scotland figure of £3,404.36
The gross cost of 'children looked after' in a community setting per child per week £	£52.15	£143.79	£155.63	£159.38	£185.70	£164.66	We are ranked 4th in Scotland for this measure and our cost per week is substantially lower than the Scotland figure of £312.73
Balance of Care for looked after children: % of children being looked after in the Community	88.35%	87.01%	90.51%	89.12%	89.81%	89.98%	<p>The HSCP's focus, along with community planning partners, on early intervention in the lives of children, young people and their parents and/or carers continues our shift to preventing crisis, and reducing risk, through assessment and appropriate intervention. We recognise that some of our children may need to be cared for away from home. As per our Community Planning West Dunbartonshire Corporate Parenting Strategy, we have strived to increase the proportion of children and young people who are looked after in the community: this has increased from 88.35% in 2011/12 to 89.98% in 2016/17. We are ranked 12th in Scotland and are slightly higher than the Scotland figure of 89.87%.</p> <p>As part of our equalities monitoring, 82% of looked after children who are from a black ethnic minority (BME) community were looked after in the community at the end of March 2017. Although this is lower than the overall figure, the numbers involved are very small, meaning the percentage fluctuates more significantly.</p>
% of Child Protection registrations re-registered within 18 months		8.06%	4.62%	0%	3.9%	7.03%	We are ranked 20th in Scotland on this measure. The Scotland figure is 6.46%.
% of looked after children who had more than one placement in the last year (August - July)	15.45%	18.93%	19.51%	20.98%	20.66%	17.02%	We are ranked 5th in Scotland on this measure. Scotland is significantly higher at 21.19%.
Home care costs for people aged 65 or over per hour £	£15.67	£17.64	£18.47	£20.91	£22.03	£24.24	We are ranked 22nd in Scotland. The Scotland figure is £22.64.
Self directed support spend for people aged over 18 as a % of total social work spend on adults	1.59%	1.45%	1.41%	1.8%	2.19%	2.37%	Expenditure on Self-Directed Support (SDS) Options 1 and 2 has increased by 82% since 2013/14 and has also increased as a proportion of adult social care spend from 1.39% to 2.37%. However, high satisfaction with social care services may also mean that clients are less motivated to actually take up SDS direct payments or individual service funds relative to other areas. This may go some way to explaining why our increased SDS expenditure has not been reflected in our ranking of 27th. The Scotland figure is 6.49%.

PERFORMANCE INDICATOR	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	
	VALUE	VALUE	VALUE	VALUE	VALUE	VALUE	NOTE
Percentage of people aged 65 or over with intensive needs receiving care at home	44.27%	42.52%	40.71%	39.32%	35.71%	33.53%	We are ranked 18th in Scotland on this measure. At the end of March 2017, 286 people with intensive needs were receiving 10 or more hours of homecare. This indicator is published by the Local Government Benchmarking Framework and measures volume of service rather than appropriate targeting or alternative supports which may augment homecare such as telecare. A change in the 2015/16 guidance for the collection of NHS Continuing Care data will affect comparability with previous figures. Scottish Government are currently examining options to resolve this and this may result in an update to the data presented here.
Net residential costs per capita per week for older adults (65+)	£554.19	£430.41	£415.97	£460.43	£466.13	£479.97	The HSCP is significantly higher than the Scotland figure of £372.36 and this is reflected in our ranking which has moved from 29th since 2014/15 to 28th in 2016/17. The LGBF Overview Report 2014/15 recognises that 'variation in net costs between councils will be largely influenced by the balance of LA funded/self-funded residents within each area, and the scale of LA care home provision and associated running costs'. The latter would include the degree to which staff employed within care homes are paid at least the National Living Wage. West Dunbartonshire local authority care homes are a significant provider of residential care placements with all of our staff paid at least the National Living Wage.

notes





WESTDUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Health and Social Care Partnership: 8th August 2018

Subject: Strategic Plan 2016 – 2019; Annual Review 2018 – 2019

1. Purpose

- 1.1** To present the Partnership Board with an annual review of its Strategic Plan 2016 – 2019 in preparation for the development of new Strategic Plan 2019 - 2022.

2. Recommendations

- 2.1** The Partnership Board is recommended to approve the Strategic Plan 2016 – 2019; Annual Review 2018 – 2019.

3. Background

- 3.1** The Public Bodies (Joint Working) (Scotland) Act 2014 states that in order for responsibilities and resources to be formally delegated in practice to an integration joint board, a local Strategic Plan must first be prepared and approved by it.
- 3.2** At its July 2015 meeting, the Partnership Board approved its first Strategic Plan for 2015/16.
- 3.3** At the 17th August 2016 meeting, the Partnership Board agreed the second Strategic Plan 2016 – 2019.
- 3.3** The need to develop a new Plan for 2019 and the agreement of a refreshed strategic planning process by the Board in 2017 requires the development of a new Strategic Plan 2019 – 2022.

4. Main Issues

- 4.1** This annual review provides an update to members of the current priorities and structures which will need to be reviewed and considered over the next six months by the Strategic Planning Group for consideration before presentation back to Board members in Spring 2019.
- 4.2** The development of the third Strategic Plan reflects the on-going, participative and community planning approach endorsed by the Partnership Board at its July 2015 meeting.
- 4.3** Considerable engagement with stakeholders and partners will be underpinned by the community planning structures led by the HSCP including the

Independent Delivery and Improvement Group; the Nurtured Delivery and Improvement Group; the Alcohol and Drug Partnership; Local Engagement Network as well as the Strategic Planning Group.

- 4.4** The membership of the Delivery and Improvement groups will take forward key local programmes and the Strategic Planning Group more broadly incorporates the entire statutory stakeholder consultees specified for the Strategic Plan.
- 4.5** The Scottish Government guidance highlights that there is a need within strategic plans to specify the total resources available across health and social care to deliver the outcomes and objectives articulated within said strategic plans. Given the budget setting processes of the partner organisations, this Strategic Plan annual review is necessarily high level in scope to reflect the uncertainties regarding the financial allocations that will be made to the Partnership Board over each financial year.

6. People Implications

- 6.1** No specific implications associated with this report.

7. Financial and Procurement Implications

- 7.1** The annual review of the Strategic Plan includes a dedicated section pertaining to this.

8. Risk Analysis

- 8.1** The Partnership Board has a duty to implement Best Value, i.e. to make arrangements to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost. Within the context of the Chief Financial Officer's 2017/18 Annual Revenue Budget Report (which has separately been presented to this meeting of the Partnership Board), the Partnership Board should have regard to economy, efficiency, effectiveness, the equal opportunities requirements, and contributing to the achievement of sustainable development in taking forward the commissioning priorities articulated within this annual review of the Strategic Plan 2018 – 2019.

9. Equalities Impact Assessment (EIA)

- 9.1** An Equalities Impact Assessment has been completed for the attached Strategic Plan, with no negative impacts identified. An updated EIA will be undertaken as part of the development of the new Strategic Plan 2018 – 2019.

10. Environmental Sustainability

10.1 It has been confirmed that there is no requirement for a Strategic Environmental Assessment.

11. Consultation

11.1 Both on-going engagement and formal consultation will be undertaken in support of the development of the next Strategic Plan 2019 – 2022 through processes outlined above and the annual review reflects ongoing participation and engagement to update activities and programmes of work.

12. Strategic Assessment

12.1 The Strategic Plan 2016 – 2019 sets out how the Partnership Board does and will plan and deliver services for the West Dunbartonshire area using the integrated budgets under its control. This will be updated as part of the development of the Strategic Plan 2019 – 2022.

Author: Wendy Jack – Interim Head of Strategy, Planning & Health Improvement, West Dunbartonshire Health & Social Care Partnership

Date: 8th August 2018

Person to Contact: Wendy Jack

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Telephone: 01389 776864

Designation Interim Head of Strategy, Planning & Health Improvement, Aurora House, Clydebank

Date: 11th July 2018

Appendices: Health and Social Care Partnership Strategic Plan 2016 – 2019; Annual Review 2018 – 2019.

Background Papers: Health and Social Care Partnership Board Strategic Plan 2016 – 2019

Wards Affected: All council Wards.

West Dunbartonshire Health & Social Care Partnership



Strategic Plan 2016 - 2019

Annual Review 2018 – 2019

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

- Mission is to improve the health and wellbeing of West Dunbartonshire.
- 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.

ACKNOWLEDGEMENTS

The Chief Officer and the Senior Management Team would like to thank everyone who contributed to the development of this annual review; 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 Annual Review of the Strategic Plan to:

Wendy Jack, Interim Head of Strategy, Planning & Health Improvement West Dunbartonshire Health & Social Care Partnership, 3rd Floor, Aurora House, 3 Aurora Avenue, Clydebank, G81 1BF. Tel: 01389 776864.

An electronic version of this annual review – alongside further information about the work of the Health & Social Care Partnership and its Board – can be accessed at: www.wdhscp.org.uk



Welcome

**Beth Culshaw
Chief Officer**

Welcome to the 2018 annual review of the HSCP Strategic Plan 2016 - 2019. This annual review provides an update on progress of the agreed priorities and actions as well as providing the direction of travel for 2019 onwards for the new Strategic Plan.

The high-level strategic actions describe our commissioning priorities and a continuing clear commitment to the delivery of effective clinical and care governance and Best Value.

Over the past year, we have seen the enactment of the Carers' Act; new Health and Care Standards from the Care Inspectorate; new Health and Well-being Outcomes, Ministerial Steering Group Targets and a new inspection regime based around topic based self-assessment and self-evaluation.

We have been able to clearly align the longstanding review and evaluation processes within the HSCP where health and social care staff regularly use a variety of tools including PDSA (Plan, Do, Study, Act) and PSIF (Public Service Improvement Framework) as well as clinical audit and significant case reviews.

The HSCP and partners have been focusing on a new Strategic Needs Assessment within our population; for adults and older people this is focusing on the burden of disease; and for children and young people we are aligning this work to deprivation and the links to Adverse Childhood Experiences. This work will help inform the new Strategic Plan 2019 – 2022 development over the next few months.

This approach will be delivered through the refreshed Strategic Planning Group to ensure that the new Strategic Plan reflects and recognises the demands of the significant pressures that local services are already facing across all stakeholders

and partners. I am delighted that Allan Macleod is taking on the role of chair for the group; his vision and drive will ensure we are able to focus our activities and efforts to meet the challenges of the recently published Strategic Needs Assessment.

The HSCP got the keys for new Dumbarton Care Home Crosslet House in 2017; over the coming years work will be focused on the new Clydebank Care Home site which is part of the new Master plan area which covers the former John Brown's Shipyard. Additionally, the HSCP will also be developing the site with a new Health and Care Centre to house GP and primary care services as well as HSCP integrated operational teams. The whole scale re-development of the area will include a range of housing, commercial and retail units making this an exciting time of development for Clydebank.

The HSCP continues to experience unprecedented demand and financial challenges as such planning activity must take account of the need for updated service delivery models in response to all of those drivers.

I am confident that in responding to these challenges, we can continue to be committed to the expectations of both the principles of the new National Care Standards and of the National Framework for Clinical and Care Governance: i.e. that 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.

I would like to thank Allan Macleod for his leadership as chair of the Health and Social Care Partnership Board and welcome him as vice chair.

I look forward to working with Councillor Marie McNair as our new chair of the Health and Social Care Partnership Board, who has always been a strong supporter of the HSCP and myself as Chief Officer.

Beth Culshaw

Health and Social Care Partnership
Chief Officer.

Updated Strategic Needs Assessment

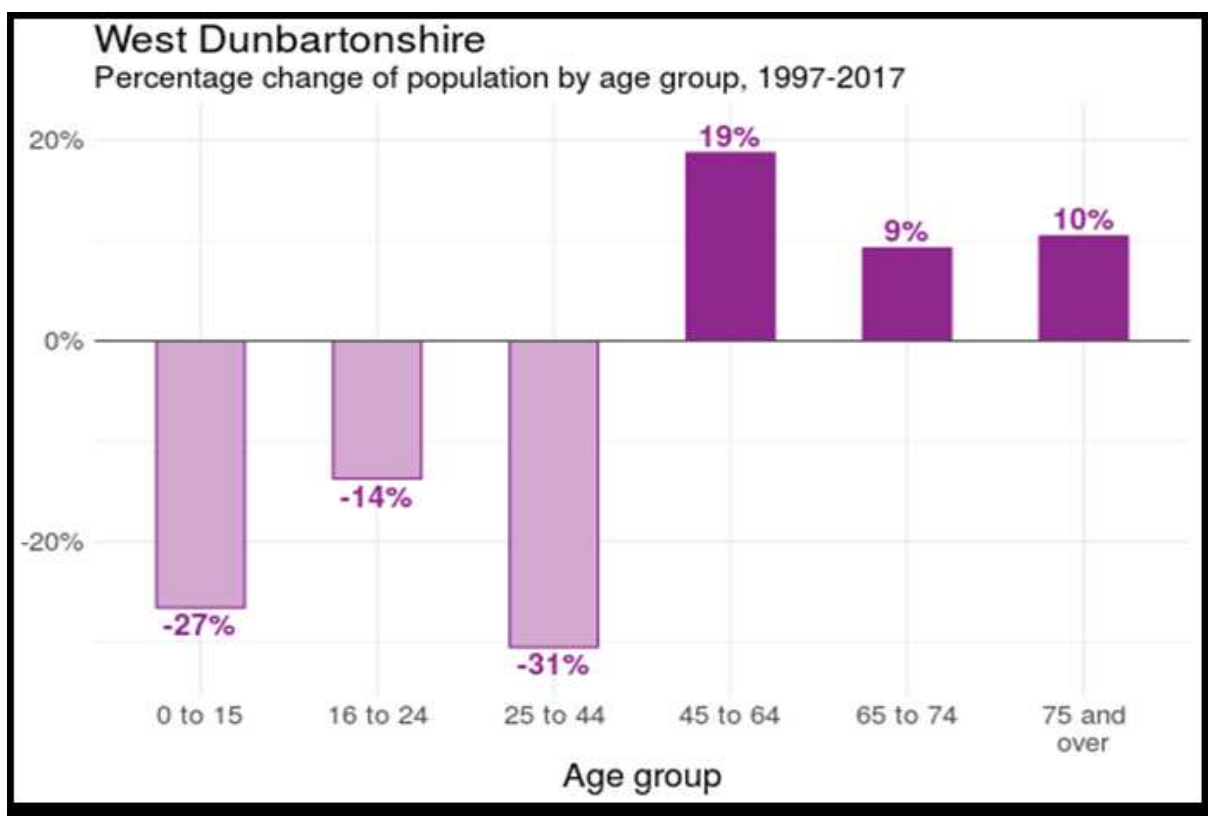
Strategic planning is central to the role that Integration Authorities have in commissioning and helping redesign local health and care services (Audit Scotland 2016). The need to change models of local health and care services is being driven predominantly to meet changing needs. People are living longer and the number of people with long-term conditions such as diabetes, and complex needs, such as multiple long-term conditions, is increasing (Audit Scotland 2016).

A recent report by Audit Scotland (2018) sets out the challenges faced by public services and acknowledges longer term robust planning is even more crucial, this necessitates looking to the future, taking into account factors such as how the landscape is changing and may further change considering not only the demographic changes, but changes to public spending and policy (Audit Scotland 2018).

West Dunbartonshire lies north of the River Clyde encompassing urban and rural communities. The population of West Dunbartonshire accounts for 1.7% of the total population of Scotland. Although population mid-year estimates for 2016 was 89 860, an increase of 0.3% from the 2015 estimate of 89 850, the trend over the last 10 years has seen a decrease from 91 420 a change of - 1.7%.

Based on the information from our new and developing Strategic Needs Assessment, the population in Scotland is projected to increase by 3% (170,000 people) by 2024 and by 7% (350,000 people) by 2039. In contrast, West Dunbartonshire will decrease by 7.1%. The under 16 population will reduce by 12%; working age by 15% yet the pensionable age will increase by 24% by 2039. West Dunbartonshire is one of the few Scottish local authority areas to have a declining population in comparison to the majority of other local authorities.

By focusing on population view, individual behaviours, burden of disease and health & social care provision in the community; trends and projections can be analysed and considerations put forward to provide a broad rationale for planning HSCP services and to anticipate needs for future services.

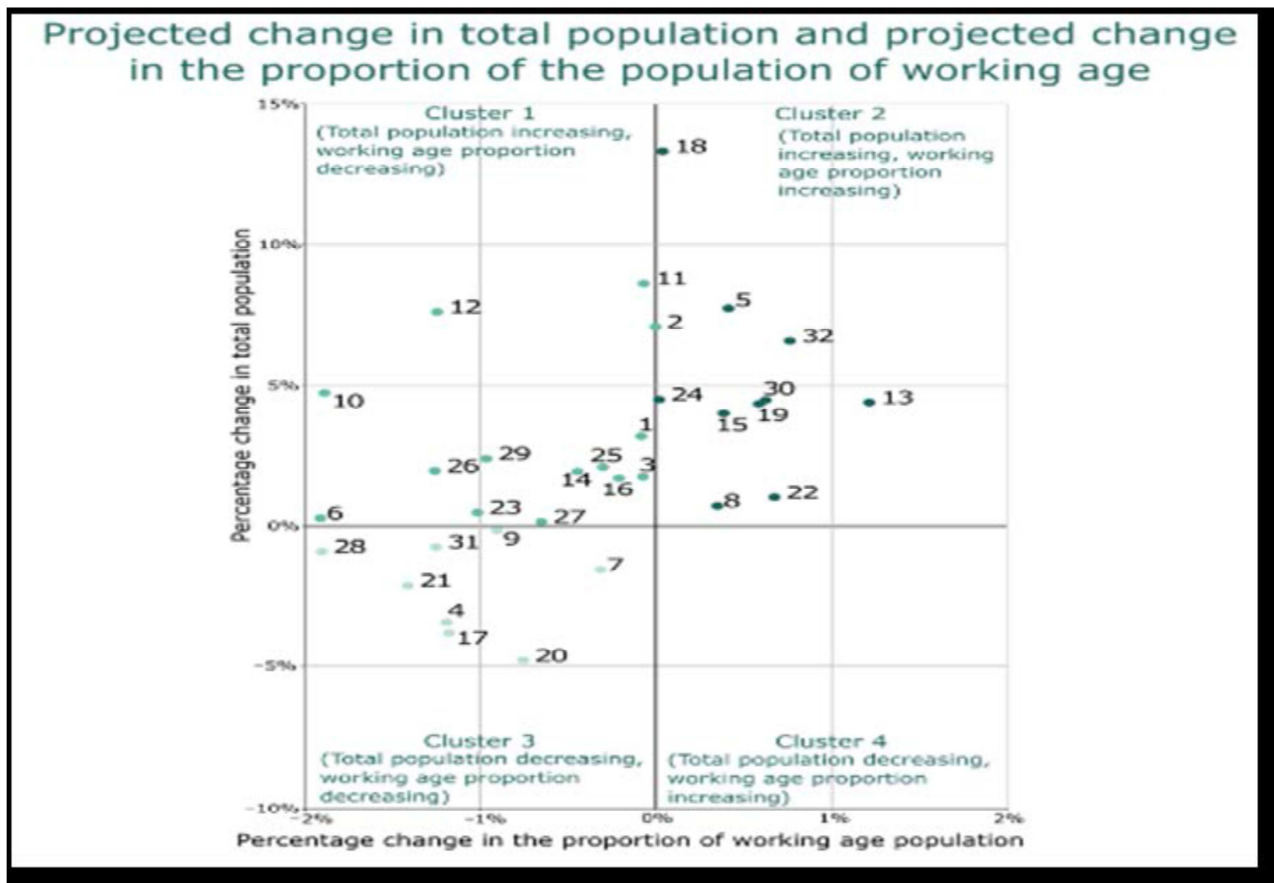


In the light of demographic changes, the 2018 Strategic Needs Assessment is taking a 'population view' by using an epidemiological approach to describe:

- Why some population groups or individuals are at greater risk of disease e.g. socio-economic factors, health behaviours
- Whether the burden of diseases are similar across the population of West Dunbartonshire
- Health & Social Care provision in the community, including the patterns of service use across West Dunbartonshire Health & Social Care Partnership.

The findings will therefore contribute to the strategic planning processes and the forthcoming refresh of the WDHSCP Strategic Plan due April 2019. The concept of using an epidemiological approach for a 'population view' underpins the discipline of health & care needs assessment (Ben-Shlomo, 2013, Bhopal, 2008).

Planning based on demographic changes, risk factors combined with trends in health status and disease patterns over time can strengthen strategic planning processes by predicting future service needs (Ben-Shlomo, 2013, Rose et al, 2009, Bhopal, 2008).



Overall the population projections indicate changes to the three key life stages of children, adults and older people. For example there is a decrease in the projected proportion of children and working age group and an increase in the proportion of people for pensionable age. There are only eight local authority areas in this position the one other in NHSGGC is Inverclyde.

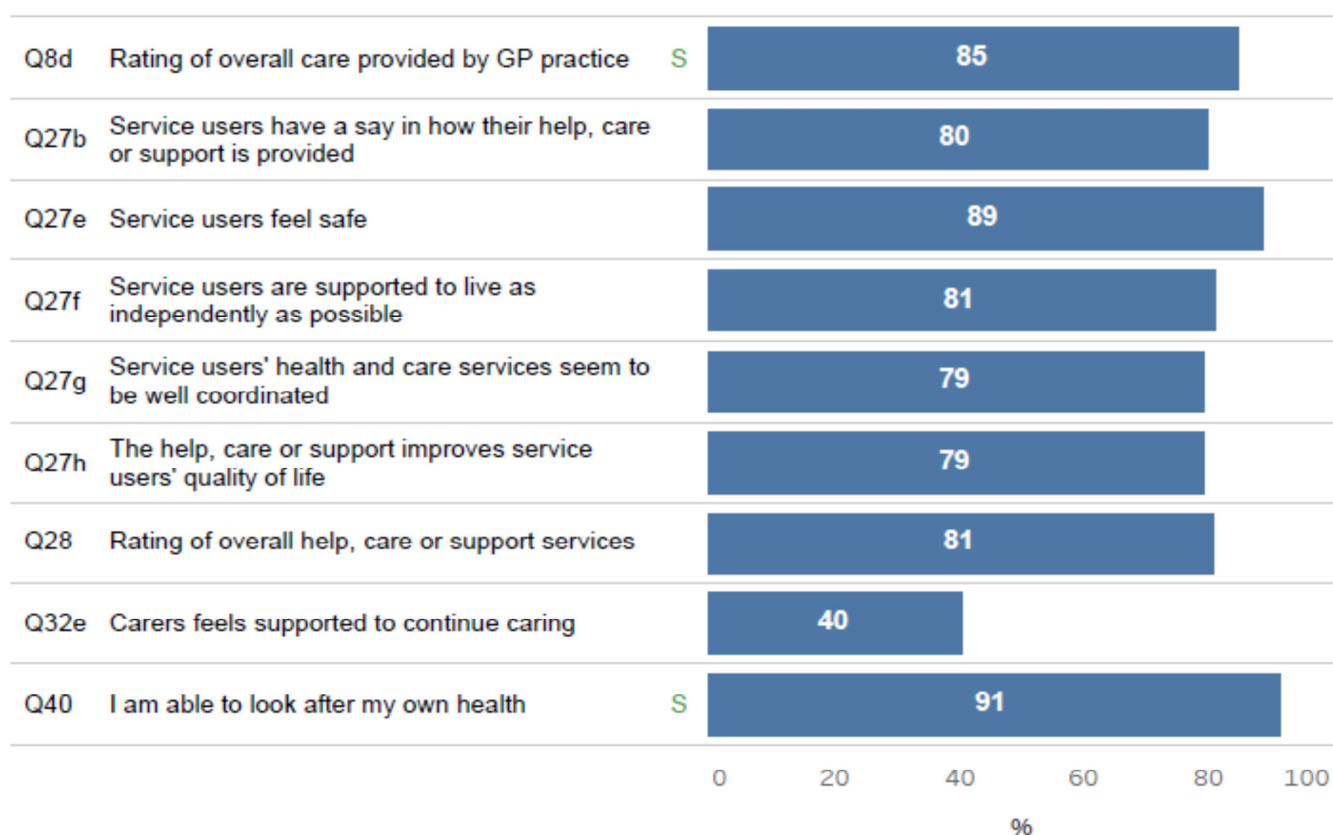
The trend over the last ten years has seen a decreasing population in West Dunbartonshire. There is a declining live birth rate and a decreasing working age population.

There is an ageing population with an increasing proportion of over 75's mid year 2016 NRS statistics estimate that there are 7051 over 75's. The current population gender split widens with increasing age e.g. more females than males from the age of 25 upwards.

In West Dunbartonshire, 17.5 per cent of the population are aged 0 to 15 years. This is larger than Scotland where 16.9 per cent are aged 0 to 15 years. Persons aged 65 and over make up 18 per cent of West Dunbartonshire. This is in line with Scotland where 18.5 per cent are aged 65 and over.

West Dunbartonshire population projections indicate that the age groups 65+ and 75+ will increase up to 2037 with other age bands decreasing.

However within this context of increasing financial pressures and demand, the HSCP is demonstrating high levels of satisfaction with services as described in the table below. (Scottish Health & Care Experience Survey 2017/18).



Our locality areas - Clydebank and Dumbarton & Alexandria - reflect natural communities in West Dunbartonshire and feel “right” to the people living and working in the area. We are committed to the principles of collaborative working and a shared vision for service delivery. Robust communication and engagement methods will continue to be applied to assure the effectiveness of our locality arrangements. The HSCP will continue to develop our locality arrangements – in tandem with our support for the development of local primary care quality clusters - to provide forums for professionals, communities and individuals to inform service redesign, transformational change and improvement.

There is a continuing commitment to engage with carers, patients, service users and their families in our Local Engagement Networks (LENs) for each locality area. Working closely with West Dunbartonshire Community and Voluntary Service (CVS) to increase the representation and diversity of those involved.

Strategic Financial Framework

West Dunbartonshire Health and Social Care Partnership Board are committed to delivering high quality services against a climate of financial austerity for all public sector organisations. The Scottish Government's Five Year Financial Strategy (issued July 2018) has acknowledged that the economic and financial outlook is uncertain; therefore delivering a Medium Term Financial Strategy is not straightforward.

The financial uncertainty coupled with austerity impacts on the levels of funding the HSCP Board have received and can expect to receive from its partner organisations of West Dunbartonshire Council and Greater Glasgow and Clyde Health Board.

The 2017/18 financial year was extremely challenging for the HSCP Board as the increase in costs due to normal inflationary factors such as pay awards and general prices coupled with demographic pressures (detailed above) outstripped the funding allocations received from our partners.

The actual 2017/18 outturn position for the HSCP Board, before any funding adjustments was a reported overspend of £1.231m (0.85%). The main reasons being:

- Community and residential placements for children and young people;
- Older people supported through care at home services or in residential or nursing care attributed to demographic demand and continued improved performance on anticipatory care planning and reduction to bed days lost through delayed discharge; and
- Difficulties implementing approved savings programmes within school nursing and mental health.

However since the establishment of the partnership in July 2015, the HSCP Board have, through strong financial management and the application of Social Care Fund resources from the Scottish Government, created a General Fund Reserve which can be applied to both specific, ringfenced service developments and a general balance available to underwrite in-year pressures (as described above). The 2017/18 overspend was covered by some of the general balance leaving an amount of £1.705m available for future years (subject to audit review).

For the 2018/19 budget setting process the assumptions made around reductions in future funding ranged from 3% to 5% of the total budget. In March 2018 residents and staff across West Dunbartonshire were invited to have their say on how West Dunbartonshire Health and Social Care Partnership (WDHSCP) should close the £3.8m budget gap by considering a wide range of savings options across both health and social care services.

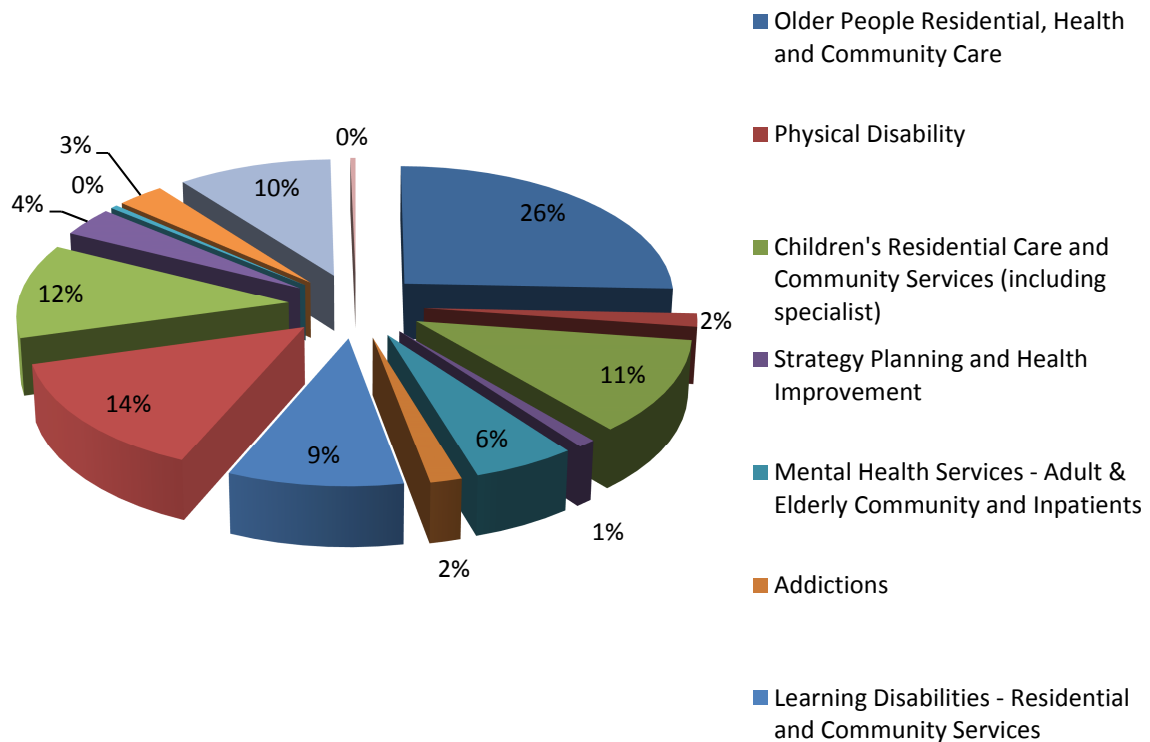
The HSCP Board carefully considered the consultation responses in conjunction with a more favourable funding settlement from our partner organisations and at its meeting on 2 May 2018 agreed a 2018/19 budget incorporating the requirement to deliver savings of £1.2m.

Details of the 2018/19 budget are provided below on a care group basis, in line with how we report within our Annual Accounts. The set aside, or notional budget, for large hospital services is included in integration authority total resources for 2018/19. At the time of writing this Strategic Plan the notional budget from the Health Board was not yet formally notified to the Partnership Board. However for indicative budget setting purposes this has been included based on the 2017/18 notional level. By the end of 2018 the Health Board in partnership with the six integration authorities within its area will finalise an agreed methodology to calculate the appropriate budget to represent consumption of unscheduled care services by residents of each integration authority area.

The challenge in 2018/19 will be to deliver services within the approved budget, given the sharp increases in demand within late 2017/18, which contributed to the reported overspend. The key to financial balance will be to work closely with staff, our funding partners and stakeholders on delivering on approved savings programmes and continuing to capture the benefits of integrated joint working.

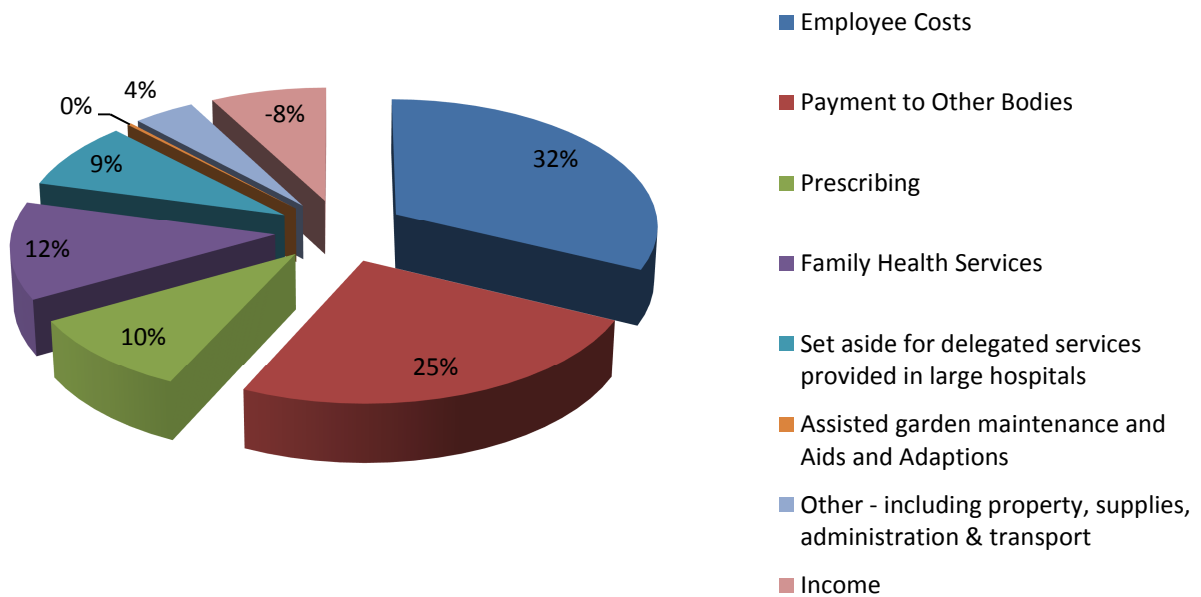
West Dunbartonshire Health and Social Care Partnership	Net Expenditure 2018/19 £000
Older People Residential, Health and Community Care	43,274
Physical Disability	2,749
Children's Residential Care and Community Services (including specialist)	19,449
Strategy Planning and Health Improvement	1,640
Mental Health Services - Adult & Elderly Community and Inpatients	9,398
Addictions	2,897
Learning Disabilities - Residential and Community Services	15,999
Family Health Services (FHS)	23,890
GP Prescribing	19,824
Hosted Services - MSK Physio	6,095
Hosted Services - Retinal Screening	796
HSCP Corporate and Other Services	5,238
Cost of Services Directly Managed by West Dunbartonshire HSCP	151,249
Set aside for delegated services provided in large hospitals	17,066
Assisted garden maintenance and Aids and Adaptions	571
Total Cost of Services to West Dunbartonshire HSCP	168,886

Net Expenditure 2018/19 £000



Subjective Summary	Net Expenditure 2018/19 £000
Employee Costs	64,485
Payment to Other Bodies	49,385
Prescribing	19,824
Family Health Services	24,899
Set aside for delegated services provided in large hospitals	17,066
Assisted garden maintenance and Aids and Adaptions	571
Other - including property, supplies, administration & transport	8,321
Income	(15,665)
Total Cost of Services to West Dunbartonshire HSCP	168,886

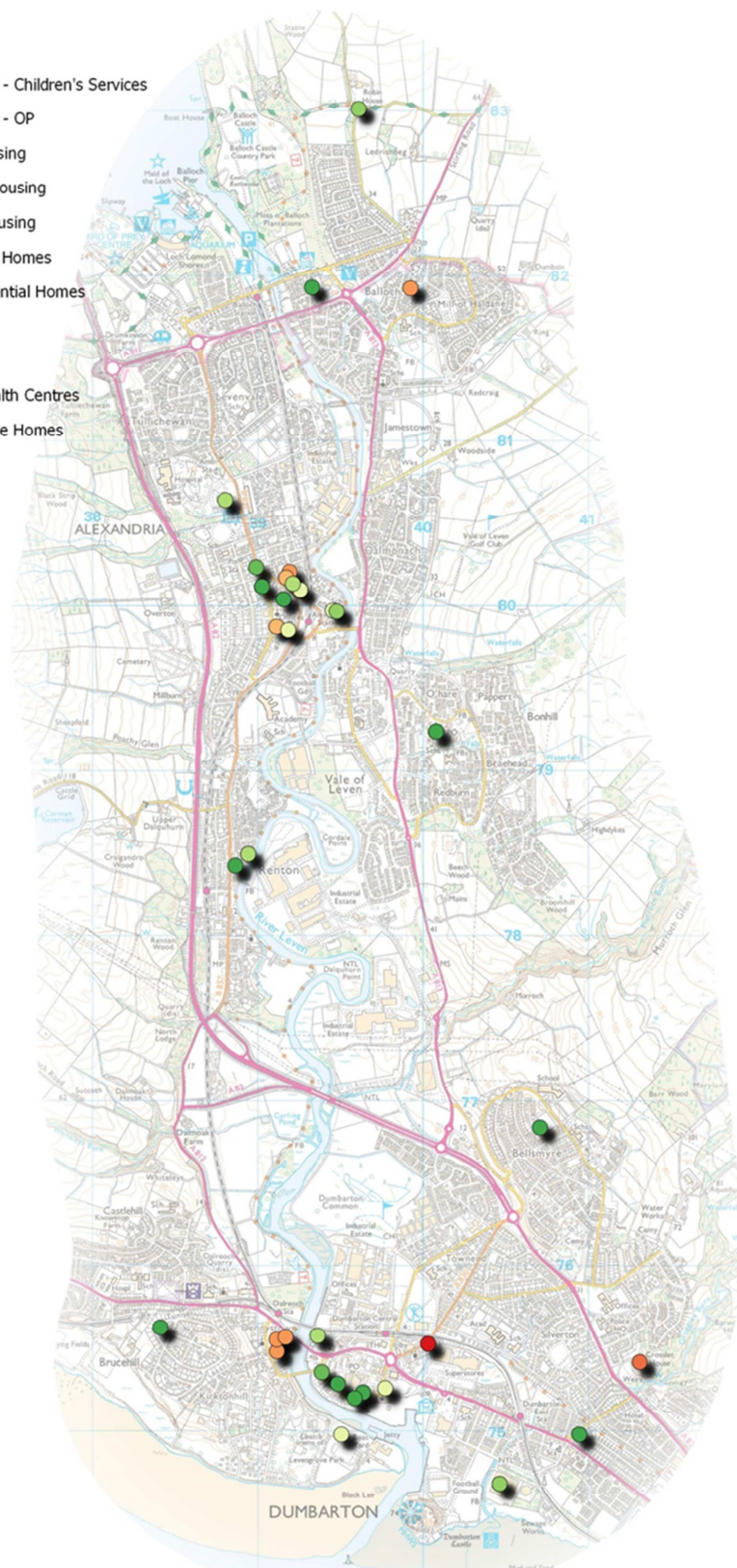
Subjective Summary



The above spend can be linked to how services are organised to support communities within our two localities: Clydebank and Dumbarton & Alexandria as described in the maps below. .

Key Services

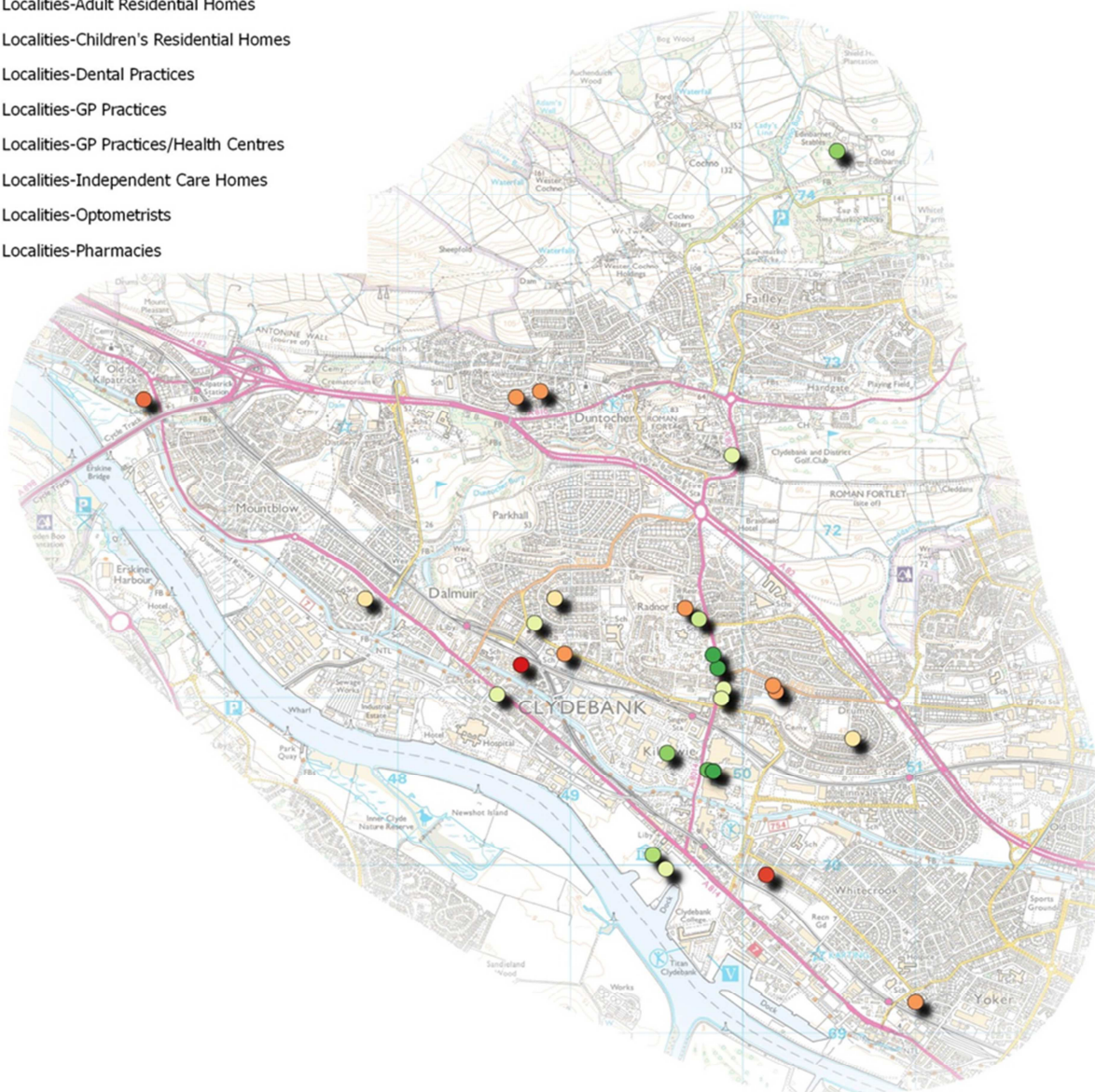
- Care Home-External - OP
- Care Home-LA Care Home - Children's Services
- Care Home-LA Care Home - OP
- Housing-LA Sheltered Housing
- Housing-RSL Retirement Housing
- Housing-RSL Sheltered Housing
- Localities-Adult Residential Homes
- Localities-Children's Residential Homes
- Localities-Dental Practices
- Localities-GP Practices
- Localities-GP Practices/Health Centres
- Localities-Independent Care Homes
- Localities-Optometrists
- Localities-Pharmacies



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Key Services

- Care Home-External - OP
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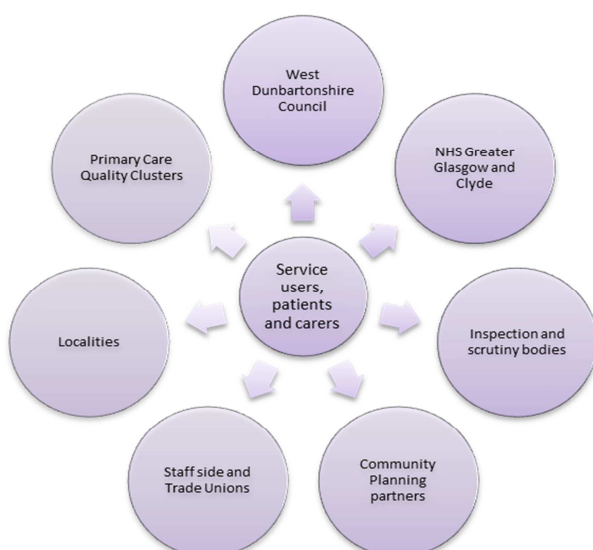
Strategic Commissioning Framework

This annual review of our Strategic Plan 2016 – 2019 recognises that changes in the current landscape, as described in our developing new Strategic Needs Assessment, mean that there is a growing complexity in the nature of the individual needs and growing expectations within the population.

West Dunbartonshire is facing issues relating to a population with complex needs linked to co-morbidity alongside growing expectations concerning how best to provide quality care, as well as meeting the quality requirements from external regulators and the requirements of new legislation such as the Carers' Act.

Within an increasingly challenging financial envelope across the public sector, the HSCP continues to be committed to a continual process of reviewing the best value achieved by, and relative merits of, investments across all partners – increasingly there is a need to map this analysis of spend and link to outcomes for patients and clients - as part of our overall strategic commissioning process. The connectivity between work streams allows us to support a co-production approach across all our communities.

The Health & Social Care Partnership continues to apply in all its relationships with stakeholders as an integral element of its mainstream planning and operational service delivery activities. As such, a programme of transformational change is underway and will be further developed through 2018 – 2019 by the HSCP and wider partners:



Primary Care Improvement Plan across West Dunbartonshire

The General Medical Services Contract in Scotland was agreed by General Practitioners in January 2018. The implementation of the contract was supported by the Memorandum of Understanding and requires Health & Social Care Partnerships (HSCPs) to develop Primary Care Improvement Plans which aim to set out a 3 year plan for the redesign of primary care services includes some of which were provided directly by GPs or their practice teams. The Primary Care Improvement Plan will be kept under review and updated annually.

The HSCP's Primary Care Improvement Plan is supporting the development of the expert medical generalist role through a reduction in current GP and practice workload. By the end of this initial three year plan, our ambition is that every practice in West Dunbartonshire will have benefited from the support of an expanded multidisciplinary team HSCP health professionals providing care and support to patients.

Underpinning the redesign of local services are the key principles to; provide safe, effective and person centred care, ensuring we make best use of available resources to deliver improvements in care and outcomes for all patients service users and carers. Our services should be equitable, sustainable, affordable and provide value for money.

The HSCP is required to redesign a number of services traditionally provided within GP practices, these include;

- Vaccination Transformation Programme,
- Pharmacotherapy Services,
- Community Treatment and Care Services
- Urgent Care (by Advance Nurse Practitioners or Advance Practice Paramedics)
- Additional Professional Roles (Advance Practice Physiotherapists and Community Mental Health Practitioners)
- Community Link Workers.

New Health and Care Centre Clydebank

Community health and care services in Clydebank serve 50,000 people. These services have been developed with an increasingly integrated health and care arrangements, the dispersed locations from which staff are based inhibits their ability to develop synergies in terms of new ways of joint working and support.

The new proposed Clydebank Health & Care Centre will accommodate six General Practices; District Nursing; Health Visiting; Physiotherapy; Podiatry; Dietetics; Diabetic Specialist Nursing; Primary Care Mental Health; Speech & Language Therapy; Community Older People Team; Hospital Discharge Team; Home Care Team; Pharmacy Team; Continence Team; Outpatients Clinics; and Community Administration.

The Initial Agreement for the project was endorsed by the WD HSCP Board Audit Committee in January 2016; and approved by the NHSGGC Health Board in February 2016, prior to then being formally submitted to the Scottish Government Health Directorate's Capital Investment Group (CIG). Subsequently agreed by West Dunbartonshire Planning Committee on 30th May 2018.

A new integrated facility for Clydebank already has widespread stakeholder support, including from local politicians and the local Community Planning Partnership. Such a replacement health and care centre build will enable the co-location of multi-disciplinary services - including integrated health and social care teams - within a new facility giving one stop access and improved accessibility for patients to an increased range and improved quality of services (including additional acute outreach clinics); a considerably improved working environment for staff; space for community and third sector partners and carer's organisations involved in the co-production of supported self care; meeting and training space for all our staff (supported by a commitment to shared and agile technology for staff) and local community groups.

Moreover, the development of a new and enhanced health and care centre within Clydebank has already been identified as a key contribution that NHSGGC could make to the wider regeneration plans for Clydebank.

Unscheduled Care across West Dunbartonshire and wider NHS system

Whilst the Health Board is responsible for overall planning of acute/hospital services, it is obliged to work with integration authorities within its area on the planning of acute services, particularly unscheduled care and including forward financial planning; on the shaping of the primary care and community services; and early patient and public engagement.

The Health Board's Clinical Services Strategy has two key aims that particularly align with the commissioning priorities within the current Strategic Plan, i.e.

- Care is patient focused with clinical expertise focused on providing care in the most effective way possible at the earliest opportunity within the care pathway.
- The pressures on hospital, primary care and community services are addressed.

The plan includes safe and effective hospital admissions and discharges; plans for additional hospital beds; discharges over weekends and bank holidays; preparation for norovirus and effective planning to monitor performance.

Severe cold weather can be dangerous for vulnerable groups including older people and those with serious illnesses, so the plan details how best to prepare to keep people healthy and warm and remain in their homes.

The plan also ensures that a continued level of support and care is provided along with the funding to meet the spike in services over the winter.

The Unscheduled Care programme is measuring success through Ministerial Steering Group agree measures of activity, as outlined in performance framework at the end, whilst also focusing on key focused areas of activity across the six partnerships:

- Early identification of frailty
- More effective and targeted work with care homes
- Anticipatory care planning across the whole system
- Monitor attendance at accident and emergency
- Access to good public information at the right time

Refreshing Self Directed Services

The Social Care (Self Directed Support) Scotland Act 2013 came into force in April 2014 and places new duties on local authorities to provide more choice and control to people who are eligible for care and support. The new Carers' Act provides the local authority with the power to provide support to carers. After assessment of the carers needs the authority should consider the carer has needs in relation to their caring role and have the power to decide if they intend to meet those needs through funded support. If they decide the carer is eligible the carer should be offered access to the 4 options and the duties apply.

As such, the HSCP is seeking to strengthen components of local arrangements for the delivery of self directed support within the context of changing legislation and of the Audit Scotland Report; Self-directed Support 2017: Progress Report on National implementation of SDS and within the proposed inspection programme focusing on, amongst other topics, self directed support.

Working with the Audit Scotland Report, we have developed a plan to refresh our approach and consider the key messages from the report within our planned response. The recommendations from the Report have concentrated our efforts to consider local practice and policy; we have sought to gather practitioner experiences of implementing the Act and feedback from service users via, for example, the HSCP Local Engagement Network and the Brain Injury Experiences Network.

The programme of work is helping to support a consistent service practice and clarity across strategic accountability and governance, a dedicated programme of work is being undertaken to review, shape and reform the policy arrangements for SDS for presentation at all levels of the HSCP.

This focus will result in refreshed and clear local practice guidance and a complete review of assessment and outcomes tools and approaches as well as quality up to date public information.

Review of Commissioning and Procurement processes

The model of commissioning in West Dunbartonshire was an established Market Facilitation Consortium model of market analysis across all health and social care services from within the statutory, independent and third sector.

The Consortium provides a framework for all partners; with clarity of roles, responsibilities, expectations and opportunities for each sector partner described within the context of market facilitation.

In partnership with West Dunbartonshire CVS, as the local third sector interface (TSI), and Scottish Care the approach was developed as a model of local market facilitation across older people, adults, and children's services – with the shared emphasis on improving quality and outcomes.

This reinforces the expectations of the national clinical and care governance framework in relation to co-ordination across a range of services - including procured services - so as to place people and communities at the centre of all activity relating to the governance of clinical and care services.

To ensure a measurable approach a Contract Management Framework is being developed; further clarifying the responsibilities and roles of strategic commissioning and contract management within the entire HSCP across all services alongside the Council's Procurement Team.

The approach will be embedded with Service Managers supporting a streamlined and consistent contract monitoring approach across the HSCP and wider partners.

This aligns more clearly to the direction of travel for the Care Inspectorate inspection processes in terms of a self evaluation quality improvement framework aligned to quality headings.

Housing Sector

The Housing Contribution Statement is being reviewed alongside the development of the new Strategic Plan for 2019 – 2022.

The Housing Contribution Statement is developed alongside partners across the housing sector including the Council Housing Service and the Strategic Housing Partner. Acting as the 'bridge' between the HSCP Strategic Plan and the Council's Local Housing Strategy for West Dunbartonshire; the statement builds on existing robust and effective mechanisms for engagement, working together closely across many service areas on issues of joint interest.

There is a shared recognition that the wider housing sector must be involved in supporting the delivery of the health and social care integration agenda. We will continue to emphasise the key role that housing associations have to play in the delivery of affordable and adaptable homes.

Third Sector

The third sector operating within West Dunbartonshire is a diverse community of over 900 organisations, varying in size and scale from small self-help groups through to national social enterprises providing directed procured and contracted services. We will continue to work with the local third sector interface (TSI) West Dunbartonshire CVS to apply its Engagement Dashboard to help positively manage constructive and effective engagement across the sector.

We will continue to work in partnership with West Dunbartonshire CVS as the local TSI and Scottish Care to develop our local Market Facilitation Consortium model of commissioning across older people, adult, and children's services – with the shared emphasis on improving quality and outcomes.

This reinforces the expectations of the national clinical and care governance framework in relation to co-ordination across a range of services - including procured services - so as to place people and communities at the centre of all activity relating to the governance of clinical and care services; and the principles that shape the National Care Standards implemented on 1st April 2018.

Equalities

The HSCP continues to be committed to integrate our obligations in respect of the equality duties into our approach to strategic planning and performance management; and into the day-to-day operational activities of the organisation.

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.

This reflects our continued local recognition of the fact that the requirements of the Equality Act dovetail with the national Integration Planning Principles, and the need to take account of the particular needs, characteristics and circumstances of different service users.

This is represented by an on-going approach to mainstreaming across five core inter-related and inter-overlapping dimensions of organisational activity as detailed within our Equalities Mainstreaming Report.

Through our mission, purpose and values (which themselves fit well with the inclusive nature of equalities responsibilities), we will continue to further integrate our approach to the equalities duties – and promote diversity - into our core business in line with the intentions and expectations of the Equalities and Human Rights Commission.



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 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 differences in health experienced by people, depending on the circumstances in which they live and the opportunities they have for health and social wellbeing. They are viewed as unjust given they are not inevitable but fundamentally socially determined as a result of inequities in power, money and resources (Marmot, 2010; NHS Health Scotland, 2014; Scottish Government, 2014). From a public policy perspective, health inequalities are what are known as a “wicked problem”, i.e. they are complex, persistent and resistant to straightforward solutions.

The HSCP will continue our commitment 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. We will continue to provide clear leadership in championing this progressive and evidence- based approach to addressing health inequalities in a streamlined and integrated manner.

Importantly, 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 itself (particularly in the short-to-medium term).

Community Planning West Dunbartonshire Local Outcome Improvement Plan (LOIP)

West Dunbartonshire's Community Planning Management Group, who oversee the programmes of work across community planning structures in West Dunbartonshire, agreed in 2017 the focus of activity as described in the Local Outcome Improvement Plan.

The Management Group proposed to adopt 5 key outcomes (listed below) for the partnership, which will be the focus for partnership activity and investment over the period of the plan.

1. Our local economy is **thriving**
2. Our communities are **safe**
3. Our children and young people are **nurtured**
4. Our older residents are supported to remain **independent**
5. Our residents are **empowered**

Each outcome is supported by a suite of priority areas, which will be the focus of activity in thematic Delivery & Improvement Groups and measured through a performance and improvement monitoring framework.

This Strategic Plan has been re-structured to reflect our commitment to integration being community planning in practice, with our Strategic commissioning outcomes articulated with respect to the Local Outcome Improvement Plan 2017 – 27.

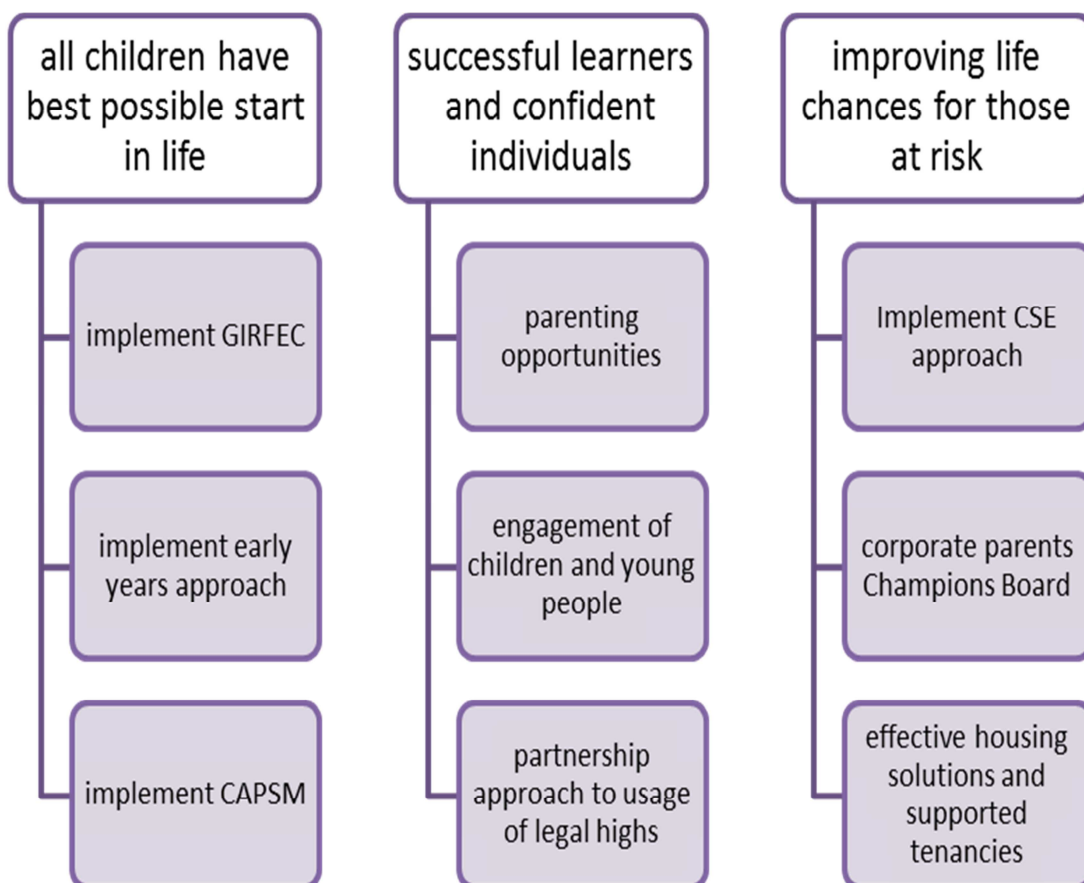
The performance framework for the newly developing HSCP Strategic Plan 2019 – 2022 will reflect these updated outcomes however for the purposes of this annual review the existing and agreed outcomes are being reported.

Strategic Commissioning Outcome: Our children and young people are Nurtured

Our strategic commissioning outcomes for children and young people in West Dunbartonshire reflect our commitment to Getting It Right For Every Child (GIRFEC).

The HSCP leads on the LOIP Strategic Outcome of “Our children and young people are Nurtured”, previously “Supporting Children and Young People”, on behalf of Community Planning partners, primarily through the vehicle of the local Integrated Children’s Services Plan (ICSP). The ICSP describes the key strategic priorities and outcomes for children and young people in West Dunbartonshire.

Our strategic commissioning priorities are as follows:



Whilst the overall proportion and number of children in the population has fallen, and will continue to fall, a greater number of children are living with increasingly complex health and care needs, and are requiring care whilst living in the community.

Children and young people living with high levels of risk are and will have to be increasingly supported in the community, with increased commitment to reducing the numbers looked after and accommodated, and living out with their communities. However, a small number of children and young people will inevitably require residential care and secure accommodation.

The HSCP will continue to provide leadership on the ICSP across community planning partners. The ICSP incorporates key strategic priorities and outcomes for children and young people as set out in West Dunbartonshire's Local Outcome Improvement Plan and a suite of agreed strategic outcomes across all services where children and young people are affected.

At the heart of this joined up approach is the shared commitment of partners to GIRFEC; to the delivery of corporate parenting responsibilities; and to improving outcomes for looked after children and young people.

The following groups are specifically identified as benefiting from additional support from across community planning partners:

- Vulnerable pregnancies.
- Children with and affected by disabilities.
- Children in need/vulnerable children, including young carers.
- Children and young people where safety and well-being is an issue.
- Children and young people affected by issues such as domestic abuse, mental health and substance misuse.
- Children who are looked after and looked after and accommodated.
- Young people leaving care.

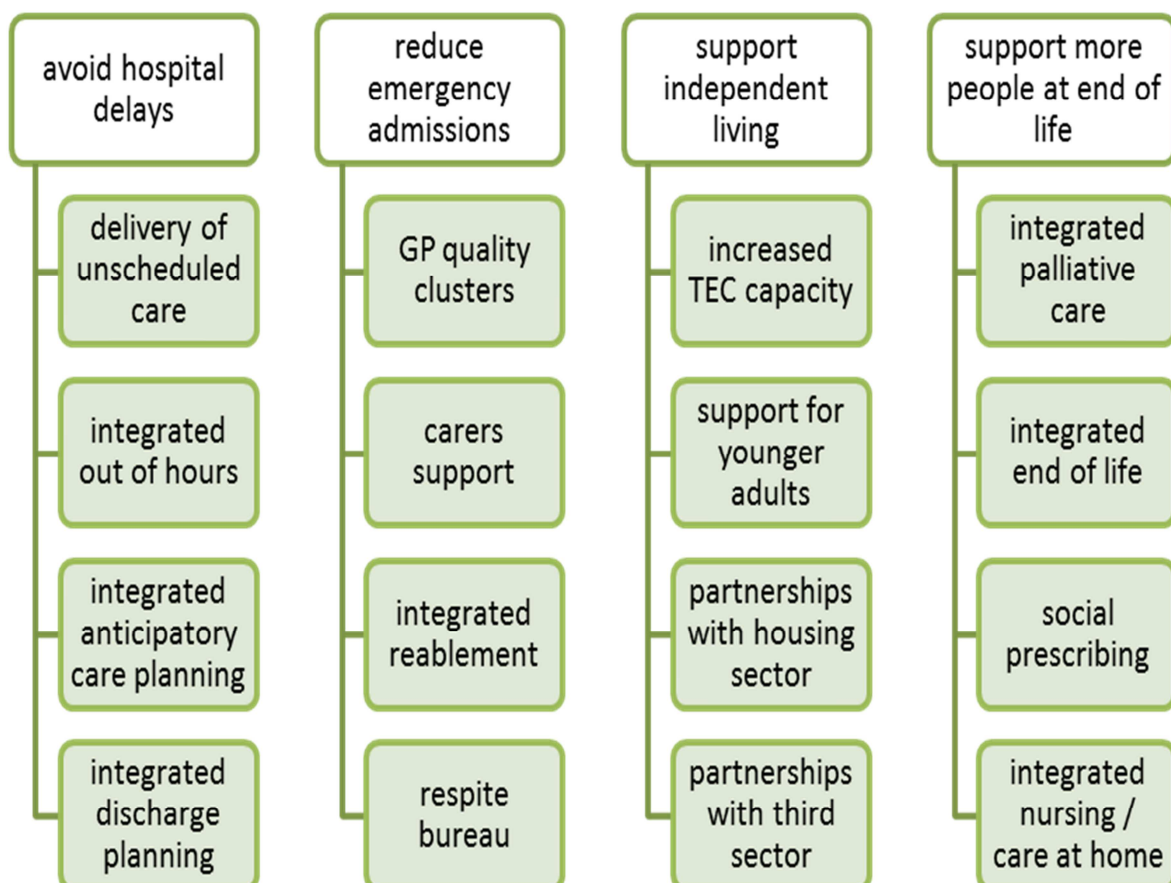
Strategic Commissioning Outcome: Our older residents are supported to remain independent

Our strategic commissioning outcomes reflect the need for transformational change in the delivery of services for adults and older people as reflected within our approach to integrated care.

The HSCP leads on the LOIP Strategic Outcome of “Our older residents are supported to remain Independent”, previously the “Supporting Older People” on behalf of Community Planning partners, primarily through the vehicle of the local integrated transformation fund.

The transformation fund describes the key strategic priorities and outcomes to support all adults to live as independently as possible and safely within a homely setting for as long as possible. It is further supported by operational unscheduled care planning with a particular focus on the winter period as per the National Preparing for Winter Guidance.

Our strategic commissioning priorities are as follows:



As the population of older people and those with long term conditions continues to increase and in keeping with the strategic approach of the HSCP as a whole, the delivery of the outcomes of the ICF is based on investment for change within services rather than project based work streams, so as to ensure that practice changes are sustainable and future proof as far as possible.

This transformational change programme describes the key strategic priorities and outcomes to support all adults to live as independently as possible and safely within a homely setting for as long as possible.

We will continue to ensure that the offer of Self- Directed Support (SDS) options is embedded in the assessment process and as described earlier this is part of one of our transformational work streams to be continued in the new Strategic Plan 2019 - 2022.

With regards to addressing particular housing needs, the HSCP continues to work closely with the housing sector and the Council to deliver the Local Housing Strategy which has three underpinning principles which impact on the needs of those with additional housing support needs; forward planning; future proofing housing; and housing support to take account of how people's social and physical needs change.

West Dunbartonshire Health & Social Care Partnership hosts the Musculoskeletal (MSK) Physiotherapy Service for the Greater Glasgow and Clyde area. Work will continue to ensure the delivery of high quality outcomes for patients alongside striving to meet extremely challenging national waiting time targets.

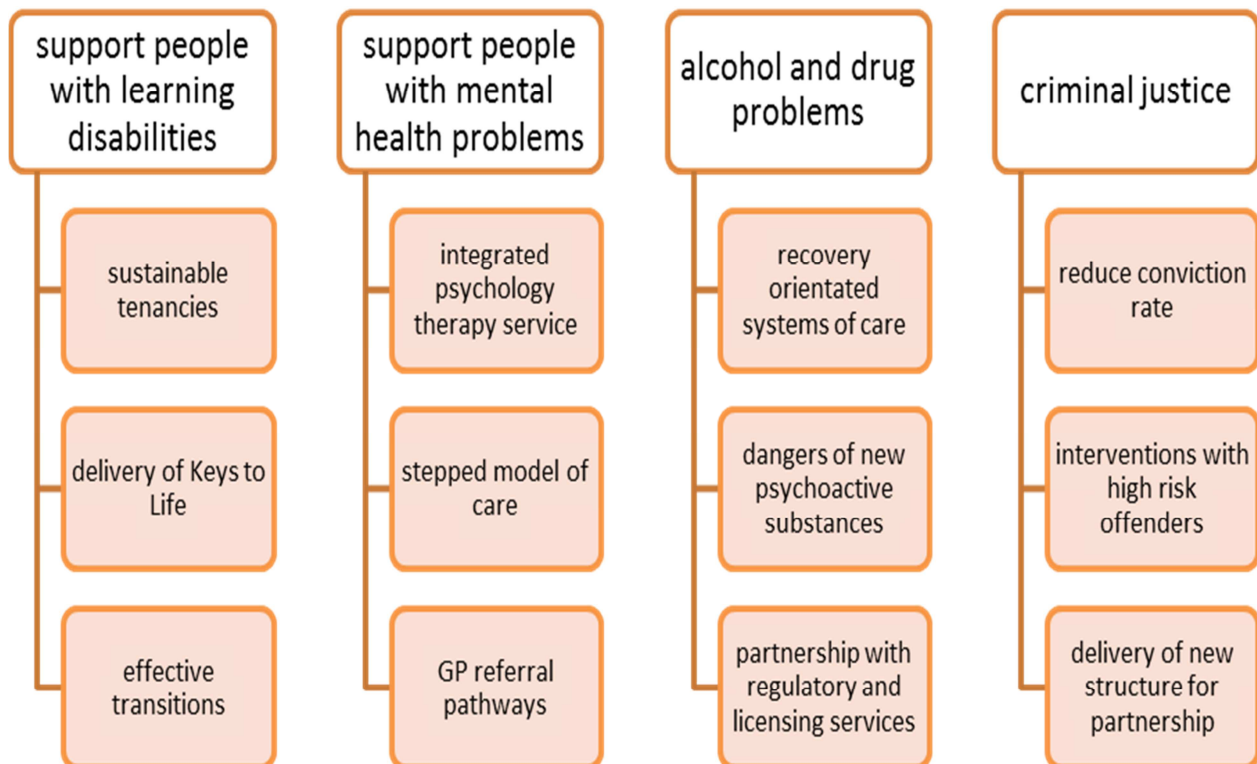
Based on changing demographics going forward there will be continued focus on the outcomes of the needs of adults and older people which will continue to be challenging and will require the HSCP to work closely with stakeholders and partners from all sectors over the next four years and beyond.

Strategic Commissioning Outcome: Our Communities are safe

Our strategic commissioning outcomes reflect our commitment to the safety and protection of the most vulnerable people within our care and within our wider communities.

Our integrated approach to service delivery across community health and care as well as third sector providers - supports the delivery of effective and targeted specialist services to support safe, strong and involved communities.

Our strategic commissioning priorities are as follows:



The delivery of mental health services and learning disability services rely on a network of community health and social care services across West Dunbartonshire, delivered by statutory, third and independent sector providers. The HSCP will continue to work with them all to support those with severe and enduring mental health problems; those living with learning disabilities; and their carers.

The HSCP will continue to lead the Community Planning Partnership Alcohol and Drugs Partnership (ADP). This has included the delivery of well received Annual Report and positive feedback from a supported Validated Self- Assessment process with colleagues from the Care Inspectorate and their partners.

West Dunbartonshire HSCP currently hosts the Community Justice Partnership, on behalf of the community planning partners in West Dunbartonshire and for East Dunbartonshire and Argyll and Bute Council areas. The Partnership Area Plan is set against a backdrop of the restructuring of community justice services and the implementation of the necessary changes that flowed from the Community Justice Act went smoothly and with no disruption to direct service provision.

Public Protection provides a range of measures which can be used together to 'protect our people'. In January 2018 the HSCP appointed a joint Public Protection Co-ordinator to work across both adult and child protection issues and to streamline the HSCP integrated approach to public protection. This includes protection from harm for children and young people, vulnerable adults and the effective and robust management of High Risk Offenders through our Multi-Agency Public Protection Arrangements (MAPPA) and serious violent offenders.

As such public protection is integral to the delivery of all adult and children's services within the HSCP and wider partners and a key element of clinical and care governance locally.

The HSCP has a significant role within the Public Protection Chief Officers Group (PPCOG). Both the Chief Officer and Chief Social Work Officer will continue to provide the necessary leadership, scrutiny and accountability for public protection matters affecting West Dunbartonshire - including the management of high risk offenders; assuring that each of the services in place for child and adult protection are performing well; and keeping the citizens of West Dunbartonshire safe.

Strategic Performance Framework

The National Framework for Clinical & Care Governance – as affirmed within the Integration Scheme for West Dunbartonshire - 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.

In scrutinising the development and delivery of the current Strategic Plan, we will build on our experience – and the very positive feedback to - our Annual Performance Report 2017/18.








The Annual Performance Report also set out the arrangements we had developed and adopted for the governance of our activities, having taken on board the general advice articulated by Audit Scotland (December 2015) that integration authorities be clear about what might be “confusing lines of accountability and potential conflicts of interest” for integration authority members and staff within health and social care partnerships.




Future Annual Performance Reports will detail progress on delivering upon our strategic commissioning priorities, including reporting on the key strategic performance indicators provided here. This will be augmented by data on a variety of monitoring indicators, including our equality outcome indicators as committed to within our Equalities Mainstreaming Report.

Our strategic performance framework for this year review of the Strategic Plan and the key strategic performance indicators that are set out overleaf; they reflect all of the above as summarised by two key principles articulated within the National Framework for Clinical and Care Governance:

- Values of openness and accountability are promoted and demonstrated through actions.
- All actions are focused on the provision of high quality, safe, effective and person-centred services

National Health and Wellbeing Outcomes for Adults												
	2017/18 Value	2017/18 Target	2017/18 Status	2018/19 Target	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 reducing any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	Resources are used effectively and efficiently in the provision of health and social care services
Number of delayed discharges over 3 days non-complex cases	4	0		0		X	X					
Number of acute bed days lost to delayed discharges (including AWI)	2,291	N/A	N/A	3,011		X	X					
Number of acute bed days lost to delayed discharges for Adults with Incapacity	461	N.A	N/A	1,455		X	X					
Number of patients in anticipatory care programmes	1,921	1,400		TBC	X	X	X	X	X		X	
Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services	43%	90%		90%	X	X	X	X	X			X
Percentage of carers who feel supported to continue in their caring role	97.4%	90%		TBC						X	X	
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	96.4%	90%		90%	X		X	X	X		X	X

Primary Care Mental Health Team waiting times from referral to 1st appointment offered within 4 weeks		90%		TBC	X		X	X	X		X	X
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National Health and Wellbeing Outcomes for Adults												
	2017/18 Value	2017/18 Target	2017/18 Status	2018/19 Target	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 reducing any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	Resources are used effectively and efficiently in the provision of health and social care services
Primary Care Mental Health Team waiting times from assessment to 1st treatment appointment offered within 9 weeks		90%		TBC	X		X	X	X		X	X
Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	92.4%	90%		90%			X	X	X		X	X
Number of attendances at Accident and Emergency (Emergency Departments and Minor Injuries Units)	30,422	N/A	N/A	28,333	X	X						
Percentage of total deaths which occur in hospital 65+	42.6%	45.9%		TBC		X	X	X				

Percentage of total deaths which occur in hospital 75+	41.7%	45.9%	✓	TBC		X	X	X				
Prescribing cost per weighted patient (£Annualised)	£173.07	£178.32	✓	GGC average								X
Percentage of patients achieved 48 hour access to appropriate GP practice team		90%	⚠	TBC	X	X	X	X	X			X
Percentage of patients advanced booking to an appropriate member of GP Practice Teams		90%	⚠	TBC	X	X	X	X	X			X

National Health and Wellbeing Outcomes for Adults												
	2017/18 Value	2017/18 Target	2017/18 Status	2018/19 Target	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 reducing any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	Resources are used effectively and efficiently in the provision of health and social care services
Compliance with Formulary Preferred List	80.2%	78%	✓	TBC								X
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	N/A	N/A	N/A	100% (new)	X	X		X	X		X	
Unplanned acute bed days (aged 65+) as a rate per 1,000 population	3,102	N/A	N/A	2,558	X	X						
Emergency admissions aged 65+ as a rate per 1,000 population	273	N/A	N/A	238	X	X						
Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	98%	98%	✓	TBC	X	X		X	X		X	

 Target achieved or exceeded
  Target narrowly missed
  Target missed by 15% or more

National Health and Wellbeing Outcomes for Adults												
	2017/18 Value	2017/18 Target	2017/18 Status	2018/19 Target	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 reducing any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	Resources are used effectively and efficiently in the provision of health and social care services
Percentage of adults with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes	64.7%	60%	✅	TBC	X	X		X	X			
Percentage of people aged 65 or over with intensive needs receiving care at home	32.2%	35%	⚠️	TBC	X	X		X	X		X	
Total number of homecare hours provided as a rate per 1,000 population aged 65+	488	518	⚠️	TBC		X		X	X		X	
Percentage of homecare clients aged 65+ receiving personal care	92.1%	90%	✅	TBC		X		X	X			
Percentage of people aged 65 and over who receive 20 or more interventions per week	34.2%	30%	✅	TBC		X		X	X			
Number of people aged 75+ in receipt of Telecare - Crude rate per 100,000 population	23,139	23,230	⚠️	TBC	X	X		X	X		X	

Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)	24.4%	30%	✔	TBC		X		X				
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✔

Target achieved or exceeded







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
Target narrowly missed

❌

Target missed by 15% or more

National Health and Wellbeing Outcomes for Adults




	2017/18 Value	2017/18 Target	2017/18 Status	2018/19 Target	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 reducing any negative impact of their caring role on their own health and wellbeing	People using health and social care services are safe from harm	Resources are used effectively and efficiently in the provision of health and social care services
Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	42.5%	35%		TBC		X		X				
Number of emergency admissions (All ages)	9,984	N/A	N/A	10,093		X		X			X	
Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	26.9%	40%		TBC	X	X	X	X	X		X	X
Total number of respite weeks provided to all client groups	4,449.25	4,110		TBC	X	X		X		X	X	
Percentage of Adult Support and Protection clients who have current risk assessments and care plan	100%	100%		TBC		X					X	
Number of clients 65+ receiving a reablement intervention	632	575		TBC		X		X			X	
Number of clients receiving Home Care Pharmacy Team support	941	900		TBC	X	X		X			X	

 Target achieved or exceeded
  Target narrowly missed
  Target missed by 15% or more

National Outcomes for Children							
	2017/18 Value	2017/18 Target	2017/18 Status	2018/19 Target	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
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	94.9%	95%	⚠️	95%	X		
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	97.7%	95%	✅	95%	X		
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	56.7%	85%	❌	TBC	X		X
Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	84.2%	90%	⚠️	90%	X	X	X
Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	7	18	✅	18	X	X	X
Percentage of child protection investigations to case conference within 21 days	79.2%	95%	❌	95%			X
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%	100%	✅	100%	X		X
Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	78%	75%	✅	TBC		X	X
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%	✅	100%	X		X
Number of referrals to the Scottish Children's Reporter on care and welfare grounds	TBC	396	TBC	TBC	X		X
Balance of Care for looked after children: % of children being looked after in the Community	90.4%	90%	✅	TBC	X		X

✅ Target achieved or exceeded ⚠️ Target narrowly missed ❌ Target missed by 15% or more

National Outcomes for Criminal Justice							
	2017/18 Value	2017/18 Target	2017/18 Status	2018/19 Target	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
Number of referrals to the Scottish Children's Reporter on offence grounds	TBC	128	TBC	TBC	X	X	X
Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling	90%	98%	▲	TBC	X		
Percentage of Community Payback Orders attending an induction session within 5 working days of sentence	79%	80%	▲	TBC	X		X
Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence	15%	80%	●	TBC	X		X

 Target achieved or exceeded
  Target narrowly missed
  Target missed by 15% or more

NB - All data above updated May 2018 but some significant gaps in the data and all targets will need to be reviewed and confirmed – even the indicators may change depending on the views of Heads of Service. The ones highlighted blue are those which may be dropped due to inability to access the data