

**Our vision:
Improving lives with the people of
West Dunbartonshire**

**Strategic Plan
2019 – 2022**

Foreword

Welcome to the third West Dunbartonshire Health and Social Care Strategic Plan 2019 – 2022.

This Strategic Plan builds on the second Plan, approved by the Health and Social Care Partnership Board on 17 August 2016 for the period 2016 – 2019; this new Plan outlines our vision for the delivery of integrated health and social care services.

The Plan contains a three year strategic planning framework for 2019 – 2022 which sets out the priorities for the Partnership.

The Plan describes how we will use our resources to continue to integrate services in pursuit of national and local outcomes as agreed by the Health and Social Care Partnership Board.

We continue to focus on the needs of our citizens and as such this is a time of exciting and transformational change for the Health and Social Care Partnership with a new strategic leadership group in place.

We are committed to the principles of Best Value and ensuring we are delivering high quality services in an environment of robust clinical and care governance. Our Annual Performance reports note the progress we have been able to make against our performance indicators and we have used case studies to bring to life what this means to our citizens.

And importantly, we are committed to working with the people of West Dunbartonshire to improve their health and well-being.

Beth Culshaw
Chief Officer
Health and Social Care Partnership



Allan Macleod, Chair
Health and Social Care
Partnership Board



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Introduction

Our vision

Improving lives with the people of West Dunbartonshire

Our vision and our desire is to ensure that our citizens have access to the right care, at the right time and in the right place. It involves a range of activities, centred around a continuous cycle of “analyse, plan, do and review” and is iterative and dynamic to support collaborative system change across health and social care and all partners working in our communities.

Our commitment to our communities

Our Plan has been developed in partnership with the Strategic Planning Group (SPG) which has the formal statutory role to prepare and monitor our strategic commissioning plan. The membership consists of an extensive range of stakeholder groups, engaging with people using services, carers, professionals and clinicians, along with the third, independent and housing sectors. Through the Local Engagement Network the relationship with the wider public continues to be developed and deepened to ensure we reflect and consider the views of the people of West Dunbartonshire.

Our Strategic Outcomes

Our commitment to:

- Children and young people reflected in Getting It Right for Every Child.
- Continual transformation in the delivery of services for adults and older people as reflected within our approach to integrated care.
- The safety and protection of the most vulnerable people within our care and within our wider communities.
- Support people to exercise choice and control in the achievement of their personal outcomes.
- Manage resources effectively, making best use of our integrated capacity

Our Key Strategic Priorities

- Early Intervention
- Access
- Resilience
- Assets
- Inequalities

What is the Health and Social Care Partnership Board?

West Dunbartonshire Health and Social Care Partnership Board was established on 1st July 2015 as the Integration Authority for West Dunbartonshire.

It is responsible for the strategic planning and reporting of a range of health and social care services delegated to it by NHS Greater Glasgow & Clyde Health Board and West Dunbartonshire Council (which are described in full within its approved Integration Scheme).

The Council and the Health Board discharge the operational delivery of those delegated services (except those related to the Health Board's Acute Division services most commonly associated with the emergency care pathway) through the partnership arrangement referred to as West Dunbartonshire Health & Social Care Partnership.

The Partnership Board has a duty to agree the Strategic Plan for the integrated functions and budgets that they control, as laid out above.

The Health and Social Care Partnership Board is responsible for allocating the integrated revenue budget for health and social care in accordance with the policy priorities set out in this Strategic Plan.

The Strategic Plan takes account of the governance of joint finances; to ensure resources are used effectively and efficiently to deliver integrated services that meet the needs of the increasing number of people with long term conditions and often complex needs of all ages.

The Partnership Board includes representatives from the Third Sector, staff representatives and others representing the interests of patients, service users and carers. This is to ensure that the Partnership Board is fully engaging strategic partners in the preparation, publication and review of each Strategic Plan.

The Health and Social Care Partnership Board is responsible for the operational oversight of West Dunbartonshire Health and Social Care Partnership. It is responsible for planning and overseeing the delivery of the full range of community health and social care services.

Within West Dunbartonshire this is undertaken in a meaningful co-productive way with all partners.

What is the Health and Social Care Partnership?

With a continued emphasis on joining up services and focussing on anticipatory and preventative care, our approach to integration aims to improve care and support for people who use services, their carers and their families.

The Health and Social Care Partnership has delegated responsibility to deliver services for:

- Adults and Older People's services across all disciplines within integrated community teams
- Children and Young People's Services across all disciplines and in partnership with Education Services
- Criminal Justice Social Work Services
- Community Mental Health, Learning Disability and Addictions across disciplines with integrated community teams and with in-patient services.

West Dunbartonshire has two localities; Alexandria/Dumbarton and Clydebank. The Health and Social Care Partnership's locality group arrangements provide a platform for engaging a wide range of stakeholders; and the opportunity to respond to locality-level feedback. Meetings are kept to a minimum and are structured to make the best use of everyone's time and commitment.

The purpose of locality planning is:

- to jointly assess need, as well as prioritise and plan how all resources, irrespective of their origin, can best be deployed in pursuit of the delivery of National and Local Outcomes; and
- to be the local focus for service delivery and support for organisations from across sectors to the population or communities within the area.

West Dunbartonshire Health and Social Care Partnership hosts the Musculoskeletal (MSK) Physiotherapy Service for the NHS Greater Glasgow and Clyde area. Work is ongoing within the service to ensure the delivery of high quality outcomes for patients whilst striving to meet national waiting time targets.

West Dunbartonshire Health and Social Care Partnership hosts a programme of retinal screening on behalf of NHS Greater Glasgow and Clyde.

The Health and Social Care Partnership leads the Community Planning Partnership Alcohol and Drugs Partnership.

Working with Partners

At the heart of this approach to strategic planning is the provision of services and support across sectors, including the Third and Independent Sectors, in a way that meets the needs of particular individuals, communities and localities.

The specific local actions reflect ongoing self-evaluation processes within the Health and Social Care Partnership service areas; engagement within local Community Planning Partnership fora; and dialogue with both service user groups and the wider communities across West Dunbartonshire.

It is underpinned by an appreciation of local health and social care needs (e.g. the area's Strategic Needs Assessment – based on burden of disease); and other relevant sources of evidence.

This approach feeds in to the commitment to improve the quality and consistency of services for patients, carers, service users and their families.

Health and Social Care Partnership Strategic Planning Group

This Strategic Plan is informed by an understanding of perspectives of the strategic planning stakeholders specified by the Joint Bodies Act (including staff side representation and the two localities identified within West Dunbartonshire) and from on-going engagement with our citizens and service users, reflecting the cyclical commissioning process for the review of services.

As such, it provides our partners who were involved in the development of the Integration Scheme, and are party to our integrated arrangements, to be involved in the development of each Strategic Plan.

A key principle of the Partnership's planning process is a co-productive approach that is equitable and transparent, and therefore open to influence from all stakeholders via an on-going dialogue with people who use services, their carers and providers.

The Strategic Planning Group has had a key role in developing and finalising the Strategic Plan and to review progress, measured against the statutory outcomes for health and wellbeing, and associated indicators.

This third Plan has been developed alongside the Strategic Needs Assessment, with different partners from across the public, third and independent sectors in a way which will help to achieve the best services for the population.

The Health and Social Care Partnership understands that providers and service users bring knowledge and experience of services. With every partner having a role in strategic commissioning, they will have a key role in developing a robust Commissioning Plan.

The Health and Social Care Partnership recognises the extent of the third sector's and Third Sector Interface's knowledge and expertise; both in relation to communities and the sector itself,

Clinicians and care professionals from each Locality have an opportunity to play a key role in ensuring that local needs are understood, and that they inform the overall priorities.

Our partners involved in the planning process have had the opportunity to develop their skills by working with a range of partners along with service users and their carers to build and implement the strategic priorities.

The Health and Social Care Partnership has well developed local arrangements, including the Strategic Planning Group and wider Community Planning Partnership which have promoted mature relationships and constructive dialogue. This promotes an environment for all parties to work with trust and mutual respect.

Community Planning West Dunbartonshire

Local Outcome Improvement Plan

Community Planning West Dunbartonshire aims to ensure that people and communities are genuinely engaged in the decisions made on public services which affect them: supported by a commitment from organisations to work together to provide better public services, including health and social care services.

Community Planning West Dunbartonshire ensures that activity is co-ordinated and focused on the value of working in partnership:

- realising the added value of working in partnership
- enabling existing and new partnership working to deliver outcomes across a range of service led and community led priorities
- providing a strategic overview which acknowledges interfaces and dependencies; and
- mitigating the shifting social and financial impact of decisions upon partners.

Both West Dunbartonshire Council and NHS Greater Glasgow and Clyde reflect in their own policy commitments the principles and outcomes that are at the heart of planning for the population and to embed a person centred approach across the totality of the population.

West Dunbartonshire Council Strategic Plan

At its core, West Dunbartonshire Council has a commitment to reduce inequality and tackle root causes of poverty. The strategic priorities adopted are focused on improving the lives of the people of West Dunbartonshire, by promoting equality for all. Underpinning the strategic priorities are key cross cutting principles, which inform all the work undertaken.

As a Council there is a desire for every employee to have PRIDE in the services they deliver:

**Personal
Responsibility
In
Delivering
Excellence**

The Council's priorities underpin our commitment to the values we have adopted to ACHIEVE:

**Ambition
Confidence
Honesty
Innovation
Efficiency
Vibrancy
Excellence**

NHS Greater Glasgow and Clyde Moving Forward Together

Moving Forward Together (MFT) describes a tiered model of services where people receive care as near home as possible, travelling to specialist centres only when expertise in specific areas is required. MFT explores the potential of using digital technology to a far greater extent and promotes maximising the utilisation of all resources, with a drive to ensure all practitioners are working to the top of their professional abilities. It recommends supported self care and better links between primary and secondary care.

The key elements on which the Moving Forward Together Programme has been based are:

- Aligned to the national strategic direction
- Consistent with the West of Scotland Programme
- Reflect a whole system programme across health and social care
- Use the knowledge and experience of our wide network of expert service delivery and management teams
- Involve our service users, patients and carers from the outset
- Engage with, and listen to, our staff and working in partnership
- Embrace new technology and the opportunities of eHealth
- Affordable and sustainable.

The Health and Social Care Partnership will continue to provide leadership on the **Children Services Plan** across community planning partners. The Children's Services Plan incorporates key strategic priorities and outcomes for children and young people as set out in West Dunbartonshire's Local Outcome Improvement Actions 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 principles; to the delivery of corporate parenting responsibilities; and to improving outcomes for looked after children and young people.

The Health and Social Care Partnership is working with West Dunbartonshire Council and the wider Housing Sector 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. This is described in more detail within the **Housing Contribution Statement**.

The Health and Social Care Partnership 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. This approach is informed by and within the principles as set out within the Partnership's Clinical and Care Governance Framework.

The Health and Social Care Partnership is working with partners to address the concerns linked to the levels of domestic abuse in West Dunbartonshire; creating a **Domestic Abuse Strategic Leaders Forum** and working with the Scottish Leaders Forum to create awareness as well as dedicated service interventions. Working

within a system wide response, we are able to provide a patchwork of timeous supports and services alongside an aspiring approach which seeks to address generational behavioural change by creating an environment where citizens and professionals are confident to challenge and take responsibility for the notion that domestic abuse is either acceptable or inevitable.

The Health and Social Care Partnership, with partners, is committed to addressing within an early intervention model linked to childhood experiences, both positive and negative, which have a impact on future violence, victimisation and perpetration, and lifelong health and opportunity. We recognise that early experiences are an important public health issue and are using the foundational research in this area which has been referred to as **Adverse Childhood Experiences** (ACEs) to inform practice and developments.

To develop and deliver clear, seamless and accessible pathways of care and support for people affected by cancer, West Dunbartonshire is delivering **Improving the Cancer Journey**, supporting timeously and appropriately accessible support across organisational and professional boundaries, based upon a holistic assessment of need and available from the point of diagnosis.

From the description of the activity above it is clear that the Health and Social Care Partnership is working well with partners to address the complex picture of need across West Dunbartonshire.

The Partnership must continue to work with our partners and communities to consider how services can be focused on not only early intervention and prevention but on how to we are able to support people to maintain their independence and to be as independent as possible. With our partners, we need to ensure that support and services interact with local communities and consider how we can better support and embed capacity building within communities.

Case for Change

The recent reports by Audit Scotland; NHS in Scotland (October 2018) and Local Government in Scotland: Financial overview 2017/18 (November 2018) set out the challenges faced by public services and acknowledge longer term robust planning is even more crucial. This necessitates looking to the future, considering not only the demographic changes but also taking into account how the landscape of policy and delivery is changing.

The need to change models of local health and care services is being driven predominantly to reflect changing needs. Demographic studies show that people are living to an older age often with complex co-morbid conditions such as diabetes (Audit Scotland 2016).

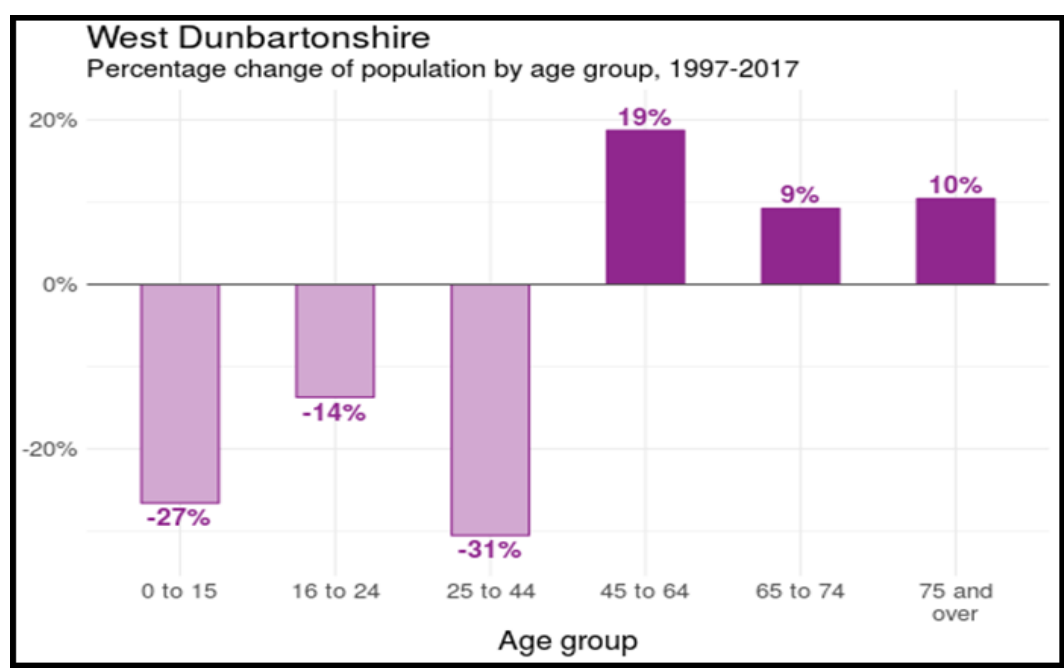
Change is necessary as demand is rising significantly whilst, in real terms, available resources are falling. This makes it challenging to give all children the best start in life, to meet the needs of a population which is ageing and which requires increasing levels of care to keep local people safe, well and content at home in their local communities.

Our Strategic Needs Assessment takes 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 and;
- health & social care provision in the community, including the patterns of service use across West Dunbartonshire Health & Social Care Partnership.

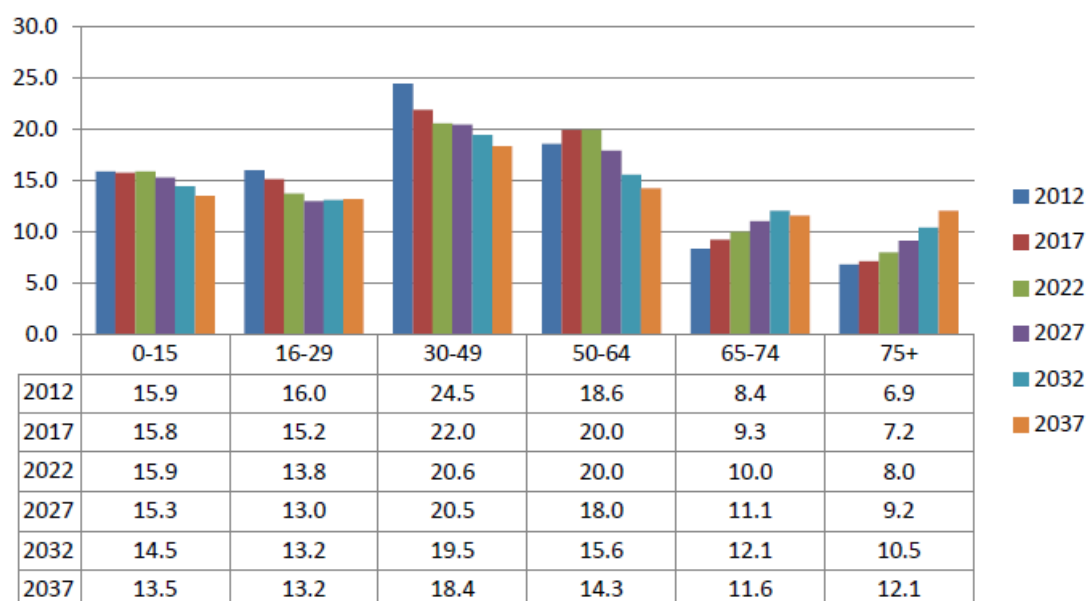
The population of West Dunbartonshire accounts for 1.7% of the total population of Scotland. The population mid-year estimate for 2017 was 89 610, a decrease of 0.3% from the 2016 estimate of 89 860 and the trend over the last 10 years has seen a decrease from 91 370 a change of - 1.9%.

As of 2017 the gender split of the population was 47.7% for males and 52.3% for females.



[National Records of Scotland \(2018\)](#)

West Dunbartonshire population projections indicate that the age groups 65+ and 75+ will increase up to the year 2037 with other age bands decreasing. This will have an overall impact on the dependency ratio. The dependency ratio is a measure of the proportion of the population seen as economically 'dependent' upon the working age population. The definition generally used in Scotland is: 'those aged under 16 or of state pensionable age, per 100 working age population.



Source: National Records for Scotland (2018) Population Projections

The population in Scotland is projected to increase by 3% (170,000 people) by 2024 and by 7% (350,000 people) by 2037. In contrast, West Dunbartonshire is projected to 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.

Overall the population projections indicate changes to the three key life stages of children, adults and older people. There is a decrease in the projected proportion of children and working age groups and an increase in the proportion of people who will be of pensionable age.

West Dunbartonshire ranks **second bottom for mortality rates** compared to Scotland as a whole and the main cause of death in West Dunbartonshire is cancer, followed by circulatory disease. Life expectancy is an indicator of underlying inequalities not limited to health. Issues such as poverty, unemployment, access to services, home environment and education are all intrinsically linked and must be addressed in a coordinated way to make significant improvements to life expectancy.

In areas with relatively high levels of socio-economic deprivation action to 'close the long term gap' needs to involve a **combination of initiatives** that address the fundamental causes of health inequalities including education, poverty and employment with preventative action in the early years.

Overall **life expectancy** in West Dunbartonshire is poor in comparison with Scotland as a whole.

Women's life expectancy is the poorest in Scotland at 78.8 years and male life expectancy is third lowest behind Glasgow City and Dundee City at age 74.7 years.

In terms of **Healthy Life Expectancy**, for West Dunbartonshire this is lower in comparison to Scotland and is second lowest for both males and females.

- Male HLE is 58.9 years compared to 63.1 years for Scotland
- Female HLE is 60.7 years compared to 65.3 years for Scotland

(Scottish Public Health Observatory (Scotpho) (2016) Healthy Life Expectancy)

To provide a deeper understanding of the population figures, the Health and Social Care Partnership worked with the Scottish Burden of Disease epidemiology study, which is based on an internationally recognised approach used to quantify the

difference between the ideal of living to old age in good health and the situation where healthy life is shortened by illness, injury, disability and early death.

The estimates describe for the first time a clearer picture of the conditions that cause ill-health and mortality in Scotland with projections of disease burdens to 2026. For the purpose of the Strategic Needs Assessment, the national Burden of Disease Team have provided estimates for West Dunbartonshire based on whole population data.

CANCER	Cancer is ranked as the top burden of disease nationally and ranked top within the burden of disease estimates for West Dunbartonshire with a projected 10% increase by 2026. The top 3 types of cancer prevalent in West Dunbartonshire are breast, colorectal and prostate. The incidence (new cases) of all cancers by age is projected to increase nationally by 33.5% by 2027.
DEPRESSION	The snapshot extract from GP registers shows that the rate of depression in West Dunbartonshire (82.9 per 1000) is higher than the Scottish rate (73 per 1000). There are locality differences with Clydebank rate 86.2 per 1000 population higher than Alexandria/Dumbarton rate of 80.3 per 1000 population (difference of 5.9).
SUICIDE RATES	Whilst suicide rates for West Dunbartonshire are lower than Scotland as a whole it remains a significant issue in West Dunbartonshire.
ALCHOL RELATED HOSPITAL STAYS	Alcohol hospital related stays for West Dunbartonshire are higher than the Scottish average and increasing which is in contrast to the Scottish position. Alcohol liver disease is increasing and alcohol related death rates are slowly decreasing however this masks an increase in deaths in the 45 - 59 years and 60 - 74 years age groups. The West Dunbartonshire rate of alcohol related mortality 27.4 per 100,000 compares to 20.2 per 100,000 nationally. The number of deaths related to alcohol in West Dunbartonshire 2016 was 28.
DRUG RELATED HOSPITAL STAYS	Drug related hospital stays for West Dunbartonshire are higher than the Scottish average.
DRUG RELATED DEATHS	Drug related deaths in West Dunbartonshire follows the national trend where nearly 80% of deaths are male. The largest number of deaths are in the 35-44 age group which makes up 42% of

	West Dunbartonshire service users as recorded on the Scottish Drugs Misuse Database.
CORONARY HEART DISEASE	Coronary Heart Disease , also known as Ischaemic Heart Disease, is a preventable disease which kills over 8,000 people in Scotland every year. CHD is a priority in Scotland where prevalence of the associated risk factors such as smoking, diet and physical inactivity is high. The snapshot extract from GP registers shows that the rate of CHD in West Dunbartonshire (45.1 per 1000) is higher than the Scottish rate (39.8 per 1000).
STROKE	The snapshot extract from GP registers shows that the prevalence of Stroke in Clydebank (27.8 per 1000) is higher than the Alexandria/Dumbarton rate (22.8 per 1000).
HYPERTENSION	Hypertension prevalence in West Dunbartonshire has a rate of 148.6 per 1000 population and is higher than national prevalence of 138.1 per 1000 population. Dumbarton/Alexandria locality has a rate of 150.0 per 1000 population, which is higher than Clydebank rate of 146.9 per 1000 population.
SMOKING	Smoking prevalence in adults (16+) currently stands at 25.6 %. Although the smoking prevalence has decreased from 2012 by 7.8 % from 33.4% to 25.6%, West Dunbartonshire smoking prevalence still remains higher than the current Scottish average of 20.7%.
ALCOHOL CONSUMPTION	Accurate alcohol consumption data for West Dunbartonshire is difficult to obtain. The Citizens' Panel Survey data showed that in 2007, the majority of Panel members (81%) stated they drank alcohol. This declined slightly in 2010, 2012 and 2013 and in the 2015 survey 75% report drinking alcohol. Between 2013 and 2015 the percentage who drink alcohol reduced in regeneration areas from 72% in 2013 – 60% in 2015. 2015 findings also show that there are a higher proportion of Panel members from the rest of West Dunbartonshire who drink (85%, compared to 60% in the regeneration areas) (Hexagon Research and Consulting, 2015).
PHYSICAL ACTIVITY	40% of over 60s do not take part in any physical activity . Active travel such as cycling and walking remains 5% lower than the Scottish average of 14.9%.

The focus of the Strategic Needs Assessment was intentionally linked to the burden of disease information as the West Dunbartonshire Council Demographic profile

describes the population in terms of equality, social and economic deprivation, housing profile, regeneration, educational attainment and community safety.

Taking the burden of disease alongside the population information lays out the challenge for West Dunbartonshire and demonstrates the scale of what needs to change. This provides a clear imperative for major transformational change across the existing health and social care system.

Housing and Households 2014 – 2039

The total number of households in West Dunbartonshire is projected to change from 42,106 in 2012 to 42,543 in 2037, which is an increase of 1 %. In Scotland, the projected number of households is set to increase by 17 % over the same 25 year period.

Percentage of households by age group is increasing for the 65yrs and over and decreasing for younger age groups, in line with population trends.

Percentage of households of 75+yrs will increase from 12 % in 2014 to 20% in 2039.

There are opportunities for preventative, population wide, public health interventions as a large proportion of the disease that leads to illness and early death is preventable.

By using all datasets we can conclude that if levels of health in Scotland matched our least deprived populations, we would have one of the lowest health loss of any developed country. As such there is an opportunity to continue to support our most deprived populations.

Alongside Community Planning West Dunbartonshire we are already focused on addressing the wider determinants of health linked to employment, income, place and education.

We have the opportunity, using existing policies and already agreed actions linked to substances that harm health; alcohol, poor diet, cigarettes, drugs, to focus on cost, availability and acceptability across our communities to have a significant impact.

In addition, the self-management of conditions, through the effective use of technology to slow progress of disease, is also essential to reduce burden on health and care services (e.g. for COPD, heart conditions, diabetes and hypertension).

Programme for Change

It is clear that the traditional approaches to the provision of health and social care services, across all sectors and across all age ranges, will not deliver the required improvements for our population.

The Health and Social Care Partnership Board is committed to a programme of change based on robust evidence of population demographics, current financial resources, more effective commissioning and national and local policy drivers for change.

A key objective of the reform programme advocated by the **Christie Commission** was that public services had to be built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience.

Since 2016, work has been underway across Scotland to integrate health and social care services in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. By integrating the planning and provision of care, partners in the public, third and independent sectors are improving people's experience of care along with its quality and sustainability.

The **National Health and Social Care Delivery Plan** recognised that if health and social care is to be transformed in the next few years, then change must be undertaken at pace and that there is continued emphasis on partnership working which is fundamental to this process, planning with partners both across and outside of the public sector (Scottish Government 2016).

This National Health and Social Care Delivery Plan set out an ambition to work across boundaries to plan and deliver services that will meet the triple aim aspiration of providing better health, better care and better value:

“we will increase the value from, and financial sustainability of, care by making the most effective use of the resources available to us and the most efficient and consistent delivery, ensuring that the balance of resource is spent where it achieves the most and focusing on prevention and early intervention”.
(Scottish Government 2016)

Setting out a significant list of objectives, including a focus on regional and national planning of services where appropriate. It draws on earlier strategies and sets out the direction of travel and expectations of a modern health and care system.

In addition, the Plan committed to the delivery of the Public Health Review findings and subsequent Public Health Reform Programme; the 2016 Health and Social Care

Delivery Plan confirmed Scottish Government and COSLA's commitment to develop a set of public health priorities for Scotland by early 2018. These priorities reflected the ambition for effective 'whole system' working to improve the public's health and reduce health inequalities with national shared Public Health Priorities developed with the key aim of supporting the collaborative work deemed necessary if these are to be delivered across the whole system e.g. whether working in health and social care services, housing, education or employment.

The **National Clinical Strategy** (February 2016) emphasises the need to fully understand the drivers for change giving a high level perspective on why change is needed and the direction that change should take in order to maximise patient benefit from the available resources. A key area identified is planning and delivery of primary care services around individuals and their communities.

The recent report from **Chief Medical Officer** reaffirms the message that a radical change is required in order to effectively meet the needs of the public and demands of the future (Scottish Government 2018). The overarching message from the Chief Medical Officer is clear in that it is not only about providing high quality healthcare but importantly and in parallel to this it is about addressing the wider determinants that impact on health; the need to give equal priority to the causes such as socio-economic factors, as to health conditions.

The **Audit Scotland report on integration** that was published in November 2018 provides important evidence for changes that are needed to deliver integration well and highlights a series of challenges that nonetheless need to be addressed, in terms particularly of financial planning, governance and strategic planning arrangements and leadership capacity. It is however acknowledged that Partnership's are operating in an extremely challenging environment and there is much more to be done to tackle the challenges within health and social care across the whole sector..

The new **Care Inspectorate inspection framework** is changing the way it carries out of regulatory inspection; starting with the inspection of care homes for older people. These new inspections reflect the new Health and Social Care Standards, published in 2017, and set out what people should experience from care and support in Scotland. A new quality framework to use on inspections has been developed, with the Care Inspectorate starting this new approach in care homes for older people during July 2018.

The approach is based on a human rights approach within a health and social care framework; which alongside **Self-Directed Support** allows individuals, their carers and their families to make informed choices on what their social care support looks like and how it is delivered, as such making it possible to meet agreed personal outcomes. The Social Care (Self-directed Support) (Scotland) Act 2013 allows people to choose how their support is provided, and gives them as much control as they want of their individual social care budget.

In accordance with the expectations of the **Carers (Scotland) Act 2016**, the Health and Social Care Partnership and partner organisations are committed to ensuring better and more consistent support for carers and young carers so that they can continue to care, if they wish, in better health and to have a life alongside their caring commitments.

The Community Empowerment (Scotland) Act 2015, the Public Bodies (Joint Working) (Scotland) Act 2014, the Equality Act 2010, and Chief Executive Letter (CEL) 4 (2010) Informing, Engaging and Consulting People in Developing Health and Community Care Services set out legal duties and **good practice in engaging communities**. The Health and Social Care Partnership Board has in place public engagement arrangements based on the National Standards for Community Engagement to meet their statutory duties. These arrangements support a flexible approach providing individuals with a range of opportunities to engage and be part of the planning, review and development of support and services.

A new national strategy '**A Connected Scotland**' has been developed to tackle loneliness and isolation to ensure those at risk of becoming lonely or isolated have access to the right support networks. Social isolation and loneliness can affect anyone at all ages and stages of life. There is increasing recognition of social isolation and loneliness as major public health issues that can have a significant impact on a person's physical and mental health.

Partnership working across **Community Planning West Dunbartonshire** affords opportunities to extend and co-ordinate reach into local communities and neighbourhoods. This link to community planning ensures that health and social care is not isolated from wider and highly relevant agendas that include transport, leisure and recreation, education, economic development, housing, policing, and fire and rescue services.

The **National Eligibility Framework** for services for adults and older people employs a four criteria approach, categorising risk as being critical, substantial, moderate or low.

- **Critical Risk:** Indicates that there are major risks to an individual's independent living or health and well-being and likely to call for the immediate or imminent provision of social care services.
- **Substantial Risk:** Indicates that there are significant risks to an individual's independence or health and wellbeing and likely to call for the immediate or imminent provision of social care services.
- **Moderate Risk:** Indicates that there are some risks to an individual's independence or health and wellbeing. These may call for the provision of some social care services managed and prioritised on an on-going basis or they may simply be manageable over the foreseeable future without service provision, with appropriate arrangements for review.
- **Low Risk:** Indicates that there may be some quality of life issues, but low risks to an individual's independence or health and wellbeing with very limited, if any, requirement for the provision of social care services. There may be some need for alternative support or advice and appropriate arrangements for review over the foreseeable future or longer term.

In these definitions, the risks do not refer only to an individual's current independence, health and wellbeing, but also to the risk that she or he may not be able to gain these outcomes without support. Additionally workforce and services should be proportionate to need, and this varies by condition.

National Health and Well-being Outcomes; and subsequent guidance framework (Scottish Government February 2015) provide a strategic framework for the planning and delivery of health and social care services. This suite of outcomes together focus on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for adults and older people.

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 well-being
People who use health and social care services are safe from harm
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
Resources are used effectively and efficiently in the provision of health and social care services

National outcomes for children form part of the fifteen National Outcomes describing what the Government wants to achieve over the next ten years, articulating more fully the government's focus. The outcomes help to sharpen the focus of government, enable the priorities to be clearly understood and provide a clear structure for delivery. By achieving these outcomes at all levels, the Scottish Government aims to make Scotland a better place to live and a more prosperous and successful country. For children and young people this means:

Improved life chances for children, young people and families at risk
Young people are successful learners, confident individuals, effective contributors and responsible citizens
Children have the best start in life and are ready to succeed

During 2018, Scottish Government published a digital maturity assessment and NHS Greater Glasgow and Clyde launched their **Digital Strategy 2018-2022**. The strategy is key to delivering the Board's vision outlined in **Moving Forward Together** and the **Council's Be the Best** programme. The health and social care sector is embracing technological change and is creating an environment which supports the development of digital solutions which make a difference to people's lives.

Scotland's Digital Health and Care Strategy states: “ *The issue is not whether digital technology has a role to play in addressing the challenges we face in health and social care and in improving health and wellbeing: the issue is that it must be central, integral and underpin the necessary transformational change in services in order to improve outcomes for citizens. Over the next decade digital services will become not only the first point of contact with health and care services for many people, but also how they choose to engage with health and care services on an on-going basis*”.

The recent release of Scottish Government's **Drug Strategy- Rights, Respect and Recovery**, and the Alcohol Framework – Preventing Harm, both identify key themes which inform the direction of travel for local services planning and delivering Recovery Orientated Systems of Care. This creates a human rights based approach to supporting those affected by addiction issues and will be the framework for the local Alcohol and Drug Partnership Improvement Plan.

The Chief Officers of the six Health and Social Care Partnerships within Greater Glasgow and Clyde, and in partnership with NHS Greater Glasgow and Clyde commissioned and developed '**The Five-year Strategy for Adult Mental Health Services in Greater Glasgow & Clyde: 2018-23**'.

The priorities for the Plan are:

Unscheduled care	crisis responses, home treatment, and acute mental health inpatient care
Recovery-oriented care	inpatient provision and a range of community-based services, including local authority and third sector provision
Well-being-orientated care	including working with children's services to promote strong relational development in childhood, protecting children from harm and enabling children to have the best start.
Productivity	initiatives in community services to enhance capacity while maintaining quality of care
Prevention	medium-long term planning for prevention of mental health problems
Bed modelling	short stay mental health beds: underpinning the first three strands is the need to estimate the number and type of hospital beds that the system needs to provide in order to deliver effective care
Shifting the Balance of Care – Rehabilitation and Long Stay Beds	moving away from hospital wards to community alternatives for people requiring longer term, 24/7 care, with residual mental health rehabilitation hospital beds working to a consistent, recovery-focussed model.

Improving health and wellbeing, building individual and community confidence and resilience, improving access to quality housing and other services, strengthening our response to offending behaviour and supporting the most vulnerable, such as young people leaving care will all help to create the conditions in which we can achieve a more resilient and confident community in West Dunbartonshire.

Working in partnership the Health and Social Care Partnership is creating an opportunity, by releasing the talents of all, which will in turn contribute to achieving our outcomes, through lowering the scale and burden of poverty, antisocial behaviour, crime and health and other inequalities. There is already local evidence is emerging of good progress linked to the impact of partnership working and integrated services within the local systems.

The programme for change is evident and complex within the current policy landscape, as such the Health and Social Care Partnership Board has set out the overarching priorities within the next sections of the Plan which will deliver the Health and Social Care Partnership vision.

Improving lives with the people of West Dunbartonshire

Financial framework

National Health and Well-being outcome

- **Resources are used effectively and efficiently in the provision of health and social care services.**

The three year planning period 2019 -2022 will be extremely challenging for the Health and Social Care Partnership Board as it seeks to balance increasing demands and costs against public sector spending constraints.

The Health and Social Care Partnership has experienced exceptional demand for services over the last three years, especially in the delivery of supporting children and young people and supporting our older and frailer residents.

This increasing demand has had to be considered within limited financial resources and the requirement for the Health and Social Care Partnership Board to agree on a programme of savings across both health and social care budgets.

The Health and Social Care Partnership Board is responsible for the **financial governance** of the budgets delegated to it by our partners West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board.

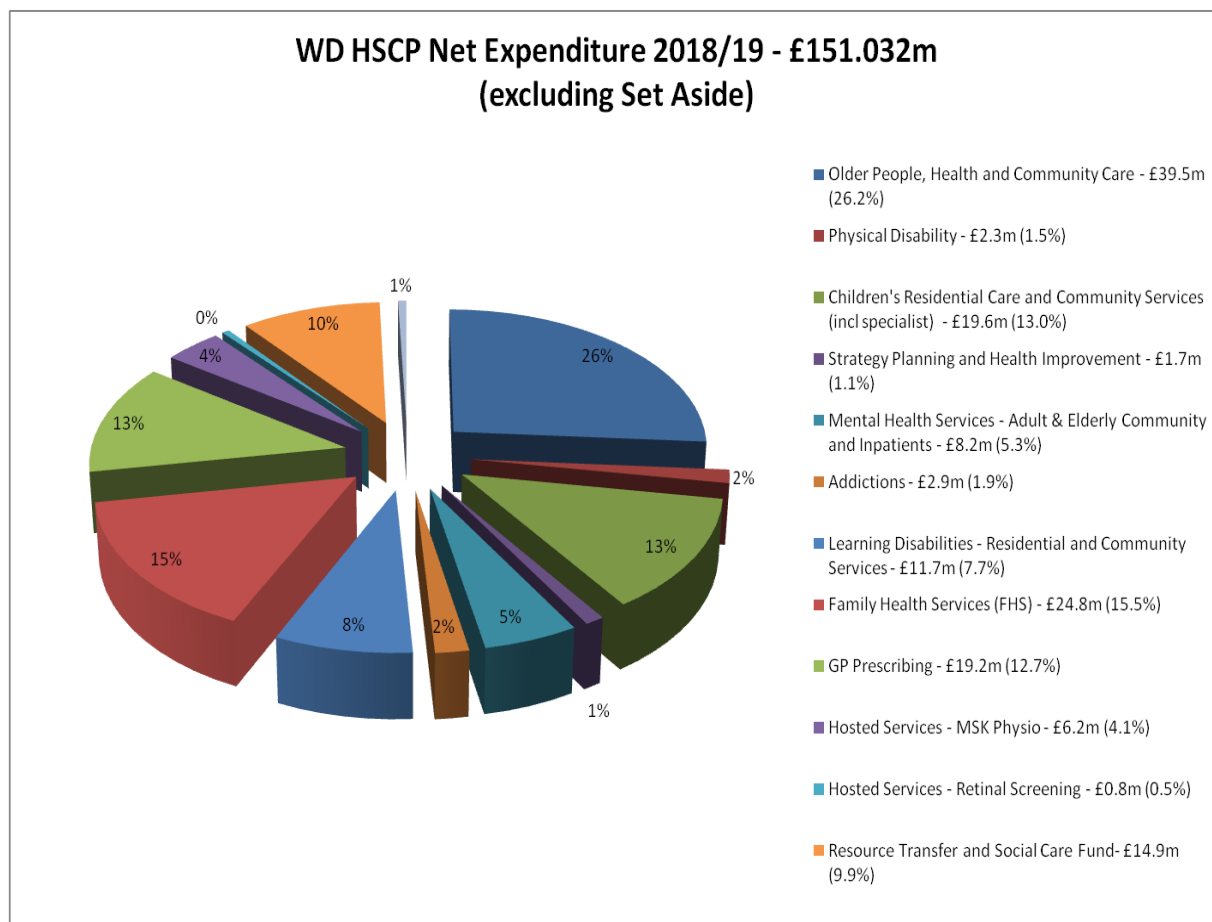
The Health and Social Care Partnership Board receive regular financial performance reports which allow members to scrutinise how public money is being used and to ensure that financial resources are being directed to services that will deliver on local and national outcomes defined in this Strategic Plan's five strategic priorities.

The original agreed budget for 2018/19 to deliver our strategic priorities was £151.032m, excluding set aside. The Health and Social Care Partnership Board choose to **consult** with the West Dunbartonshire wider community in April 2018 on a range of savings options which will impact on the available budget over the next three financial years. The Health and Social Care Partnership Board considered the responses to the consultation and agreed to savings totalling: £1.216m in 2018/19, increasing to £1.831m and £2.321m in 2019/20 and 2020/21 respectively.

The **set aside budget** was approved later in the year at £18.210m and is West Dunbartonshire's share of the NHS Greater Glasgow and Clyde resource to meet the costs of unscheduled care or emergency admissions to hospital.

While the **set aside** budget is part of the Health and Social Care Partnership's total financial resource, the acute hospital sector delivers the care and spends the money. Successful delivery of the strategic priorities will reduce demand in unscheduled care allowing savings to be re-invested in community based services.

The chart below details how this funding is allocated across the main care groups.



The Scottish Government has through its **Health and Social Care Delivery Plan** set out key reform programmes including how health and social care integration will have a focus on prevention, early intervention and supported self-management. This was followed in October 2018 with its **Medium Term Health and Social Care Financial Framework**.

This sets out the government's spending commitments including additional funding dedicated to primary care (including GP services) and mental health as well as the re-investment of shifting the balance of care, meaning that a greater proportion of care is provided in a setting close to a person's home rather than in hospital.

The Health and Social Care Partnership has in 2018/19 received additional funds, to those detailed above, to help deliver on these commitments. This funding is committed to continue over the period of this Strategic Plan.

Additional Investment

Scottish Government Funding	2018/19	2019/20	2020/21	2021/22
	£m	£m	£m	£m
Primary Care Improvement Fund	0.837	1.037	2.100	2.900
Mental Health – Action 15	0.201	0.311	0.439	0.585

It is anticipated that the public sector in Scotland will continue to face a very uncertain medium to long term financial outlook. The three year financial planning period 2019 – 2022 will be extremely challenging for the Health and Social Care Partnership Board as it seeks to balance increasing demand against diminishing resources, and new developments within the additional investment received.

While future funding settlements are uncertain, both of our partners West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board have set out the anticipated scale of their funding challenges in the medium to long term, including savings targets for the Health and Social Care Partnership Board. This coupled with increasing demand for services will require careful assessment, but early scenario planning would suggest the scale of the savings challenge could range from 3% to 5% of the Health and Social Care Partnership Board's current resources.

A **medium term Financial Strategy** will be developed centred on financial sustainability and service redesign. In order to understand the scale of the financial challenge a detailed analysis of costs and demands is required including:

- Pay inflation and pension costs – uncertainty around pay settlements for public sector workers and additional investment in pension schemes;
- Demographics – reflecting the increases in over 65+ and over 75+ years population often coping with a range of health conditions against a challenging social and economic climate;
- Contractual price increases – commitment to adhering to the National Care Home Contract and to deliver Scottish Living Wage to adult social care workers employed by our third sector and private providers;
- Prescribing Costs – inflationary increases, short supply issues and treatment of complex health conditions.

With growing costs and demands the Financial Strategy will reflect how we can work with the people of West Dunbartonshire by focussing on some key themes including:

- Better ways of working – integrating and streamlining teams to deliver services more efficiently will release financial savings and protect front line services;
- Prioritise our services – local engagement and partnership working are key strengths of the Health and Social Care Partnership. We must think and do things differently and find new solutions to providing support to those who need it;
- Service redesign and transformation – build on the work already underway redesigning support to people to remain or return to their own homes or a homely setting for as long as possible. This will be across all care groups including older people, learning, physical and mental disabilities and children and families, in partnership with housing sector, third sector and local providers.

The priorities for the Health and Social Care Partnership as described below, form the basis for the commissioning of services; and are informed by the strategic needs assessment and integrated performance framework of the Health and Social Care Partnership.

In partnership with West Dunbartonshire CVS, as the local Third Sector Interface and Scottish Care, our independent sector partner, we developed a model of local market facilitation consortium 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. 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. This approach alongside the Strategic Needs Assessment and Financial Plan will form the basis of the Commissioning Plan.

To ensure a more measurable approach, a Contract Management Framework is being developed; further clarifying the responsibilities and roles of strategic commissioning and contract management within the entire Health and Social Care Partnership 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 Health and Social Care Partnership 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 measures as well as robust commissioning within a context of clinical and care governance.

Making the Change – adults and older people

The Health and Social Care Partnership has agreed, alongside partners, five key strategic priorities for the next three years; these are based on consultation with staff groups and with our communities.

1. Early Intervention
2. Access
3. Resilience
4. Assets
5. Inequalities

These priorities align to the National Health and Wellbeing Outcomes as high-level commitments relating to the actions the Health and Social Care Partnership is endeavouring to achieve through integration and ultimately through the pursuit of quality improvement across health and social care sectors.

Health and social care services focus on the needs of the individual to promote their health and wellbeing, and in particular, to enable people to live healthier lives in their community.

Key to this is people's experience of health and social care services and that the impact of support and services is positive for individuals both as outcomes as well as within a clinical and care governance context. People are enabled to shape the care and support that they receive; and that those using services, whether health or social care, can expect a quality service regardless of where they live.

This is all underpinned by a robust approach to quality assurance as well as governance arrangements overseen by the Chief Social Work Officer, Lead Nurse and Lead Allied Health Professional aligned to the Partnership.

The format of this Plan outlines how the Health and Social Care Partnership priorities will meet the overarching strategic priorities of the Plan and to help to inform how services are planned across the whole pathway of care, to ensure a focus on individuals, and also the practice changes within integrated multidisciplinary teams, that will make a difference to the care people receive.

1. Early Intervention

Adults and older people will have access to more opportunities to engage in meaningful activities within care homes and day services; and the Health and Social Care Partnership is committed to ensuring greater use of and a greater variety of **day service activities** available across a range of community settings.

We will provide preventative interventions to ensure people are supported to remain active and enjoy life by rolling out the use of the **Rockwood Frailty tool** to support the early identification of people who are becoming increasingly frail.

We aim to create a **clear pathway to support** individuals and develop a range of interventions to support people at home, as they become more frail and work with the **voluntary sector** to create opportunities for older people to volunteer and to be supported by volunteers.

With the support of the third sector and the Leisure Trust, we are able to promote self-management and independence within care homes and within communities to support **rehabilitation and re-ablement**, using strength and balance and access to appropriate exercise opportunities. Exercise regimes promoted are based on academic evidence of impact for older people or those with additional needs.

Social prescribing is an approach for connecting people with non-medical sources of support or resources within the community which are likely to help with the health problems they are experiencing as well as the wider circumstances that affect an individual's health and wellbeing. Community Link practitioners will become part of primary care teams as part of integrated multi-disciplinary teams in West Dunbartonshire throughout the lifetime of the plan.

We will continue to work in partnership with Carers of West Dunbartonshire to ensure **carers** have easy access to support, advice and information at each stage of their caring journey and support for carers in their caring role will be consolidated in all our service areas.

We will, with partners, provide **community access opportunities** for access the arts, physical activity, learning, volunteering, social support, mutual aid, befriending, self-help as well as support with benefits, debt, legal advice and parenting.

Anticipatory Care Planning has been adopted across many GP practices and community teams; this ensures multi-disciplinary working focusing on the development of robust care plans for individual patients. Plans, which have the person's wishes at the centre, will be developed which will help maintain individuals within their own homes; through a coordinated community response to any

deterioration in their health and care needs. this approach has already been incorporated into the refreshed self directed support person centred assessment tool.

Given the age profile of the population of West Dunbartonshire the prevalence of Dementia is greater than that for Scotland as a whole. The Partnership continues to support **Dementia Friendly Communities** across the 22 neighbourhoods of West Dunbartonshire and is preparing a local Dementia Implementation Plan for the whole area which is aligned to the priorities within the national dementia strategy.

All individuals accessing community addiction services will be continue to be offered testing and subsequent treatment locally for **blood borne viruses** via the multi-award winning testing and treatment service; this ensures continuous growth of local treatment rates for Hepatitis C. In the coming year there will be a continuation of assertive outreach in an attempt to maximise those completing treatment across all our communities.

Community addiction services will continue to work with partners and Police Scotland in the multi agency task group to identify individuals who are potentially vulnerable and at risk in order to create a joint care pathway which will reduce their **episodes of distress** and multi agency contact; we will be putting in place a process to ensure that we are able to identify those who are known to us however are presenting repeatedly to emergency departments. This will ensure a multi disciplinary care review to ensure that any additional needs are identified and support maximised timeously and in a community setting.

Our commitment to the most vulnerable and at risk in our community is a key priority; a partnership with Police Scotland, health and social care community services from addictions and adult care has come together to offer coordinated care and support to West Dunbartonshire residents who have complex needs and struggle to work with services. This can lead to people being in a cycle of presentations to a range of different Health and Social Care Partnership services, Police Scotland and emergency departments but being unable to access the right support or achieve meaningful outcomes.

2. Access

The agreed **Primary Care Improvement Plan** creates the opportunity to improve the delivery of these community based services and ensures those accessing support and their carers are at the heart of how these are designed, planned and provided.

The Health and Social Care Partnership is committed to respond quickly when people experience crisis or are suffering from increased frailty. By creating a circle of support, we are able to help people remain safely at home or in a homely setting through a newly developing **Focussed Intervention Team**. The Team will be focussing on frailty and complex needs and providing appropriate and timeous support.

The newly agreed **Mental Health Action 15 Development Plan** was developed with partners and lays out the commitments of the Health and Social Care Partnership to support people with long term and enduring mental health as well as creating a community and on-line self management support service for those living in West Dunbartonshire.

The new **Self Directed Services Assessment Tool** and refreshed **Self Directed Support Care Manager Guidance** reflects our approach to anticipatory care planning and person centred planning as well as access to all four self directed support options within one streamlined process. The newly refreshed Guidance and Assessment Tool will be rolled out beside a programme of refreshed awareness of the legislation over the first year of this Plan.

The new **Health and Care Centre for the people of Clydebank** has received full planning permission and once complete, will be in a state of the art centre ensuring that integrated community based teams and services can be accessed in one single place. Based on the significant demographic challenges for West Dunbartonshire, the creation of a state of the art centre will additionally provide support in the form of health promoting community services and access to a range of third sector support, advice and information.

The **Single Point of Access** for adult and older people community health and care services will continue to be delivered and developed across services in West Dunbartonshire for all integrated community teams to ensure those using services can easily and effectively find the right support.

The **Keys to Life**, the national strategy for learning disability, provides a local framework for the delivery of support services for people with a learning disability and working in close partnership with those who use our services; and those who

provide services and their carers. With a focus on enhancing the technology enabled care currently available to enable access to effective, risk free and non-intrusive support.

The Health and Social Care Partnership, following consultation with carers and carer organisations, published West Dunbartonshire **Carers Eligibility Criteria** in 2017. The Eligibility Criteria states that all carers will have access to support to continue their caring role; the impact of this approach will be reviewed over the next year alongside carers and carers' representatives. This aligns to the new Carers Strategy for West Dunbartonshire, developed with carers and local carer organisations.

By continuing to focus on **Recovery Orientated Systems of Care**, we are able to bring together partners from welfare rights, prisons and justice, employability, housing and homeless, Police Scotland and third sector to effectively plan services that will support individuals in recovery to fully develop a sense of citizenship and become valued in their community. Key to this is reducing stigma and maximising opportunities for development and growth.

A validated patient reported experience measure (**CARE**) used in the MSK Physiotherapy Service seeks feedback from patients on their experience of the therapeutic interaction. The average score was 48.4 out of 50 demonstrating the empathy and interpersonal effectiveness of our excellent clinicians.

Easy and timeous access to advice and support is key to ensuring all our citizens have access to the right support at the right time; supporting well-evidenced outcomes which are achievable with early intervention.

3. Resilience

The Health and Social Care Partnership is committed to ensuring that those who use our services are confident that the care delivered by all parts of primary and community care is **safe, effective and person centred**. The Health and Social Care Partnership, alongside key stakeholders is creating a culture of ongoing review of decisions taken, and interventions made, whilst encouraging comment and input from service users, carers and the wider public.

There will be agreed care pathways to assist both staff and service users to understand and achieve the best approaches for care which is safe, person centred and clinically and cost effective. It is recognised that the combination of **targeted action within primary and community care**, and both informing and empowering the individual to manage well with a long term condition, will improve their sense of wellbeing and avoid repeated admissions to hospital.

The Health and Social Care Partnership will continue to support **people who live in care homes** who need to go to hospital to access the right level and type of care and to be able to return home as soon as is possible and appropriate. Continuing to work with partners as part of the Providers Forum and Commissioning Consortium.

My Home Life is a social movement that aims to enhance the quality of life for all who live, die, visit and work in care homes through transformational change and encourages partnership working through appreciative relationship centred practice. The Health and Social Care Partnership has been pleased to support this programme which has been delivered by staff from the University of the West of Scotland and demonstrates a strong partnership arrangement between these bodies and Scottish Care, the representative body for Independent Care Providers.

Recovery groups and cafes will continue to be developed, to enhance those already in Clydebank and Dumbarton. They offer peer support, social activities and a way back to mainstream community activities for those affected by issues associated with addictions. New family and carer support services are being developed in West Dunbartonshire, offering vital peer-based support for families affected by someone else's substance use. These activities reduce social isolation and stigma, provide information and advice, and promote self-management.

There will be a review of the local **alcohol treatment pathway**, allowing us to explore how we can more effectively engage with those longer term drinkers who do not identify abstinence as their goal, in particular where there are concerns in regard to vulnerability and cognitive impairment. Ensuring those already receiving other services are offered specialist support appropriate to their needs.

The Health and Social Care Partnership's community addiction services, alongside partners, will be reviewing the clinic model of service delivery particularly for **Opiate Replacement Therapy**. By conducting tests of change, we will be able to test a more assertive outreach approach, with individuals being seen at home to support a family inclusive approach.

Local protocols will be developed in response to perceived gaps as a result of reflective practice for example **Benzodiazepine prescribing guidance**. As previously mentioned there will be a focus going forward on harm reduction and assertive outreach which will ensure that we are engaging with those most at risk in our communities, alongside community planning partners.

Locally we will implement the recommendations from The NHS Education Scotland Report (June 2018) in the delivery of a matched approach to the delivery of **psychological interventions in trauma informed substance misuse services**. We look forward to the recruitment of a Clinical Psychologist and we will support staff to improve their skill and knowledge in the area of ACES and trauma informed

approaches; which also aligns to our approach to addressing behaviours linked to domestic abuse.

Mental health services continue to integrate with partners to give rapid access to a range of supports and treatments which meet the needs of local residents. By building community resilience, we aim to reduce delays in getting access to the correct care and treatment through new investment in partnership working within local health and care centres. We aim to provide a range of self-management supports, developed in partnership with patients, to help citizens build their own resilience around their mental health and well-being.

By working with the third sector and other partners, we are seeking to develop **public access e-health resources** and self-help and condition management packages for individuals to access. This will be aligned to the investment in a **Wellbeing Nurse** who will work with GPs offering access to support for people with common mental health problems and emotional distress.

Well-being is a priority within our communities but also within our staff group and moving forward the Health and Social Care Partnership continues to support the **well-being and resilience of our own staff** through making training, awareness and support opportunities available.

The Health and Social Care Partnership, alongside community planning partners have agreed a partnership approach to **addressing domestic abuse**; which focuses on primary prevention within schools, workplaces, organisations and communities across West Dunbartonshire. This emphasis is on behavioural change building the knowledge and skills of individuals across all sectors and communities; and delivering a progressive shift in the structural, cultural and societal contexts in which violence occurs. By prioritising primary prevention, we are able to challenge the notion that domestic abuse is inevitable or acceptable.

As a Health and Social Care Partnership, we have recognised the historical low numbers of people over the age of 65 with **functional mental illnesses** that are in treatment. As a result, we are investing in cognitive behavioural therapy within the community provided by community nurse specialists. We expect people to have a diagnosis of dementia at an earlier stage which will help improve their outcomes and live independently for longer within the community. .

The Health and Social Care Partnership is committed to ensuring carers have access to support to continue in their caring role by working with Carers of West Dunbartonshire, Y Sort it and carers to ensure **carers** are included within the assessment and care planning processes for those they care for and ensure that all carers are offered assessment and support as carers and that their voice is heard.

The newly refreshed Care Manager **Guidance for Self Directed Services** places those who use our services at the centred of the assessment and care planning process; creating a person centred ethos of delivery of care to meet individual care needs. This supports individuals to maintain independence and access a range of appropriate support at the right time to meet their identified outcomes.

The Health and Social Care Partnership continues to be committed to the long established **Local Engagement Networks**, chaired by local people. Aware that time is precious; the Local Engagement Networks have been developed as a dynamic forum for local people to engage, share their experiences and support operational services to ensure that every user can gain the maximum benefit from the services provided by the Health and Social Care Partnership. Each Network meeting has operational service managers present to listen to people and to review issues around distinct community health and social care services; people have an opportunity to feedback on how services could be improved across the local area.

4. Assets

Our staff are our most valuable asset and the Health and Social Care Partnership is committed to providing **ongoing support and training to all staff** to ensure they are working effectively and are well-prepared to deliver services in a complex system.

Both employing organisations, West Dunbartonshire Council and NHS Greater Glasgow and Clyde, have continuous development as well as supervision and management programmes for staff at all levels. Front-line practitioners continue to have the opportunity to access a range of training and learning resources as well as access to professional forums for all disciplines for reflective practice, case review and learning, peer support and professional discussions.

For those living within care homes, the Health and Social Care Partnership, alongside Scottish Care, will expand opportunities for inter- generational learning; by creating **“enjoy each other’s company”** programmes with local nurseries, early years centres and primary school children visiting care homes.

Using the newest technology available within the new care homes, the Health and Social Care Partnership is creating teenager and older people social activities; by **promoting digital inclusion** for older people and young people providing internet café sessions in all Health and Social Care Partnership care homes.

The **Local Housing Strategy** describes the housing sector's provision of appropriate information and advice to help individuals make informed choices and that older people and those with additional housing needs are assisted to remain in and make best use of existing housing stock.

Additionally the Health and Social Care Partnership is working with the wider housing sector to invest in new housing, the **Strategic Housing Investment Plan**, aims to meet the housing needs of older people and to provide low level preventative support. The significant cohort of younger adults with complex health conditions who also require a strategic approach to their housing needs will be a focus for the Health and Social Care Partnership and housing sector over the life of this Plan.

Within a commitment to the principles of the **Housing Contribution Statement**, the Health and Social Care Partnership alongside the housing sector is developing specialist models of housing; within Dunbritton Harbour Development, St Andrews Housing Development and Haldane Housing Development for people with learning disabilities who are ordinarily resident within West Dunbartonshire and to support them in their aspiration towards independent living.

5. Inequalities

The **Strategic Planning Group** in West Dunbartonshire continues to develop and seeks to ensure leadership from the group in developing the Strategic Commissioning Plan, review of performance and involvement from the members of the group in the wider planning arena. The group will continue to act throughout the lifetime of the Plan to understand and plan for the challenges ahead.

West Dunbartonshire has well established **locality planning** whose role and function is to jointly assess need, prioritise and plan how all resources, irrespective of their origin, can best be deployed in pursuit of the delivery of the National and Local Outcomes; and to be the local focus for service delivery and support by organisations from across the sectors to the population or communities within the area.

The **Locality Groups in Clydebank and Dumbarton/Alexandria** provide local district forums for the partners to promote details of their local initiatives, projects and to seek details of partner programmes to ensure the maximum health gain for the people of West Dunbartonshire.

The Health and Social Care Partnership, alongside Carers of West Dunbartonshire and carers, have been working for two years in preparation for the **enactment of the Carers Act**. This work has produced a programme of activity which continues to be a clear commitment of the Health and Social Care Partnership.

The new Health and Social Care Partnership's **Carers Strategy** has been developed alongside carers and carer organisations and describes the key local priorities as identified by carers and in line with the requirements of the Carers Act.

The Health and Social Care Partnership's **Short Breaks Statement** has been developed using national and local learning to create innovative and appropriate short breaks and respite opportunities for carers in West Dunbartonshire.

Support for carers continues to be funded and supported by the Health and Social Care Partnership directly and by supporting third sector partners including Carers of West Dunbartonshire. Support for carers, from the Health and Social Care Partnership, can be accessed easily through **Tier 1 Carer Conversation and Tier 2 Self Directed Services Assessment**. Carers have the opportunity to effectively manage their caring role and access support as required and to help them to continue in their caring role.

The Health and Social Care Partnership alongside carers and carer organisations is developing **emergency plans** to ensure the carer for person is always supported and carers can continue to maintain their caring role.

By working in partnership with the Carers of West Dunbartonshire a range of **information, advice and support services for carers** are now in place in West Dunbartonshire. Carers can access face to face and telephone contact, peer group support, health interventions, financial inclusion, short breaks and respite provision for young carers and adult carers.

In addition, **carers support workers** are based within the Health and Social Care Partnership's integrated, multi-disciplinary teams to ensure carers' needs are at the centre of person centred planning for the cared for person and the carer.

The Health and Social Care Partnership is committed to supporting the housing sector to sustain the tenancies of vulnerable households by providing early support and social care interventions; and by working with partners to promote and encourage the payment of rent, signing up for benefits and access to employability support via Working 4U. For those with complex needs, the Health and Social Care Partnership is working with the housing and third sector to seek to develop supported housing solutions for younger adults; ensuring appropriate and person centred **Housing Options**.

Working4U is a Council run service which supports people who are unemployed return to work, providing assistance with benefits and debt, learning, digital literacy and preparation for work; the Health and Social Care Partnership continues its commitment to working in partnership with colleagues in Working4U and third sector partners particularly around the **Child Poverty Action Plan** and benefits maximisation across our communities.

Making the Change – Children and Young People

Disadvantages experienced from birth will impact adversely the life chances of our children. Evidence tells us that by the time children reach their third birthday, those from deprived backgrounds can be as much as a year behind their peers in **cognitive and social development**.

The impact of this disadvantage can be seen throughout an individual's life; manifesting in their poor health, employment opportunities and social outcomes. By **acting swiftly in identifying and dealing with risks** to children, young people and families, we can prevent these risks from becoming long-term problems. The Health and Social Care Partnership, with partners, will continue to build the capacity and resilience of children, young people and families.

We will continue to be focusing on the **health and wellbeing needs** of all children in our community, with recognition that some children, young people and families have additional vulnerability, risk and need.

As such the Health and Social Care Partnership and our partners have agreed that the following groups will benefit from additional support:

Children and young people who are looked after and looked after and accommodated including those looked after 'at home'	Children and young people affected by issues such as domestic abuse, mental health and substance misuse
Children and young people where safety and wellbeing is an issue	Young people leaving care young people involved in offending
Children with or affected by disability	Children in need/vulnerable children
Those at risk due to a vulnerable pregnancy	Children who are young carers

In order to ensure that we fulfil our commitment to supporting children and young people to remain in their communities wherever possible and appropriate, we will commit to a **service review and redesign across children's services** within the Health and Social Care Partnership.

This will consider the means of collectively achieving more efficient and effective **prioritisation and targeting of resources**, and will be undertaken along with inputs

from key partners and stakeholders with the aim of significant and lasting change within a service delivery model for vulnerable children and young people. Improving the outcomes of children and young people is our overarching priority and will guide our service redesign, informed by the voices of our children and young people.

Supported through our engagement with the national **root and branch review of looked after children services**, the Health and Social Care Partnership will ensure that our statutory services have appropriate capacity moving forward to enhance family support and all aspects of care for our looked after children.

This will include our ongoing priority of supporting children and young people to remain in their communities wherever possible and appropriate and a shared multi professional and service user approach to developing an effective, **targeted model of intervention to support children**, young people and their families in West Dunbartonshire.

The over-arching commitment alongside our community planning partners to **Getting It Right for Every Child** puts the needs of all children and young people at the centre of the planning, delivery and review of services.

By recognising connectivity across key priority areas, we will further strengthen links between our identification and interventions.

1. Early Intervention

Health and Social Care Partnership adult services will work to identify parental need and risk with regard to their adult clients who have parenting roles. We will implement our **'Child Wellbeing Assessment'** as an initial stage assessment for adults being offered support through our services, with specific initial emphasis on adults affected by **mental ill health and addiction**. This reflects that parental mental health, addiction and domestic abuse continue to be primary factors in identifying and mitigating risk for children and young people in West Dunbartonshire.

The Health and Social Care Partnership will provide a tiered approach to offending behaviour via our **Whole Systems Approach** to provide early and effective intervention and in targeting more harmful behaviour and risk through more intensive approaches. Focusing on redevelopment of the Whole Systems Approach in considering young people aged up to 18 years, reflecting Getting It Right for Every Child and corporate parenting responsibilities. Children's and Criminal Justice services will maintain a model of proactive discretionary decision making in respect of the best approach to addressing offending and at risk behaviour with young people aged over 16.

Over the next three year, we will prioritise the implementation of the revised **health visitor universal pathway** as a key priority area for children's services, increasing the number of universal visits from three home visits to eleven home visits, eight of which are in the first year of life, and includes one in the antenatal period. This allows the opportunity for the earliest building of therapeutic relationships between health visitors and families, and promotes early intervention and prevention.

The Health and Social Care Partnership, alongside NHS Greater Glasgow and Clyde will work to roll out of financial incentives for **smoking cessation in pregnancy** given the high rates of smoking within West Dunbartonshire.

West Dunbartonshire will maintain its excellent **immunisation uptake** rates for routine childhood immunisations, while implementing and establishing local community immunisation teams, in line with the Primary Care Improvement plan. This service will provide more flexibility to families in clinic attendance in order to promote earlier engagement and further improve immunisation uptake

The **Family Nurse Partnership** service will be based in West Dunbartonshire; this is an intensive, preventive, home-visiting programme for first time young parents that

begins in early pregnancy and ends when the child reaches the age of two. The programme goals are to improve maternal health; improve pregnancy outcomes child health and development; and improve parent economic self-sufficiency. This is a licensed, structured programme delivered by specially trained family nurses who have mainly been drawn from public health nursing/health visiting/midwifery and mental health.

West Dunbartonshire Health and Social Care Partnership will build on the success of achieving the **UNICEF Gold sustainability award**, which recognises the high standard of practice and service for infant feeding within West Dunbartonshire. With focus on families living in the most deprived areas who will be our priority over the next 2 – 3 years, with the aim of increasing breast feeding rates.

2. Access

The Health and Social Care Partnership will support children and young people affected by **disability and issues of mental health**; social work and health care staff within community teams through specialist knowledge, skills and intervention, including a review of commissioning and procurement of services in supporting the best outcomes for all children affected by disabilities in accessing community based supports.

Use learning from **Self Directed Support** to develop further more flexible and person centred approaches to family support. We will use learning from our successful approach in supporting transitions for children with disabilities in receiving proportionate person centred support into adulthood.

We recognise that children can be vulnerable for many reasons, including lack of opportunity, developmental delay, and physical disability. Some will require additional input from **Specialist Children's Services** to ensure that they achieve their full potential. The Community Paediatric Team will continue to provide specialist health support both in health locations and also through staff outreach to schools, nurseries and clients own homes.

The Health and Social Care Partnership will further develop and embed our **Initial Referral Discussion** model across core agencies to ensure early multi agency communication and analysis identifies and addresses children and young people at risk proportionately and timeously, informed by national work to improve this process

We will continue to work closely with our partners across community planning colleagues to ensure that children and young people receive the advice, support and intervention they require to enable them to be as **active and independent** as possible; participating to their potential in education, self-care and leisure activities.

Universal services delivered through community health visiting services includes an ongoing commitment to embedding the **universal health visiting pathway** and the use of the Neglect Toolkit across health and social work to raise awareness across all community planning partners.

In partnership with Centre for Excellence for Looked after Children, the Health and Social Care Partnership is committed to embedding **Permanence and Care Excellence Programme** to review and develop our processes to improve the journey of children through permanence planning and to ensure that children reach a permanency decision more quickly and with less drift, providing improved certainty and clarity, only after all possible options to returning to the birth family have been fully explored. We will be seeking to move children through permanency faster and improve our consideration of returning children home.

The **school nursing service** in West Dunbartonshire is in a period of service development, in line with the national priority areas for school nursing, and reflecting the NHS Greater Glasgow and Clyde three key areas of emotional health and wellbeing, vulnerability and transitions.

The Health and Social Care Partnership will use Scottish Government investment in the **school nurse service** to address the wellbeing needs of children and young people by:

- As part of the development of the school nurse service, Build on the established relationships between the school nursing service and child and adolescent mental health service (CAMHS)
- Provide Tier 2 support for mild to moderate anxiety for children and young people who do not require the specialist intervention of CAMHS.
- Strengthen links between the Looked After Children's (LAC) Nurse and Children and Families social work services by providing a health assessment for children and young people who are looked after at home.

3. Resilience

West Dunbartonshire has also established a clear approach to supporting resilience and trauma informed practice across services, supported through development of the Health and Social Care Partnership **multi-agency Hub**.

The Health and Social Care Partnership will ensure that **trauma informed practice** is at the core of health visiting and school nursing practice, in working with children, young people and families who have experienced **adverse childhood experiences**. We will develop these approaches through training the workforce in trauma informed approaches to identify adverse childhood experiences early, and support and empower families to mitigate against the effects of adversity in childhood. The Health and Social Care Partnership are committed to building on our sector leading progress, through the creation of a **dedicated nurse-led service** committed to supporting the awareness raising and trauma informed approach in adverse childhood experiences.

The Health and Social Care Partnership will support a **systemic family therapeutic** approach to assessment and intervention, particularly to support children and young people returning home and to reduce the risk of breakdown of fostering placements for children and young people.

The Health and Social Care Partnership dental health support worker team focus on improving the **oral health of the pre 5 population**. They now link with all local authority and partnership nurseries within West Dunbartonshire to support tooth brushing programmes in nurseries, as well as following up children who are not registered with a local dentist with the aim of improving oral health and dental registrations in the under 2 population.

Allied Health Professions within West Dunbartonshire have been instrumental in the build and development of **KIDS (Kids Independently Developing Skills)** a digital platform that provides universal and targeted information and resources for children and young people, carers and the wider team around the child. This resource will continue to be widely used in health and education settings and by families themselves to support self-management, without the need for onward referral to specialist children services.

4. Assets

Supported by the Life Changes Trust, our **West Dunbartonshire Champions Board** creates a unique space for care experienced young people to influence service design and delivery in areas which affect them and will be part of all aspects of service redesign. The Champions Board Coordinator and three care experienced workers have been appointed as part of the Champions Board to work alongside the Health and Social Care Partnership and other corporate parents to raise awareness of corporate parenting responsibilities and influence positive change.

This provides a **voice for care-experienced young people** and reflects our commitment to the Scottish Care Leavers Covenant. This will be expanded with continued commitment to focus more strongly on the voices of all our Looked After children and young people and learning from the experience of the Champions Board to shape and improve services.

The Health and Social Care Partnership will build on the success of our **parenting programmes** within West Dunbartonshire, using Incredible Years groups to appropriately support our families to build their children's resilience and their capacity as parents.

The Health and Social Care Partnership will maintain our strong links with **Early Years Education** in West Dunbartonshire, through the development of professional networks and ensuring the transition from home to nursery is supported through our universal services.

5. Inequalities

The Health and Social Care Partnership will further embed our **Kinship Care Strategy** and practice, utilising national and local learning and will work with local Kinship Carers to involve them in strategic planning and to develop opportunities for supports for kinship carers.

For those children and young people who have had to take on a caring role, the Health and Social Care Partnership will ensure that they are recognised by all partners as children and young people first; as such we are committed to assessing

and supporting them within this context. Working with our third sector partners Y Sort It to ensure joined up and appropriate supports are in place for **young carers**.

A range of measures to reduce and address **young people involved in offending** behaviour and continued adoption of ‘Getting it Right for Young People Who Offend’ will reflect young people who offend as children and young people in need, upholding a balance between addressing the individual needs of vulnerable young people and community safety.

The HSCP, with partners, will prioritise **accident prevention** in our under five population. As part of the revised universal pathway, efforts to address the high rates of accidental injury in the pre 5 population will be one of the key priority areas, recognising that accidental injuries are more likely to occur for those living in deprived areas.

The Health and Social Care Partnership will ensure that efforts to address **child poverty** by maximising income and reducing living costs are undertaken and those seeking services can access support easily and timeously. Working with Community Planning West Dunbartonshire to deliver the **Child Poverty Strategy**.

Making the Change – Criminal Justice

Health and Social Care Partnership Criminal Justice services undertake a range of statutory duties concerned with the **assessment and supervision of offenders** subject to community sentences or subject to supervision following a custodial sentence.

The same demographic and financial challenges already referred to in this Strategic Plan are also reflected within the population of West Dunbartonshire of people who offend. It is essential for there to be **joint partnership response** to addressing offending behaviour in our communities and being able to provide effective interventions to reduce the impact of offending behaviour and the likelihood of reoffending.

The national average for reconvictions per individual is 0.47%; East and West Dunbartonshire have combined rates published which reflect the national average. In West Dunbartonshire both the **reconviction rate** and average number of reconvictions per individual have **generally decreased over the past decade**; over the past 10 years, the reconviction rate decreased by 5.4% from 32.4% to 27.0%. This is an encouraging picture, however as an Health and Social Partnership, we are aware of the serious impact that offending has in our communities and also how offending affects the ability of individuals to move on and begin to build a positive, achieving future. As such, the management and delivery of **criminal justice social work services** needs to continue to develop and evolve.

Until March 2017, West Dunbartonshire Health and Social Care Partnership hosted a tripartite Criminal Justice Partnership, on behalf of community planning partners in West Dunbartonshire, East Dunbartonshire and Argyll and Bute Council. The national shift away from Community Justice Authorities, where local authority areas worked together to plan and deliver services has led to a return to single authority accountability, alongside the development of local **Community Justice Partnership** which provide opportunities to improve planning and delivery of services in West Dunbartonshire.

Criminal Justice Social Work Services are measured against a number of **National Outcomes and Standards** and key performance indicators, this joint framework ensures an ability to map progress within our evolving service and measure impact for individuals following interventions.

The role of technology in improving communication with offenders is a key priority and their compliance means that, during the next three years we will:

- maximise the use of our Information Technology including GeoPal and our social work electronic information systems
- develop monthly performance reporting to address any issues with individuals complying with community based disposals.

West Dunbartonshire has agreed a **Community Justice Outcome Improvement Plan 2019-20**; this alongside the national Health and Social Care Standards will guide our work with all our partners to address common issues which make it more difficult for people to live their lives without offending; joint working with services linked to support with addiction, mental and physical health issues are vital as well as supporting the re-integration of offenders to their communities by supporting them to access appropriate housing, employability and other community services.

As with children and young people's services, West Dunbartonshire Criminal Justice Social Work Service provides opportunities for feedback from people who have committed offences. During the lifespan of the Community Justice Outcome Improvement Plan, it will be important for the Health and Social Care Partnership to improve the range of feedback we are seeking and receive both from people who commit offences and those who benefit from our services; for example unpaid work undertaken in the community.

As part of our **person-centred approach to interventions**, the Health and Social Care Partnership recognises the impact that adverse emotional and physical trauma can have on people's risk of offending. As a result, West Dunbartonshire's Criminal Justice Social Work Service, alongside the Community Brain Injury Service, will continue to participate in research by Glasgow University on the prevalence of **head injury amongst people involved within the criminal justice system**.

The service will also explore using the '**Justice Star**' **assessment** which could improve our ability to measure change within individuals during supervision in the community which could support an effective, responsive and flexible approach to supporting individuals to move away from offending with improved outcomes.

Moving forward, the Health and Social Care Partnership is undergoing a **Criminal Justice Inspection**; a process which is undertaken by the Care Inspectorate this is an opportunity for reflection and self-evaluation across the Community Justice Partnership as well as shared learning and good practice models from other areas.

Housing Contribution Statement

The joint Housing Contribution Statement sets out the arrangements for carrying out the housing functions delegated to the West Dunbartonshire Health and Social Care Partnership Board under s29(2)(a) of the 2014 Act; and, in accordance with s(29)(2)(c) of the Act, sets out an overarching strategic statement of how the Partnership Board intends to work with housing services (whether delegated to it or not) to deliver its outcomes.

The Housing Contribution Statement sets out the role and contribution of the local Housing Sector – through the offices of West Dunbartonshire Council in its role as a strategic housing authority - in meeting the outcomes and priorities identified within the Strategic Plan.

As such, the Housing Contribution Statement acts as the 'bridge' between the Local Housing Strategy and the Strategic Plan for West Dunbartonshire.

Articulating the role of the local housing sector in the governance arrangements for the integration of health and social care.
Providing an overview of the shared evidence base and key issues identified in relation to housing needs and the link to health and social care.
Set out the shared outcomes and service priorities linking the Strategic Plan and Local Housing Strategy
Set out the current and future resources and investment required to meet these shared outcomes and priorities, and identify where these will be funded from the integrated budget and where they will be funded by other (housing) resources
Provide an overview of the housing-related challenges going forward and improvements required.
Cover key areas such as adaptations, housing support and homelessness, including articulating the housing contribution across a wide range of groups including older people and those with disabilities, mental health and addictions.

Local Housing Strategy Outcome under the Addressing Particular Housing Needs theme reads:

People with particular needs have access to suitable housing with any necessary support to optimise their independence and wellbeing.

The key highlighted areas where the Housing Sector (through the office of the Council as strategic housing authority) and the Health and Social Care Partnership will be working together in the coming period to continue to:

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

Making the change through Partnership Working

Integration and joint strategic commissioning offer real potential for the driving forward of **transformational change in health and care** in Scotland. Key to this is maximising effective cross-sector relationships; ensuring a culture of true partnership, shared language, shared understanding and clear access and engagement routes which bring a level of consistency and make the commissioning landscape easier for all to navigate.

An intelligent **commissioning plan** begins to explore a rights-based approach and prioritises smart investments that not only represent best value but crucially consider the broad impact of investment, across national outcomes and across those outcomes most important to our communities.

Alongside this Plan, there is a commitment to develop a detailed Commissioning Plan which will take account of the detail of the Strategic Needs Assessment, Annual Performance Report and the Financial Strategy to align the spend to the population need across all sectors. This Plan will be developed in a sector wide approach with all partners, including those in the Strategic Planning Group, having a active role in the Plan's development and implementation.

The Scottish Government has recognised the importance of **third sector engagement** in this; further identifying the importance of a coherent and coordinated structure at local authority level.

The third sector in West Dunbartonshire is diverse in scope, size and function. The nature of the sector is complex with West Dunbartonshire CVS (the local Third Sector Interface) providing a valuable 'front door' for the Health and Social Care Partnership, offering opportunities for the third sector to:

Find a route into new and emerging health and social care structures	Become an integral part of the strategic commissioning landscape
Engage and collaborate effectively; make a difference; and enable change as a result	Gain recognition for the quality and outcomes delivered.

Within the partnership structure, the role of the Third Sector Interface is to also represent the interests of the third sector and explicitly capture, codify and convey sector information, experience and perspective. This includes raising the profile of the sector as contributing partners – capturing activity at local level, with evidence to inform outcomes and making visible the assets of the whole system.

Undertaken since 2004, the **annual WDCVS Sector Census**, most recently completed in October 2018, identified 911 active third sector organisations with 20% of organisations engaged directly in health and wellbeing activity and 13% in the field of social care; 48% of organisations identified a key role in reducing social isolation and loneliness.

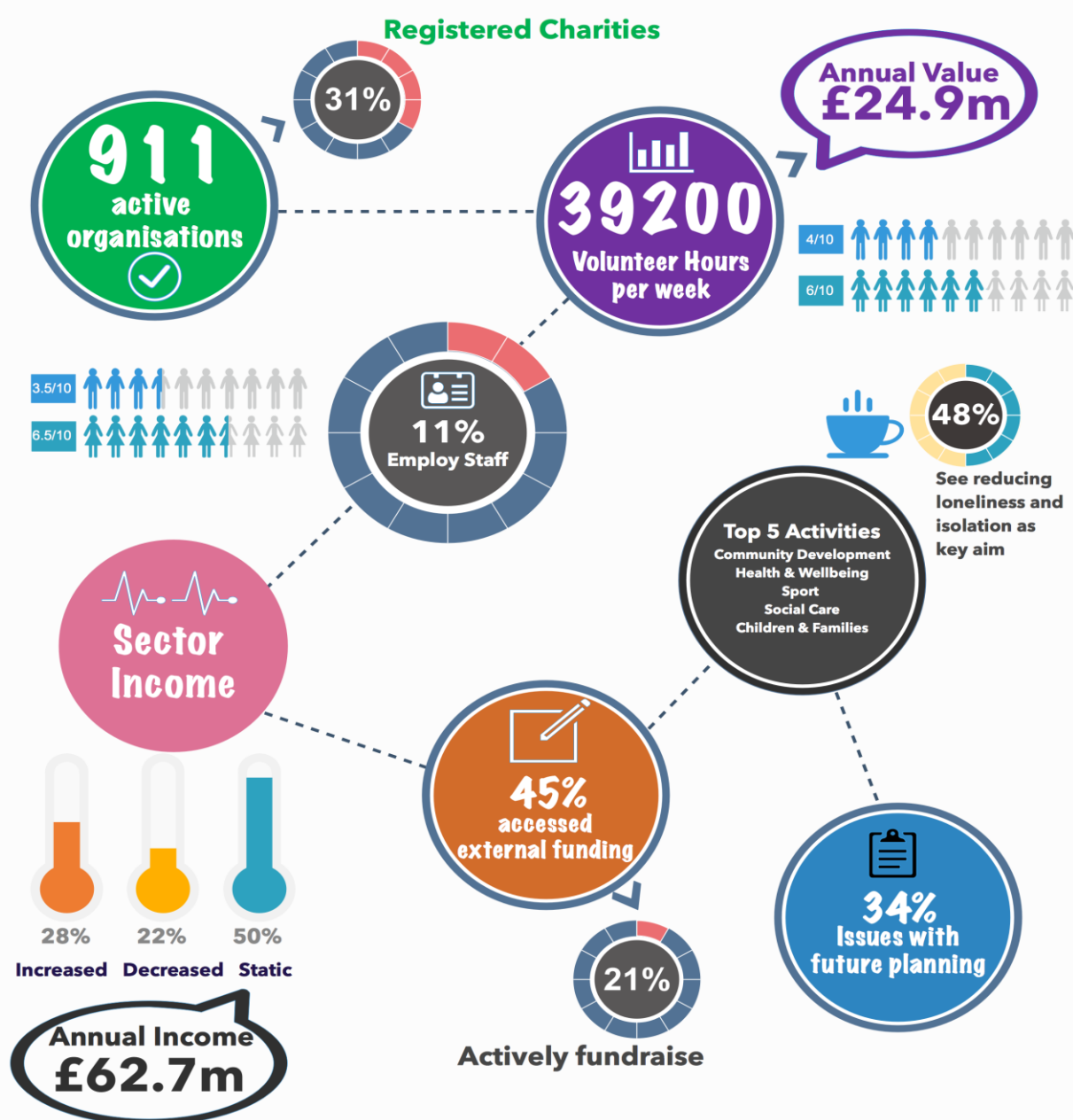
In addition to the capacity impact of the **39,200 volunteer hours** provided by local residents, the adult volunteering rate of 38% represents a strong core of citizenship and cohesion; an important asset base on which to support the development of increasingly confident, resilient communities, co-producing their own solutions as active citizens with a focus on upstream prevention actions.

The census identifies the third sector as a **significant local employer** in the West Dunbartonshire area with a workforce of 977 staff; 68% employed on full time contracts and 64% female. Developing and implementing strategic workforce development across statutory, third and independent sectors providers offers the opportunity to up-skill a whole system workforce and breakdown perception barriers.

85% of direct service organisations in the sector highlight their active use of monitoring and evaluation methodologies – many bespoke in nature due to the diversity of activity undertaken and the inability of the sector to secure partner investment to support certain identified 'core' costs such as adopting recognised quality assurance frameworks. Sector concerns around an ongoing focus on output monitoring and time-consuming duplications in reporting requirements, support the development of intelligent commissioning and the development of a common evaluation framework based on realistic deliverables and outcomes.

Our strategic commissioning approach, in partnership with West Dunbartonshire CVS and Scottish Care, will embrace positive ongoing third and independent sector engagement in service planning and ongoing assessment of the impact of commissioning practice on the local supplier base.

West Dunbartonshire Third Sector Census 2018



Measuring Change

Resources are used effectively and efficiently in the provision of health and social care services.

The integrated performance framework includes children's outcomes and criminal justice outcomes as well as the National Health and Wellbeing Outcomes.

The Health and Social Care's Annual Performance Report sets out the arrangements developed and adopted for the governance of local actions and activities within a reporting context.

The Annual Performance Report details progress on delivering upon the strategic commissioning priorities as described within the Making the Change section of this Plan.

The Annual Report includes reporting on the key strategic performance indicators provided here and will be augmented by data on a variety of monitoring indicators, including our equality outcome indicators as committed to within our Equalities Mainstreaming Report.

The strategic performance framework for this Strategic Plan – and the key strategic performance indicators that are set out overleaf - then 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.

The Health and Social Care Partnership has a well established integrated **Performance Management Framework** to monitor and report performance across all service areas against the National Health and Wellbeing Outcomes, National Outcomes for Children and Young People, National Outcomes for Criminal Justice and the Core Integration Indicators developed by the Scottish Government. This has formed the basis of our previous Annual Performance Reports

National Health and Well-being Outcomes

Number of delayed discharges over 3 days non-complex cases

Number of acute bed days lost to delayed discharges for people aged 65+

Number of acute bed days lost to delayed discharges for Adults with Incapacity aged 65+

Number of emergency admissions for people aged 65+ and as a rate per 1,000 population

Number of unplanned acute bed days for people aged 65+ and as a rate per 1,000 population

Number of emergency admissions for people of all ages

Number of attendances at Accident & Emergency (Emergency Departments & Minor Injuries Units)

Number of people receiving a re-ablement intervention

Percentage of people with assessed Care at Home needs and a re-ablement package who have reached their agreed personal outcomes

Number of people in anticipatory care programmes

Number of people in receipt of Telecare

Number of people receiving Care at Home

Number of Care at Home hours received by people aged 65+ and as a rate per 1,000 population

Percentage of people aged 65+ receiving personal care

Percentage of people aged 65+ assessed with complex needs living at home or in a homely setting (local definition in development)

Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment

Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)

Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)

Percentage of people newly diagnosed with dementia who have received 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

Percentage of people seen within 4 weeks for musculoskeletal physiotherapy services

Number of people receiving Home Care Pharmacy Team support

Prescribing cost per weighted patient

Compliance with Formulary Preferred List

Percentage of people waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

Percentage of people who started Psychological Therapies treatments within 18 weeks of referral

Percentage of Adult Support and Protection clients who have a current risk assessment and care plan

National Outcomes for Children and Young People

Percentage of children and young people starting treatment from Child and Adolescent Mental Health Service (CAMHS) within 18 weeks of referral

Average number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services

Percentage of Measles, Mumps & Rubella (MMR) immunisations at 24 months

Percentage of Measles, Mumps & Rubella (MMR) immunisations at 5 years

Percentage of looked after children being looked after in the community

Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care

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

Percentage of children on the Child Protection Register who have a completed and current risk assessment

Percentage of child protection investigations to case conference within 21 days

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

Number of referrals to the Scottish Children's Reporter on care and welfare grounds.

National Outcomes for Criminal Justice
Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling
Percentage of Community Payback Orders attending an induction session within 5 working days of sentence
Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence
Number of referrals to the Scottish Children's Reporter on offence grounds.

The national outcomes above are further enhanced by feedback from the Care Inspectorate linked to inspection processes both regulatory and strategic; analysis of feedback and complaints and recognition of local good practice shared across the Health and Social Care Partnership to provide a multi-faceted picture of local services.

Workforce Planning for Change

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

As outlined previously within this Plan the increasing population demand and number of policy drivers there is a need to transform services to meet future demand. The first **integrated Workforce and Organisational Development Strategy** and support plan was developed for the lifetime of Strategic Plan for 2015 – 2018.

The intention moving forward is to integrate this into the strategic planning process and develop an annual support plan for lifetime of Strategic Commissioning Plan. A Workforce and **Organisational Development Strategy** will be developed to accompany the Strategic Commissioning Plan.

Effective workforce planning ensures that services and organisations have the necessary information, capability, capacity and skills to plan for current and future workforce requirements. This means planning a sustainable workforce of the right size, with the right skills and competencies, which is responsive to health and social care demand and ensures effective and efficient service delivery across a broad range of services and locations.

Fortunately West Dunbartonshire has had the benefit of a strong local track record in developing a **joined-up workforce planning** across health and social care services, coupled to a clear commitment to the principles of Staff Governance: i.e. that staff should be well informed; appropriately trained; involved in decisions which affect them; treated fairly and consistently; and provided with an improved and safe working environment.

Overview of the Workforce		The split is 69% Council Employees and 31% NHS employees	
The headcount for the Health and Social Care Partnership as of 1 st March 2018 was 2,395, equating to 1,774 whole time equivalent posts		There has been an increase in headcount and reduction in whole time equivalents since 2015 this may be due to staff opting for more flexible working patterns	
There are 85% females and 15% males working for the Health and Social Care Partnership		Council employees make up approximately two-thirds of the Health and Social Care Partnership workforce by headcount, with NHS-employed staff filling the remaining third.	

This age profile highlights the Health and Social Care Partnership has an ageing workforce

60% of the workforce are over 46 years of age 30% of staff working in Health and Community Care are over 60 years	45% of the workforce is over 50 years old, with the largest age band falling between 51 and 56 years of age
10% of the workforce are over 60 years old, with some staff working beyond the “historic” retirement age of 65 years; and a small number of mostly council-employed staff working into their seventies	Only 1% of the workforce are under 20 years old

These figures above have remained static since the 2015 workforce plan and may be due to some staff still having preserved benefits under old pension schemes, which means staff are opting to leave early.

To deliver future service delivery there will need to be changes to the workforce to meet future demand. We have developed Health and Social Care Partnership Workforce and Transformation Model which explains how we will do this:

HSCP Workforce Transformational Model



A key component of development of our Workforce and Organisational Development Strategy is aligning our **resources** to our needs and taking into account some of our workforce challenges such as our ageing workforce.

Effective workforce planning will ensure that services have the necessary information, capability, capacity and skills to plan for current and future workforce requirements. This means planning a sustainable workforce of the right size, with the right skills and competences, which is responsive to our needs.

The Health and Social Care Partnership will need to rebalance our people against demands so we can deliver for the future. This will be achieved by **redesigned roles and services**, for example our Focussed Intervention Team and the review of children's service, learning disability services and care at home services.

Health and social care services across Scotland are, and will, have to continue to manage rising demands, not least related to demographic change, increasing entitlements, changing public expectations and extremely challenging finances.

Audit Scotland have stated that public bodies need to think differently about what they deliver - prioritising activities, redesigning services and re-shaping their workforces. Some changes will be nationally driven and others locally determined. This is certainly the case in West Dunbartonshire, and just as true for the Health and Social Care Partnership as it is for other areas of public service.

The Health and Social Care Partnership has an excellent foundation of working with partners through community planning structures; **focussing on strong partnerships** and supporting development of collaborative culture that will continue to embrace new ways to redesign health and social care .

Clinical and care governance

People who use health and social care services are safe from harm.

The Health and Social Care Partnership has established clinical and care governance structures and processes by which accountability for the quality of health and social care is monitored and assured, supporting staff in continuously improving the quality and safety of care and ensuring that wherever possible poor performance is identified and addressed.

Effective clinical and care governance arrangements are in place to support the delivery of safe, effective and person-centred health and social care services within integrated services.

The Health and Social Care Partnership, through the Chief Social Work Officer, Lead Nurse and Lead AHP, who have established unified quality care and professional governance arrangements; work to ensure **all services are compliant with national standards and guidance**.

The Health and Social Care Partnership through the Senior Management Team and wider compliance and quality assurance structures within the Council and the Health Board, manage and promote local arrangements to ensure safe and effective practice and to **promote culture of learning and support** across the Partnership.

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

As such, the clinical and care governance leadership within the Health and Social Care Partnership continues to be committed to robust clinical and care governance and to supporting staff in continuously improving the quality and safety of care; and ensuring that wherever possible poor performance is identified and addressed.

The **Scottish Government's Clinical and Care Governance Framework** states that all aspects of the work of Integration Authorities, Health Boards and local authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care.

All health and social care professionals will remain accountable for their individual clinical and care decisions. Clinical and care governance within the Health and Social Care Partnership is achieved by co-ordinating three interlinking strands of work:

Robust national and local systems and structures that help identify, implement and report on quality improvement

Quality improvement work involving staff, service users and the public

Establishing a supportive, inclusive learning culture for improvement based on self-evaluation and critical reflection

The Chief Officer has delegated responsibilities, through the Chief Executives of the Council and the Health Board, for the professional standards of staff working in integrated services.

The Chief Officer, relevant lead health professionals and the Council Chief Social Work Officer will continue to work together to ensure appropriate professional standards and leadership.

Integrated managers manage teams of Health Board employed staff, Council employed staff or a combination of both; and promote best practice, cohesive working and provide guidance and development to their team. This includes effective staff supervision and implementation of staff support policies. Where groups of staff require professional leadership, this will be provided by the relevant Health Board professional lead or the Council's Chief Social Work Officer as appropriate.

Public Protection

Through the wider Public Protection agenda the Health and Social Care Partnership will work to ensure that people, particularly the most at risk, are kept safe from harm and that risks to individuals or groups are identified and managed appropriately.

Public Protection in West Dunbartonshire provides a range of measures which can be used together to 'protect our people'. This includes multi-agency strategic planning and operational services which provide protection from harm for children, young people, and adults at risk. In addition effective and robust management of High Risk Offenders through our Multi-Agency Public Protection Arrangements and serious violent offenders provide protection to the community.

- Our multi-agency approach requires agencies to co-ordinate an effective response that gives at-risk individuals the timely and proportionate support they need to reduce the risk in their lives.
- Public protection is integral to the delivery of all adult and children's services within the Health and Social Care Partnership and across key partners. This will continue to be based on West of Scotland Child and Adult Protection Guidance and local interagency procedures.

The development of a Public Protection Coordinator post in West Dunbartonshire in 2018 reflects the commitment to developing a shared public protection framework to provide a consistent and robust approach to public protection.

Working together, partners are strengthening local identification, assessment, support and outcomes for children, young people and adults at risk, including those affected by domestic violence.

There are key priorities for the Health and Social Care Partnership and wider partners, who will :

Work to ensure that people, particularly the most vulnerable, are kept safe from harm and that risks to individuals or groups are identified and managed appropriately.

Continue to ensure that services and processes work to protect all vulnerable and at risk individuals irrespective of age as agreed by the Public Protection Chief Officers Group and our Child Protection Improvement Plan and Adult Protection Improvement Plans.

Continue to implement the Scottish Governments Child Protection Improvement Programme, including early intervention and prevention and within adult support and protection we will develop out responses to specific areas of harm, initially addressing financial harm and mate crime.

Ensure knowledge, skills and awareness across public protection continues to be promoted through the multi- agency training programme, including raising community awareness to ensuring intensive professional training

The Public Protection Performance and Review framework, reported to the Public Protection Chief Officers Group, provides ongoing performance and monitoring reflecting local and national priorities of public protection.

The Framework also provides a vehicle for formal reporting to the Health and Social Care Partnership through the Audit Committee; the report provides a Quality, Care and Professional Governance reporting for the Health and Social Care Partnership Board.

Community Justice

Criminal Justice services undertake a range of statutory duties concerned with the **assessment and supervision of offenders** subject to community sentences or subject to supervision following a custodial sentence. 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 Health and Social Care Partnership is crucial in supporting people and their families and carers through statutory criminal justice services, and importantly through Health and Social Care Partnership and third sector partnership provision: reflecting the often poor physical and mental health of people involved in offending behaviour.

Equalities

To consider the differing needs of people with the nine “protected characteristics” of age; disability; gender; race; religion and belief; sexual orientation; gender reassignment; pregnancy and maternity; and marriage and civil partnership.

The Health and Social Care Partnership as a public sector body has a duty to meet the responsibilities of the Equality Act 2010. The Health and Social Care Partnership has to consider the differing needs of people with the nine “protected characteristics” of age; disability; gender; race; religion and belief; sexual orientation; gender reassignment; pregnancy and maternity; and marriage and civil partnership.

The following information will help the Health and Social Care Partnership planning to fulfil the general equalities duties of:

Eliminating discrimination, harassment and victimisation
Advancing equality of opportunity between people who share a protected characteristic and those who do not
Fostering good relations between people who share a protected characteristic and those who do not

The Health and Social Care Partnership 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 Health and Social Care Partnership published its second Equality mainstreaming report in April 2018 and will be required to publish its third Equality Mainstreaming report by the 30th April 2020.

The Equality Act responsibilities have been expanded for the Health and Social Care Partnership with the introduction of the Fairer Scotland Duty from the 1st of April 2018 of Part 1 of the Equality Act 2010. This requires the Health and Social Care Partnership alongside all the other named public bodies to actively consider how to reduce inequalities of outcome caused by socio-economic disadvantage, when making strategic decisions.

In practice, this means that the Health and Social Care Partnership needs to actively consider how they could reduce inequalities of outcome in major strategic decisions.

The Health and Social Care Partnership has also updated its equality impact assessment processes to enable consideration of socio-economic disadvantage in published assessments.

The Health and Social Care Partnership continues to ensure that the particular needs, characteristics and circumstances of different service users are considered through its interlinked approach including

- Clinical and Care Governance and implementation of the Health and Social Care standards
- Strategic commissioning and planning recognising the needs of those with distinct protected characteristics and the need to consider the impact of poverty on health and social care
- Participation and Engagement ensuring that the needs of particular groups are included in line with major service development
- Performance Management with a focus on implementation of the Equality Outcomes as outlined in our 2018 Equality Mainstreaming report and the identification of further equality outcomes prior to the publication of our 2020 Equality Mainstreaming Report
- Workforce Development ensuring access to and uptake of relevant equalities training and development.

The Health and Social Care Partnership continues to contribute to, and implement the relevant actions of West Dunbartonshire Council and NHS Greater Glasgow and Clyde action plans for the functions delegated to them in new legislation e.g. the British Sign Language Plan and the local Child Poverty Action Plan.

ACKNOWLEDGEMENTS

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

Please send any feedback on this Strategic Plan to:
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 Plan – alongside further information about the work of the Health and Social Care Partnership and its Board – can be accessed at:
www.wdhscp.org.uk

APPENDIX 1: HEALTH AND SOCIAL CARE PARTNERSHIP BOARD DELEGATIONS

Services delegated by the Health Board

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

Services delegated by the Council

- Social work services for adults and older people.
- Services and support for adults with physical disabilities and learning disabilities.
- Mental health services.
- Drug and alcohol services.
- Adult protection and domestic abuse.
- Carers support services.
- Community care assessment teams.
- Support services.
- Care home services.
- Adult placement services.
- Health improvement services.
- The legislative minimum delegation of housing support, including aids and adaptations.
- Day services.
- Local area co-ordination.
- Self-Directed Support.
- Occupational therapy services.
- Re-ablement services, equipment and telecare.
- Residential and non-residential care charging.
- Respite provision for adults and young people.
- Social work services for children and young people:
- Child Care Assessment and Care Management.
- Looked After and Accommodated Children.
- Child Protection.
- Adoption and Fostering.
- Child Care.
- Special Needs/Additional Support.
- Early intervention.
- Throughcare Services.
- Social work criminal justice services, including Youth Justice Services.

APPENDIX 2: PERFORMANCE MONITORING

National Health and Wellbeing Outcomes

Performance Indicator	2017/18 Value	2019/20 Target
Number of delayed discharges over 3 days (72 hours) non-complex cases	4	0
Number of bed days lost to delayed discharge: All reasons	3,439	TBC
Number of bed days lost to delayed discharge: Complex cases	1,127	TBC
Number of acute bed days lost to delayed discharges (inc Adults with Incapacity): 65 years & over	2,291	TBC
Number of acute bed days lost to delayed discharges for Adults with Incapacity: 65 years & over	461	TBC
Number of emergency admissions: All ages	10,316	TBC
Emergency admissions aged 65+ as a rate per 1,000 population	273	TBC
Number of unscheduled acute hospital bed days: All ages	75,297	TBC
Unscheduled acute bed days (aged 65+) as a rate per 1,000 population	3,102	TBC
Number of attendances at Accident and Emergency (Emergency Departments and Minor Injuries Units)	30,463	TBC
Number of clients 65+ receiving a reablement intervention	632	600
Percentage of adults with assessed Care at Home needs and a reablement package who have reached their agreed personal outcomes	64.7%	60%
Number of patients in anticipatory care programmes	1,921	1,400
Number of people in receipt of Telecare aged 65+	1,848	1,910
Total number of homecare hours provided as a rate per 1,000 population aged 65+	488	518
Percentage of people aged 65 or over with intensive needs receiving care at home	32.2%	35%
Percentage of homecare clients aged 65+ receiving personal care	92.1%	90%
Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	98%	98%
Percentage of people aged 65+ admitted twice or more as an emergency who have had an assessment	73.1%	70%
Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)	24.4%	30%

Performance Indicator	2017/18 Value	2019/20 Target
Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	42.5%	35%
Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	43%	90%
Percentage of people newly diagnosed with dementia who have received a minimum of a year's worth of post-diagnostic support co-ordinated by a link worker, including the building of a person-centred support plan	N/A	TBC
Number of clients receiving Home Care Pharmacy Team support	941	900
Prescribing cost per weighted patient	£173.07	NHS GGC average
Compliance with Formulary Preferred List	80.2%	78%
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%
Percentage of Adult Support and Protection clients who have current risk assessments and care plan	100%	100%
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	96%	90%

National Outcomes for Children and Young People

Performance Indicator	2017/18 Value	2019/20 Target
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	94.9%	95%
Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	97.7%	95%
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	Published March 19	85%
Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	84.2%	90%
Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	7	18
Balance of Care for looked after children: % of children being looked after in the Community	90.4%	90%

Performance Indicator	2017/18 Value	2019/20 Target
Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	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	100%	100%
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%
Percentage of child protection investigations to case conference within 21 days	79.2%	95%
Number of referrals to the Scottish Children's Reporter on care and welfare grounds	288	288

National Outcomes for Criminal Justice

Performance Indicator	2017/18 Value	2019/20 Target
Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	90%	98%
Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	79%	80%
Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	15%	80%
Number of referrals to the Scottish Children's Reporter on offence grounds	275	275

Core Integration Indicators

The HSCP has developed a Performance Management Framework to monitor and report performance across all service areas against the National Health and Wellbeing Outcomes, National Outcomes for Children and Young People, National Outcomes for Criminal Justice and the Core Integration Indicators developed by the Scottish Government.

Performance Indicator	2017/18 Value
Premature mortality rate per 100,000 persons	513.6
Emergency admission rate per 100,000 population	13,578
Emergency bed day rate per 100,000 population	135,856
Readmission to hospital within 28 days per 1,000 population	88.8
Proportion of last 6 months of life spent at home or in a community setting	88.93%
Falls rate per 1,000 population aged 65+	24.44
Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	92%
Percentage of adults with intensive care needs receiving care at home	N/A
Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	334
Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23%
Percentage of adults able to look after their health very well or quite well	91%
Percentage of adults supported at home who agree that they are supported to live as independently as possible	81%
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	80%
Percentage of adults supported at home who agree that their health and care services seem to be well co-ordinated	79%
Percentage of adults receiving any care or support who rate it as excellent or good	81%
Percentage of people with positive experience of the care provided by their GP practice	85%
Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	79%
Percentage of carers who feel supported to continue in their caring role	40%
Percentage of adults supported at home who agree that they felt safe	89%