Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board

Date: Wednesday, 8 May 2019

Time: 14:00

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

Contact: Scott Kelly, Committee Officer
Tel: 01389 737210 Email: scott.kelly@west-dunbarton.gov.uk

Dear Member

Please attend a meeting of the **West Dunbartonshire Health & Social Care Partnership Board** as detailed above.

The business is shown on the attached agenda.

Yours faithfully

BETH CULSHAW

Chief Officer of the
Health & Social Care Partnership

Distribution:-

Voting Members

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

Non-Voting Members

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

Senior Management Team – Health & Social Care Partnership

Date of issue: 26 April 2019

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

WEDNESDAY, 8 MAY 2019

AGENDA

1 APOLOGIES

2 DECLARATIONS OF INTEREST

Members are invited to declare if they have an interest in any of the undernoted items of business on this agenda and, if so, state the reasons for such declarations.

3 MINUTES OF PREVIOUS MEETINGS 7 – 15

Submit, for approval as correct records, the Minutes of Meetings of the Health & Social Care Partnership Board held on:-

(a) 20 February 2019 (Ordinary); and

(b) 28 March 2019 (Special).

4 VERBAL UPDATE FROM CHIEF OFFICER

The Chief Officer will provide a verbal update on recent business of the Health & Social Care Partnership.

5 FINANCE UPDATE To follow

Submit report by the Chief Financial Officer on the above.

6 PROCUREMENT OF CONTRACTS To follow

Submit report by the Chief Officer seeking authorisation to initiate procurement processes for procurements which may be awarded to third party providers.

7/

7 2018/19 ANNUAL ACCOUNTS AUDIT PROCESS 17 – 20

Submit report by the Chief Financial Officer:-

(a) providing an overview of the preparation of the 2018/19 Annual Accounts; and

(b) seeking approval to remit the unaudited accounts to the Audit Committee for approval.

8 PUBLIC PERFORMANCE REPORT OCTOBER 2018 TO DECEMBER 2018 21 – 36

Submit report by the Interim Head of Strategy, Planning & Health Improvement providing information on the Health & Social Care Partnership's Public Performance Report for the third quarter of 2018/2019 (October to December 2018).

9 PREPARATION FOR IMPLEMENTATION OF CARERS (SCOTLAND) ACT 2016 37 – 73

Submit report by the Interim Head of Strategy, Planning and Health Improvement presenting a re-drafted West Dunbartonshire Health & Social Care Partnership's local Carers Strategy 2019 - 2022.

10 UPDATE ON THE LOCAL ELIGIBILITY CRITERIA FOR CARERS 75 – 77

Submit report by the Interim Head of Strategy, Planning and Health Improvement presenting an update on the local Eligibility Criteria for Carers which was published on 31 March 2018 in line with Carers (Scotland) Act 2016.

11 WEST DUNBARTONSHIRE LOCAL PRIMARY CARE IMPROVEMENT PLAN 79 – 113

Submit report by the Head of Health and Community Care providing an update on the performance of the Primary Care Improvement Plan for 2018/19 (Year 1).

12/

12 WEST DUNBARTONSHIRE WINTER PLAN UPDATE 115 – 122

Submit report by the Head of Health and Community Care providing an overview of the implementation of plans across West Dunbartonshire to ensure readiness for the additional pressures in unscheduled care often experienced over winter.

13 UPDATE ON THE MINISTERIAL STEERING GROUP TARGETS FOR WEST DUNBARTONSHIRE HSCP 123 – 126

Submit report by the Head of Health and Community Care presenting the proposed 2019/20 Ministerial Strategic Group targets for West Dunbartonshire HSCP and outlining actions intended to facilitate delivery of these targets.

14 MINUTES OF MEETINGS FOR NOTING 127 – 137

Submit for information, the undernoted Minutes of Meetings:-

(a) Minutes of Meeting of the Local Engagement Network Event held on 13 March 2019;

(b) Minutes of Meeting of the Local Engagement Network Event held on 19 March 2019; and

(c) Minutes of Meeting of WD HSCP Health and Safety Committee held on 29 January 2019.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

At a Meeting of the West Dunbartonshire Health & Social Care Partnership Board held in the Council Chamber, Clydebank Town Hall, Dumbarton Road, Clydebank, on Wednesday, 20 February 2019 at 2.00 p.m.

Present: Bailie Denis Agnew and Councillors Marie McNair and John Mooney, West Dunbartonshire Council; Allan MacLeod, Rona Sweeney and Audrey Thompson, NHS Greater Glasgow and Clyde Health Board.

Non-Voting Members: Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Jonathan Hinds, Head of Children's Health Care and Criminal Justice Services; Barbara Barnes, Co-Chair of the WD HSCP Public Engagement Network for the Alexandria & Dumbarton area, John Kerr, Housing Development and Homelessness Manager; Anne MacDougall, Co-Chair of WD HSCP Public Engagement Network for the Clydebank area; Kim McNab, Service Manager of Carers for West Dunbartonshire; Janice Millar, MSK Physiotherapy Service Manager; Peter O'Neill, WDC Staff Side Co-Chair of Joint Staff Forum and Selina Ross, Chief Officer – WD CVS.

Attending: Jo Gibson, Head of Health and Community Care; Wendy Jack, Interim Head of Strategy, Planning & Health Improvement; Julie Lusk; Head of Mental Health, Addictions and Learning Disability; Nigel Ettles, Principal Solicitor and Nuala Quinn-Ross, Committee Officer.

Apologies: Apologies for absence were intimated on behalf of Alison Wilding and Serena Barnatt.

Also Attending: Peter Barry, Strategic Lead, Housing and Employability and Gillian Kirkwood, Y Sort-It.

MR ALLAN MACLEOD IN THE CHAIR

DECLARATIONS OF INTEREST

It was noted that there were no declarations of interest in any of the items of business on the agenda.

MINUTES OF PREVIOUS MEETINGS

The following Minutes of Meetings were submitted and approved as a correct record:-

(1) the Health & Social Care Partnership Board held on 14 November 2018; and

(2) the Health & Social Care Partnership Board Audit Committee held on 12 December 2018.

UPDATE FROM CHIEF OFFICER

The Chief Officer provided an update on recent business of the Health and Social Care Partnership.

FINANCIAL PERFORMANCE REPORT AS AT PERIOD 9 (31 DECEMBER 2018)

A report was submitted by the Chief Financial Officer providing an update on the financial performance as at period 9 to 31 December 2018.

After discussion and having heard the Chief Financial Officer and the Head of Children's Health Care and Criminal Justice Services in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the updated position in relation to budget adjustments to the 2018/19 approved budget allocation by WDC and NHSGGC and direction back to our partners to deliver services in line with the strategic priorities of the HSCP Board;

(2) to note the revenue position for the period 1 April 2018 to 31 December 2018 is reporting an overspend of -£0.305m (-0.26%);

(3) to note the projected 2018/19 outturn position of -£0.228m (-0.15%) and the potential impact on the reserves position if new demand is not minimised by recovery plan actions; and

(4) to note the update on the capital position and the projected timelines for completion.

2019/20 ANNUAL BUDGET SETTING UPDATE

A report was submitted by the Chief Financial Officer providing an update on the 2019/20 Annual Budget Setting progress and interim funding assumptions by our partner organisations.

After discussion and having heard the Chief Financial Officer in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to note the 2019/20 budget update in relation to the partner bodies indicative budget offers.

STRATEGIC COMMISSIONING PLAN 2019 – 2022

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement presenting a consultation draft of the Strategic Commissioning Plan 2019 – 2022.

After discussion and having heard the Interim Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the process of the consultation on the Health and Social Care Strategic Commissioning Plan 2019-2022; and

(2) that the final draft be presented to the Partnership Board in March 2019.

PREPARATION FOR IMPLEMENTATION OF CARERS (SCOTLAND) ACT

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement providing an update on the activity relating to the Carers (Scotland) Act 2016 following commencement on 1 April 2018; and

A presentation was then given by the Interim Head of Strategy, Planning & Health Improvement and Gillian Kirkwood, Y Sort-it on the above.

After discussion and having heard the Interim Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the progress made to implement the requirements of the Carers Act;

(2) to approve the draft HSCP Short Breaks Statement prepared with partners;

(3) to approve the draft Carers Strategy 2019 – 2022 prepared with partners and carers across West Dunbartonshire; and

(4) that further reports be presented to the Partnership Board during 2019 on the progress against the actions.

ADJOURNMENT

Having heard the Chair, Mr MacLeod, the Partnership Board agreed to a short adjournment.

The meeting resumed at 4.21 p.m. with all those Members noted in the sederunt being present, with the exception of Barbara Barnes.

PROGRESS ON THE WEST DUNBARTONSHIRE HOUSING CONTRIBUTION STATEMENT AND HOME AT THE HEART WEST DUNBARTONSHIRE COUNCIL'S RAPID REHOUSING TRANSITION PLAN

A report was submitted and a presentation given by the Housing Development and Homelessness Manager providing an update on the joint working between West Dunbartonshire Health and Social Care Partnership and West Dunbartonshire Council Housing Services in delivering agreed outcomes.

After discussion and having heard the Strategic Lead, Housing and Employability and the Housing Development and Homelessness Manager in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the progress made on the Housing Contribution Statement and in developing positive joint working arrangements between the HSCP and Housing Services;

(2) to note that the Housing Contribution statement will be subject to a full review as part of the HSCP Strategic Plan Consultation; and

(3) to endorse West Dunbartonshire Council's Rapid Rehousing Transition Plan 'Home at the Heart', detailed within Appendix 1 to the report.

Note:- Councillor McNair left the meeting during discussion on the above item of business. The Strategic Lead, Housing and Employability and the Housing Development and Homelessness Manager left at this point in the meeting.

NHS GREATER GLASGOW AND CLYDE AND WEST DUNBARTONSHIRE WINTER PLAN UPDATE

A report was submitted by the Head of Health and Community Care providing an overview of the implementation of plans across West Dunbartonshire in order to ensure readiness for the additional pressures in unscheduled care often experienced over winter.

After discussion and having heard the Head of Health and Community Care in further explanation of the report, the Partnership Board agreed to note the contents of the Winter Plan Update.

PUBLIC PERFORMANCE REPORT JULY TO SEPTEMBER 2018

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement providing details of the Health and Social Care Partnership's Public Performance for the second quarter of 2018/19 (July to September 2018).

After discussion and having heard officers in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to approve the Partnership Public Performance Report for July to September 2018 for publication.

WEST DUNBARTONSHIRE INTEGRATION JOINT BOARD RECORDS MANAGEMENT PLAN

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement seeking approval of the draft Records Management Plan.

After discussion the Partnership Board agreed:-

(1) to approve the draft Records Management Plan; and

(2) that authority be delegated to the Chief Officer, to finalise the West Dunbartonshire Health and Social Care Partnership Board's Records Management Plan in collaboration with the Keeper of the Records of Scotland.

CRIMINAL JUSTICE SOCIAL WORK INSPECTION

A report was submitted by the Head of Children's Health, Care and Criminal Justice Services providing an update on the ongoing Criminal Justice Social Work Inspection for West Dunbartonshire.

After discussion and having heard the Head of Children's Health Care and Criminal Justice Services in further explanation of the report and in answer to Members' questions, the Partnership Board agreed to note contents of the report and the role of senior managers within the inspection.

GENERAL DATA PROTECTION REGULATIONS (GDPR) REQUIREMENTS FOR INTEGRATION JOINT BOARD (IJB)

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement providing an overview of the changes and accountabilities arising from new Data Protection laws.

After discussion and having heard the Interim Head of Strategy, Planning & Health Improvement and the Principal Solicitor in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to note the requirement to comply with the guidance appended to the report; and

(2) to approve the proposed arrangements for an appointment of a Data Protection Officer (DPO), subject to their being no conflict of interest.

FREQUENCY OF MEETINGS OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement seeking approval to increase the frequency of Board meetings from four per annum to six per annum.

After discussion and having heard the Interim Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to approve the proposal for a change in the number of meetings for the Health and Social Care Partnership Board from 4 to 6 meetings per annum;

(2) that a Special Meeting of the Health and Social Care Partnership Board be arranged for 28 March 2019; and

(3) that the Meeting of the Health and Social Care Partnership Board Audit Committee scheduled to be held on 12 June 2019 be moved to 19 June 2019.

MINUTES OF MEETINGS FOR NOTING

The undernoted Minutes of Meeting were submitted for information:-

(1) Minutes of Meeting of the WD HSCP Board Audit Committee held on 26 September 2018;

(2) Minutes of Meetings of the Local Engagement Network Events held on 4 and 5 October 2018; and

(3) Minutes of Meeting of WD HSCP Health and Safety Committee held on 23 October 2018.

The meeting closed at 5.40 p.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

At a Special Meeting of the West Dunbartonshire Health & Social Care Partnership Board held in the Council Chamber, Clydebank Town Hall, Dumbarton Road, Clydebank on Thursday, 28 March 2019 at 10.00 a.m.

Present: Bailie Denis Agnew and Councillor Marie McNair, West Dunbartonshire Council; Allan MacLeod and Audrey Thompson, NHS Greater Glasgow and Clyde Health Board.

Non-Voting Members: Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Jonathan Hinds, Head of Children's Health Care and Criminal Justice Services; Barbara Barnes, Co-Chair of the WD HSCP Public Engagement Network for the Alexandria & Dumbarton area; Anne MacDougall, Co-Chair of WD HSCP Public Engagement Network for the Clydebank area; Kim McNab, Service Manager of Carers for West Dunbartonshire; Janice Millar, MSK Physiotherapy Service Manager; Peter O'Neill, WDC Staff Side Co-Chair of Joint Staff Forum and Selina Ross, Chief Officer – WD CVS.

Attending: Jo Gibson, Head of Health and Community Care; Wendy Jack, Interim Head of Strategy, Planning & Health Improvement; Julie Lusk, Head of Mental Health, Addictions and Learning Disability; Nigel Ettles, Principal Solicitor and Nuala Borthwick, Committee Officer.

Also Attending: Brian Polding-Clyde, Scottish Care Representative.

Apologies: Apologies for absence were intimated on behalf of Councillor John Mooney and Alison Wilding, Chair of the Local Group for Clydebank area.

MR ALLAN MACLEOD IN THE CHAIR

DECLARATIONS OF INTEREST

It was noted that there were no declarations of interest in any of the items of business on the agenda.

BUDGET UPDATE AND BUDGET SETTING 2019/2020

A report was submitted by the Chief Financial Officer providing an update on the anticipated and indicative budget offers from the Board's funding partners and a proposed 2019/20 revenue budget.

The Chief Financial Officer was heard in further explanation of the report and thereafter an updated Appendix 4, a letter from Greater Glasgow and Clyde NHS Board received on 26 March 2019 providing an updated indicative financial allocation for 2019/20, was circulated to Members of the Board.

After discussion and having heard the Chief Officer, the Chief Financial Officer and relevant officers in further explanation of the report and in answer to Members' questions, the Board agreed:-

(1) to note the current and projected reserves position and to approve the utilisation of transformational earmarked reserves for four fixed term posts;

(2) to accept the 2019/20 revenue budget contribution of £67.813m from West Dunbartonshire Council as agreed by West Dunbartonshire Council on 27 March 2019;

(3) to note the increases to charges levied across services as agreed by West Dunbartonshire Council at its Budget Setting meeting on 27 March 2019, including social care services and the impact on the budget gap had the recommendations not been accepted in full;

(4) to note the update to West Dunbartonshire Council's 10 Year Capital Plan from 2019/20 to 2028/29 and the programmes linked to the strategic priorities of the HSCP Board;

(5) to accept the 2019/20 allocation for Criminal Justice Social Work Services of £2.018m funded by Scottish Government grant via West Dunbartonshire Council;

(6) to accept the 2019/20 budget allocations for Housing Aids and Adaptations of £0.250m and the Care of Gardens budget of £0.440m, held and managed by West Dunbartonshire Council's Regeneration, Environment and Growth Directorate on behalf of the Health and Social Care Partnership Board;

(7) to approve the recommendation to close the social care funding gap of £0.700m from a proportion of the new investment in integration funding;

(8) to accept the 2019/20 indicative budget contribution of £91.113m from NHS Greater Glasgow and Clyde subject to formal approval by the Health Board on 16 April and any final adjustments to the recurring budgets at month 12;

(9) to approve an indicative 2019/20 Revenue Budget of £158.946m required to deliver the strategic priorities of the Health & Social Care Partnership Board;

(10) to approve the 2019/20 Set Aside budget of £18.673m, based on the 2018/19 budget with a 2.54% uplift;

(11) that a report would be provided to a future meeting of the Partnership Board on the impact of increases to the charges levied across services; and

(12) that a report would be provided to the next meeting of the Partnership Board on planned Service Redesign and Transformation to drive forward service redesign, service improvements and efficiencies.

ADJOURNMENT

Having heard the Chair, Mr MacLeod, the Partnership Board agreed to a short adjournment.

The meeting resumed at 11.14 a.m. with all those Members noted in the sederunt being present.

STRATEGIC PLAN 2019 - 2022

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement presenting a revised version of the Strategic Plan following a process of consultation with stakeholders and partners.

The Interim Head of Strategy, Planning & Health Improvement was heard in further explanation of the report and thereafter she, the Chief Officer and the Head of Community Health and Care were heard in answer to Members' questions.

After discussion, the Partnership Board agreed:-

(1) to note the process of consultation with all partners and stakeholders on the draft Health and Social Care Partnership Strategic Plan 2019 – 2022;

(2) to approve the final draft of the Strategic Plan as presented to the Board; and

(3) to approve a process of development for a Commissioning Plan based on the priorities within the Strategic Plan which would be presented at a future meeting of the Partnership Board.

The meeting closed at 11.27 a.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

8 May 2019

Subject: 2018/19 Annual Accounts Audit Process

1. Purpose

1.1 To provide the HSCP Board with an overview of the preparation of the 2018/19 Annual Accounts and to seek approval to remit the unaudited accounts to the Audit Committee for approval.

2. Recommendations

2.1 Members are asked to:

- Note the contents of the report; and
- Agree to delegate authority for the Audit Committee to approve the unaudited annual accounts, for submission to the HSCP Board's external auditors, Audit Scotland, by 30 June 2019.

3. Background

3.1 The West Dunbartonshire Integrated Joint Board (WDIJB), known as the West Dunbartonshire Health and Social Care Partnership Board (HSCP), is a legal entity in its own right.

3.2 Integrated Joint Boards are specified in legislation as a "section 106" body under the terms of the Local Government Scotland Act 1973 and as such is expected to prepare annual accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

4. Main Issues

4.1 The annual accounts for the HSCP Board will be prepared in accordance with appropriate legislation and guidance. An overview of the process is set out below.

4.2 **Financial Governance & Internal Control;** the regulations require the Annual Governance Statement to be approved by the HSCP Board or a committee of the HSCP whose remit include audit & governance. This will assess the effectiveness of the internal audit function and the internal control procedures of the HSCP Board. Under the approved Terms of Reference the Audit Committee meets this requirement.

4.3 **Unaudited Accounts;** the regulations state that the unaudited accounts are submitted to the External Auditor no later than 30th June immediately following the financial year to which they relate. Scottish Government

guidance states that best practice would reflect that the HSCP Board or committee whose remit includes audit and governance should consider the unaudited accounts prior to submission to the external auditor.

4.4 **Right to Inspect and Object to Accounts:** the public notice period of inspection should start no later than 1st July in the year the notice is published. This will be for a period of 3 weeks and will follow appropriate protocol for advertising and accessing the unaudited accounts.

4.5 **Approval of Audited Accounts**: the regulations require the approval of the audited annual accounts by the HSCP Board or a committee of the HSCP whose remit include audit & governance. This will take account of any report made on the audited annual accounts by the "proper officer" i.e. Chief Financial Officer being the Section 95 Officer for the HSCP Board or by the External Auditor by the 30th September immediately following the financial year to which they relate. In addition any further report by the external auditor on the audited annual accounts should also be considered.

4.6 The Audit Committee will consider for approval the External Auditors report and proposed audit certificate (ISA 260 report) and the audited annual accounts at its meeting on 25 September 2019.

4.7 **Publication of the Audited Accounts:** the regulations require that the annual accounts of the HSCP Board be available in both hard copy and on the website for at least five years, together with any further reports provided by the External Auditor that relate to the audited accounts.

4.8 The annual accounts of the HSCP Board must be published by 31st October and any further reports by the External Auditor by 31st December immediately following the year to which they relate.

4.9 **Key Documents:** the regulations require a number of key documents (within the annual accounts) to be signed by the Chair of the HSCP Board, the Chief Officer and the Chief Financial Officer, namely:

Document	**Signatory**
Management Commentary	Chair of the HSCP Board Chief Officer
Statement of Responsibilities	Chair of the HSCP Board Chief Financial Officer
Remuneration Report	Chair of the HSCP Board Chief Officer
Annual Governance Statement	Chair of the HSCP Board Chief Officer
Balance Sheet	Chief Financial Officer

5. People Implications

5.1 There are no people implications.

6. Financial Implications

6.1 There are no financial implications other than those detailed in the report.

7. Professional Implications

7.1 None

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 No risk analysis was required.

10. Impact Assessments

10.1 None

11. Consultation

11.1 This report was approved at the February HSCP Audit Committee.

12. Strategic Assessment

12.1 Proper budgetary control and sound financial practice are cornerstones of good governance and support the Partnership Board and officers to pursue the strategic priorities of the Strategic Plan.

The report is in relation to a statutory function and is for noting. As such, it does not directly affect any of the strategic priorities.

12.2 This report links to the strategic financial governance arrangements of both parent organisations.

Author: **Julie Slavin – Chief Financial Officer**
Date: **17 April 2019**

Person to Contact: Julie Slavin – Chief Financial Officer,
Council Offices, Church Street, Dumbarton G82 1QL
Telephone: 01389 737311
e-mail : julie.slavin@ggc.scot.nhs.uk

Appendices:	None
Background Papers:	**Audit Committee Terms of Reference** **CIPFA Audit Committees - Practical Guidance Local Authorities and Police**
Wards Affected:	None

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

8 May 2019

Subject: Public Performance Report October to December 2018

1. Purpose

1.1 To present the Partnership Board with the Health & Social Care Partnership's Public Performance Report for the third quarter of 2018/19 (October to December 2018).

2. Recommendations

2.1 The Partnership Board is recommended to approve the Partnership Public Performance Report for October to December 2018 for publication.

3. Background

3.1 The Health & Social Care Partnership's Strategic Plan was approved by the Partnership Board at last meeting on 28 March 2019.

3.2 Building on the annual Public Performance Report 2017/18 (received by the Partnership Board at its August 2018 meeting), the third quarterly Public Performance Report for 2018/19 is appended here for consideration (Appendix 1).

4. Main issues

4.1 The Public Performance Report for October to December 2018 focuses on those key strategic performance indicators for the Partnership where performance data is available for that specific time period. It has been augmented with data on key aspects of workforce and financial performance.

4.2 Once considered by the Partnership Board, this third quarterly Public Performance Report will be published on the Health & Social Care Partnership's website and cascaded to stakeholders.

5. People Implications

5.1 The Public Performance Report has been augmented with data on key aspects of workforce performance linked to the Partnership's Workforce & Organisational Development Strategy 2015-2018 (approved by the Partnership Board at its November 2015 meeting).

6. Financial and Procurement Implications

6.1 The Public Performance Report has been augmented with data on key aspects of financial performance (the latter of which have been previously reported to the Partnership Board by the Chief Financial Officer for that period).

7. Risk Analysis

7.1 Audit Scotland has stated that public reporting is an important element of best value. This Public Performance Report has been informed by the practice promoted by Audit Scotland, and work will continue to develop local arrangements accordingly.

8. Equality Impact Assessment (EIA)

8.1 None required.

9. Consultation

9.1 None required.

10. Strategic Assessment

10.1 The Public Performance Report has been produced to enhance in-year scrutiny of the delivery of the Strategic Plan in an open and accountable manner.

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

Date: 8th April 2019

Person to Contact: Wendy Jack – Interim Head of Strategy, Planning & Health Improvement, Aurora House, Clydebank.
E-mail:wendy.jack@west-dunbarton.gov.uk
Telephone: 01389 776864

Attached:	West Dunbartonshire Health & Social Care Partnership Public Performance Report October to December 2018
Background Papers:	HSCP Board Report (August 2016): Strategic Plan 2016-2019 HSCP Board Report (August 2018): Public Performance Report 2017/18 HSCP Board Report (November 2015): Workforce & Organisational Development Strategy & Support Plan Scottish Government (2015) National Framework for Clinical and Care Governance: http://www.gov.scot/Resource/0049/00491266.pdf Audit Scotland (2010) Best Value Toolkit: Public Performance Reporting: http://www.audit-scotland.gov.uk/docs/best_value/2010/bv_100809_public_performance_reporting_toolkit.pdf
Wards Affected:	All

West Dunbartonshire
Health & Social Care Partnership

Public Performance Report

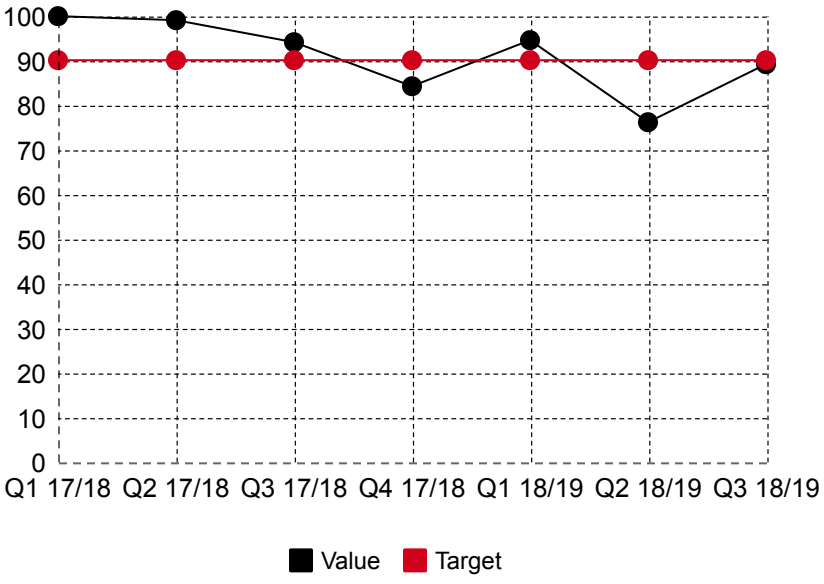
October - December 2018

Our vision:
Improving lives with the People of West Dunbartonshire

Welcome to West Dunbartonshire Health and Social Care Partnership's third Public Performance Report for 2018/19.

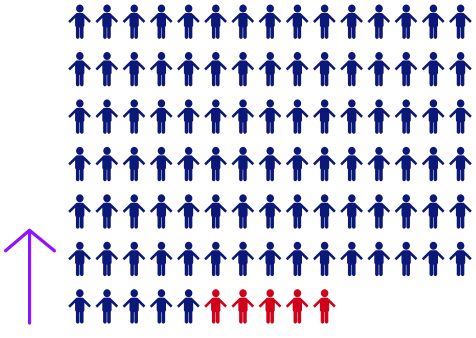
Supporting Children and Families

Child and Adolescent Mental Health Services within 18 weeks



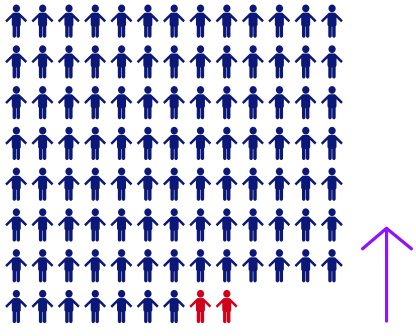
- **89.1% started treatment within 18 weeks**
- **Longest wait 34 weeks**
- **Average wait 9 weeks**
- **135 referrals**

95.4% of children had an MMR at 24 months



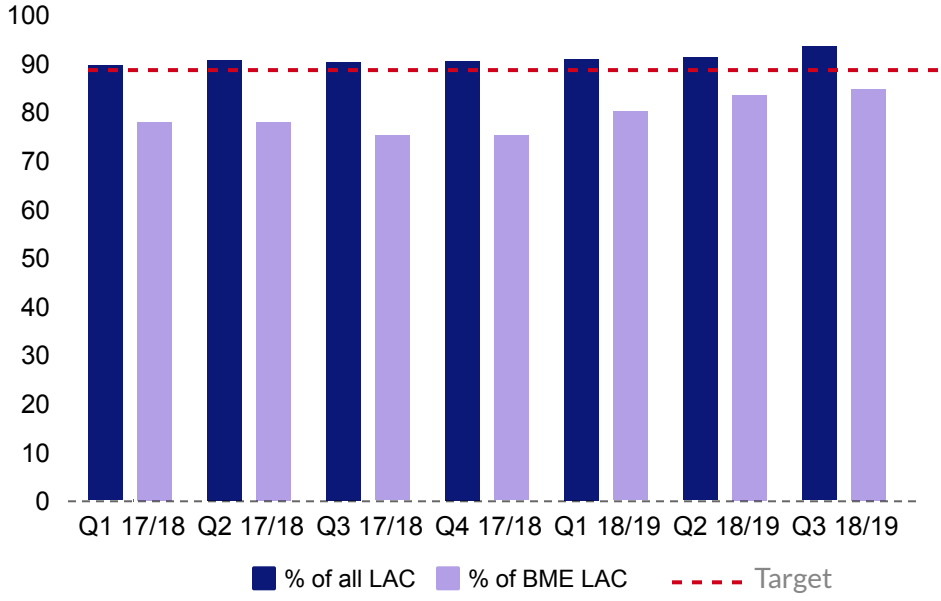
Target 95%

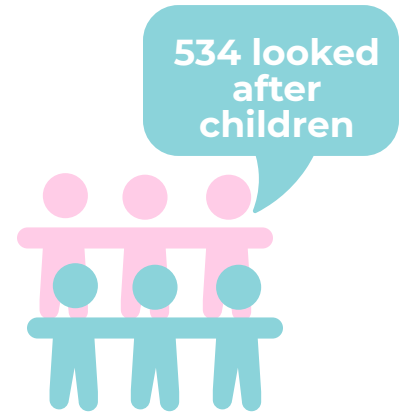
97.9% of children had an MMR at 5 years



1,381 children had their first Measles Mumps and Rubella (MMR) vaccination between April and December 2018.

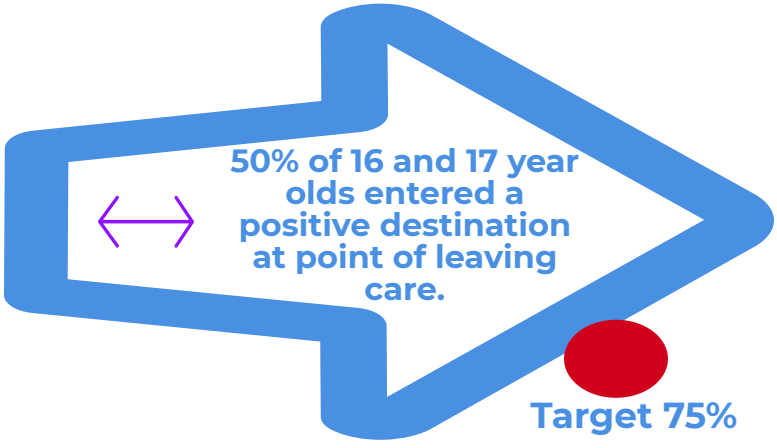
Percentage of Looked After Children (LAC) who are looked after in the community

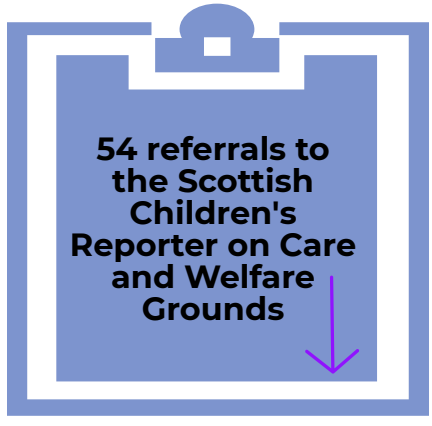




498 of the 534 looked after children (93.3%) are being looked after in the community. 11 of the 13 looked after children (84.6%) who were from Black Minority Ethnic (BME) communities were looked after in the community.

As part of our local Equalities Indicators we continue to monitor that the number of Black Minority Ethnic (BME) children who are looked after are being looked after within the community in a similar proportion. As the number of BME looked after children within West Dunbartonshire is very low, small changes may mean percentages fluctuate more significantly. Our data continues to show similar trends for BME children as the total looked after children population.



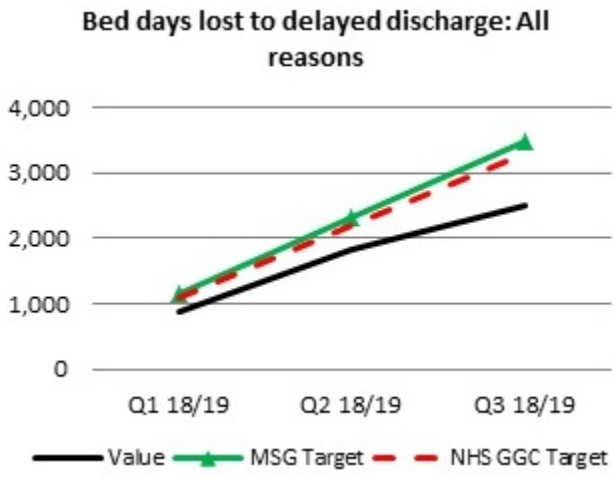


Supporting Older People

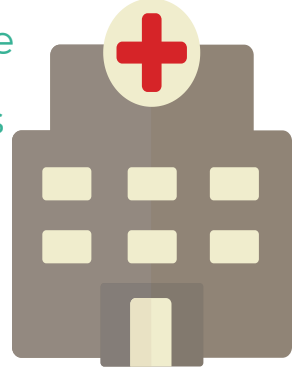
The Ministerial Steering Group (MSG) for Health and Community Care is closely monitoring the progress of HSCPs across Scotland in relation to unscheduled care. Within the HSCP we are monitoring our performance against locally set MSG targets and against NHS Greater Glasgow and Clyde's target 10% reduction in unscheduled bed days, unnecessary hospital admissions and A&E attendances across the health board area.

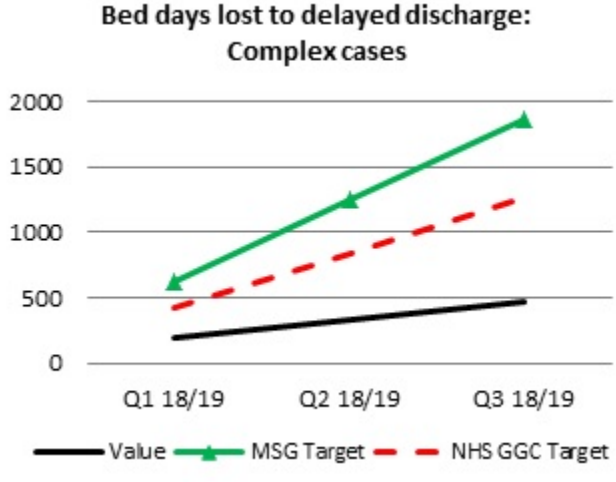
Between April and December 2018 we have seen significant progress in reducing the number of bed days lost to delayed discharges. With 2,513 bed days lost we exceeded both the MSG and NHS GGC targets and delivered an 11.7% decrease on the same period in 2017/18. Bed days lost due to delayed discharge for complex cases saw a significant 57% reduction on the same period.

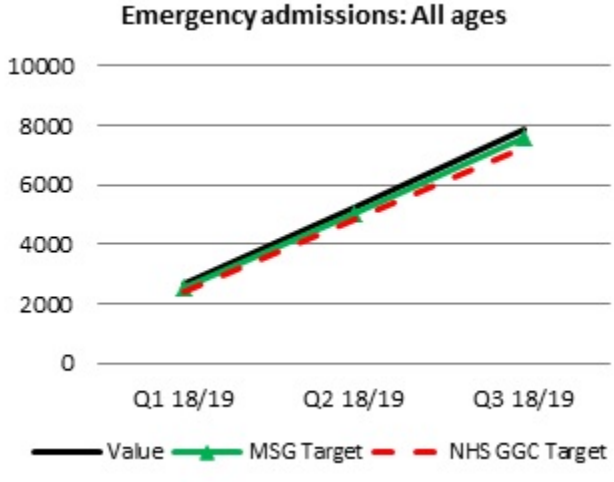
Targets for emergency admissions and unscheduled bed days are proving more challenging. However while there has been a 1.5% increase in emergency admissions on April-December 2017 there has been a 6% decrease in unscheduled bed days.

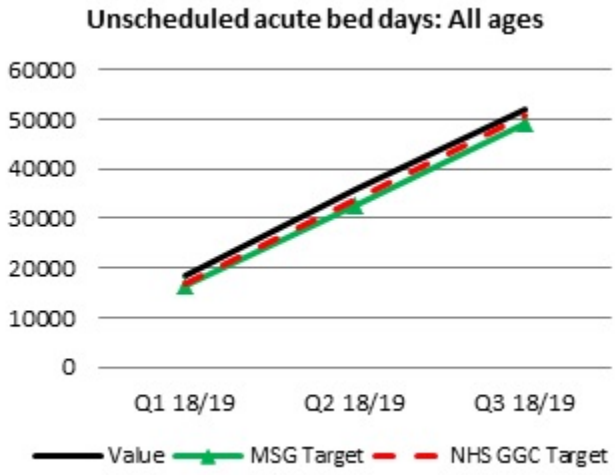


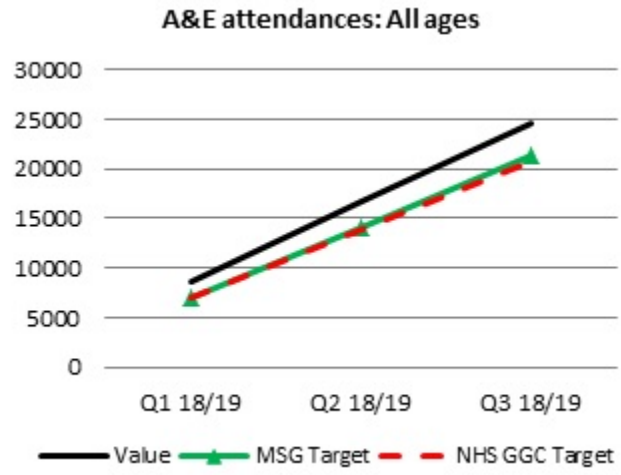
2 delayed discharges of more than 3 days at December census point (non-complex cases)

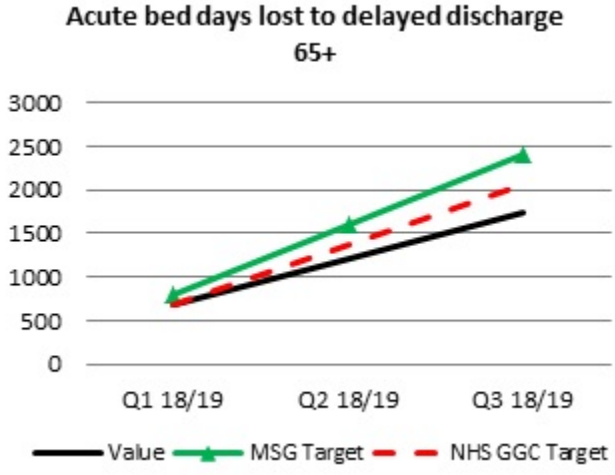


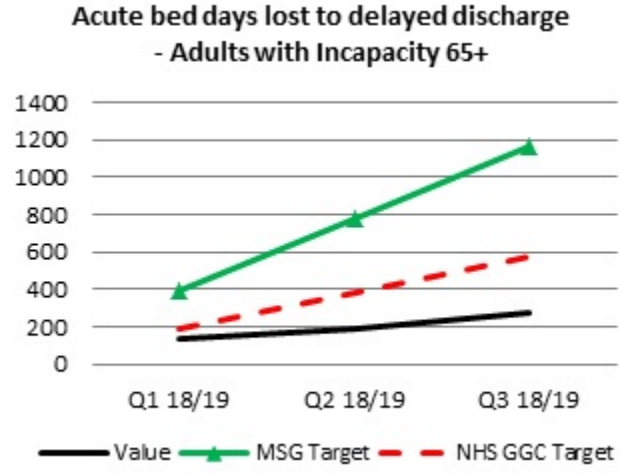


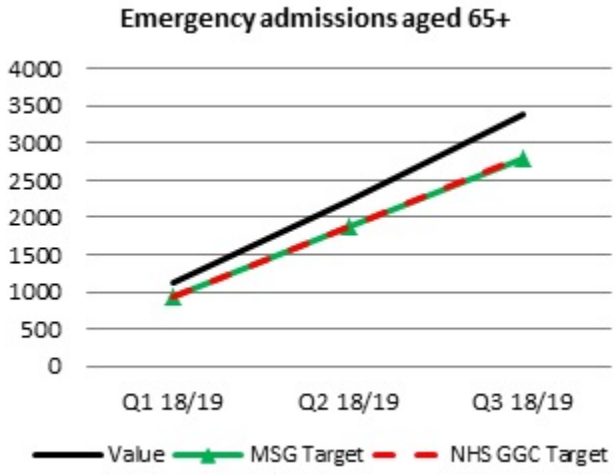


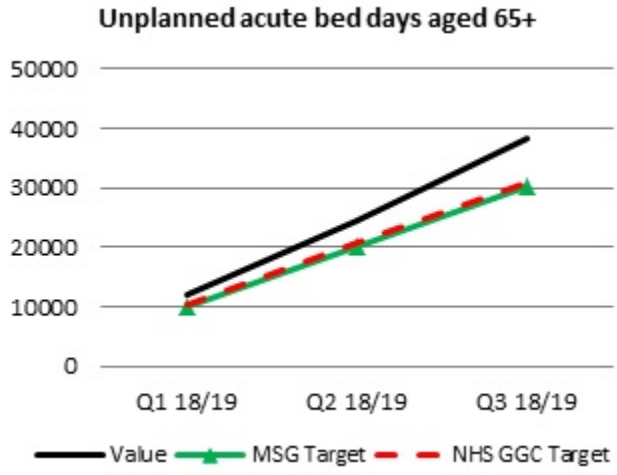

Unscheduled acute bed days: All ages
60000
50000
40000
30000
20000
10000
0
Q1 18/19
Q2 18/19
Q3 18/19
Value
MSG Target
NHS GGC Target


A&E attendances: All ages
30000
25000
20000
15000
10000
5000
0
Q1 18/19
Q2 18/19
Q3 18/19
Value
MSG Target
NHS GGC Target


Acute bed days lost to delayed discharge 65+
3000
2500
2000
1500
1000
500
0
Q1 18/19
Q2 18/19
Q3 18/19
Value
MSG Target
NHS GGC Target


Acute bed days lost to delayed discharge - Adults with Incapacity 65+
1400
1200
1000
800
600
400
200
0
Q1 18/19
Q2 18/19
Q3 18/19
Value
MSG Target
NHS GGC Target


Emergency admissions aged 65+
4000
3500
3000
2500
2000
1500
1000
500
0
Q1 18/19
Q2 18/19
Q3 18/19
Value
MSG Target
NHS GGC Target


Unplanned acute bed days aged 65+
50000
40000
30000
20000
10000
0
Q1 18/19
Q2 18/19
Q3 18/19
Value
MSG Target
NHS GGC Target

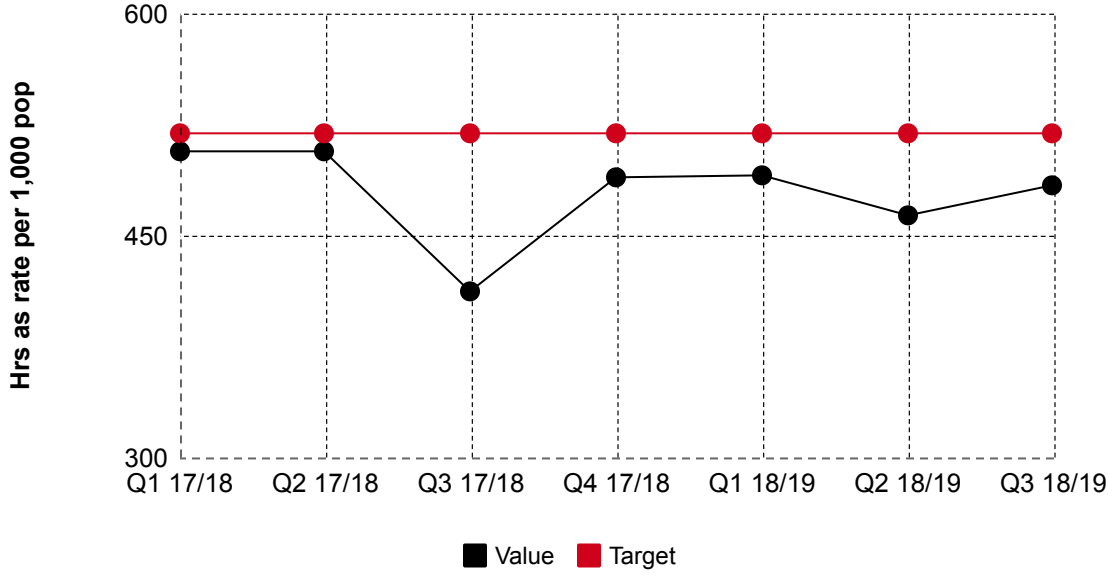
95% of carers asked as part of their Adult Carer Support Plan felt able to continue in their caring role

Target 90%

1,513 people have an Anticipatory Care Plan in place

Target 1,400

Number of homecare hours received 65+ (Rate per 1,000 population)



2,225 people have a Community Alarm/Telecare (All ages)

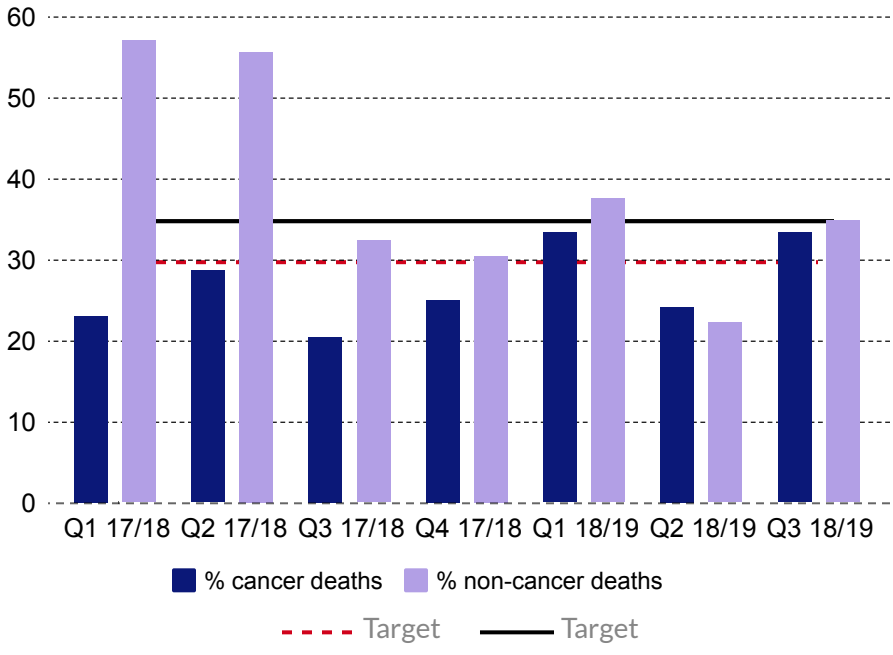
9,444 hours of home care per week (All ages)

31% receiving 20 or more visits per week (65+)

1,361 people receiving home care (All ages)

95.8% receiving personal care (65+)

% of Patients Dying in Hospital (Palliative Care Register)



64% of people supported to die in a homely setting

75% of people aged 65+ admitted twice or more as an emergency have had an assessment

1,514 referrals for musculoskeletal physiotherapy services (MSK)

39% of patients are seen within 4 weeks for MSK assessment and treatment

Target 90%

257 people supported with their medication

Target 225

79.3% compliance with Formulary Preferred List

Target 78%

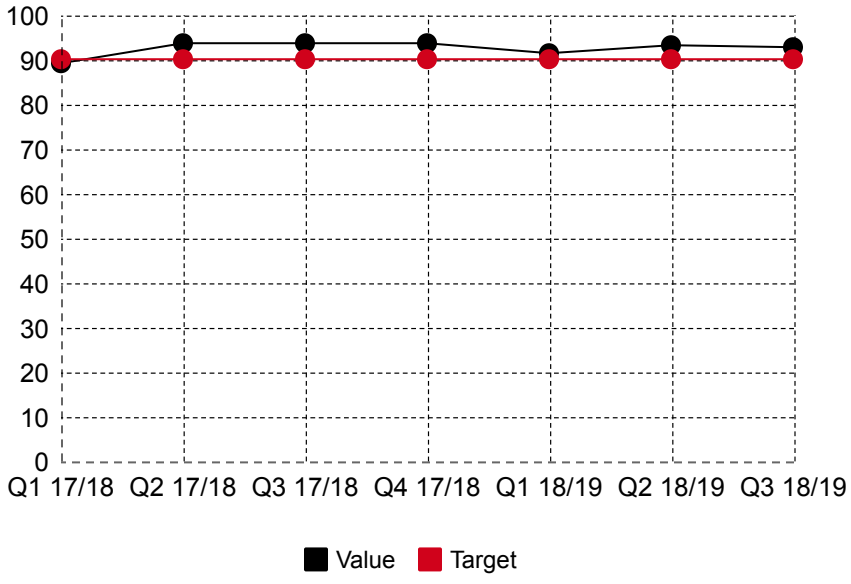
£168.53 prescribing cost per weighted patient

100 people received a reablement service **53%** achieved their agreed personal outcomes

Target 60%

Supporting Safe, Strong and Involved Communities

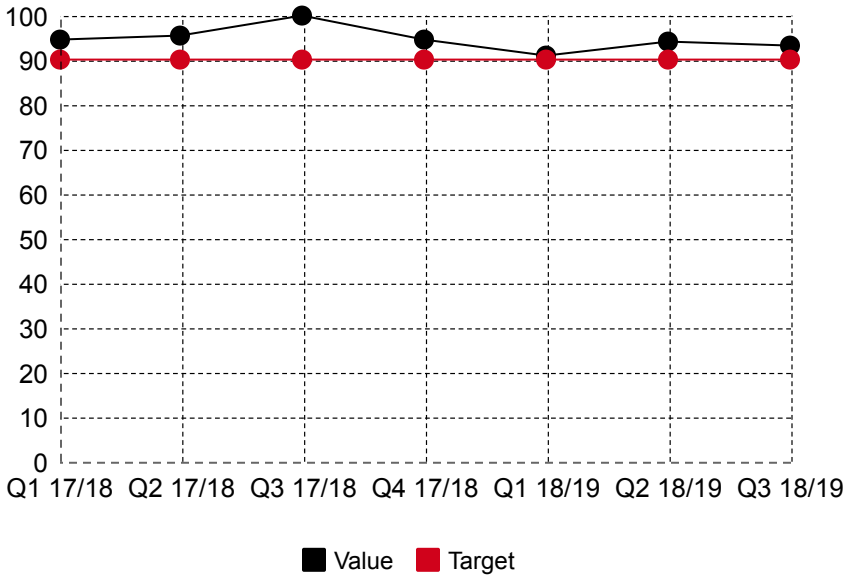
% of people waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery



194 people (92.4%) receiving treatment within 3 weeks

210 referrals for drug or alcohol treatment

% of people who began Psychological Therapies treatments within 18 weeks of referral

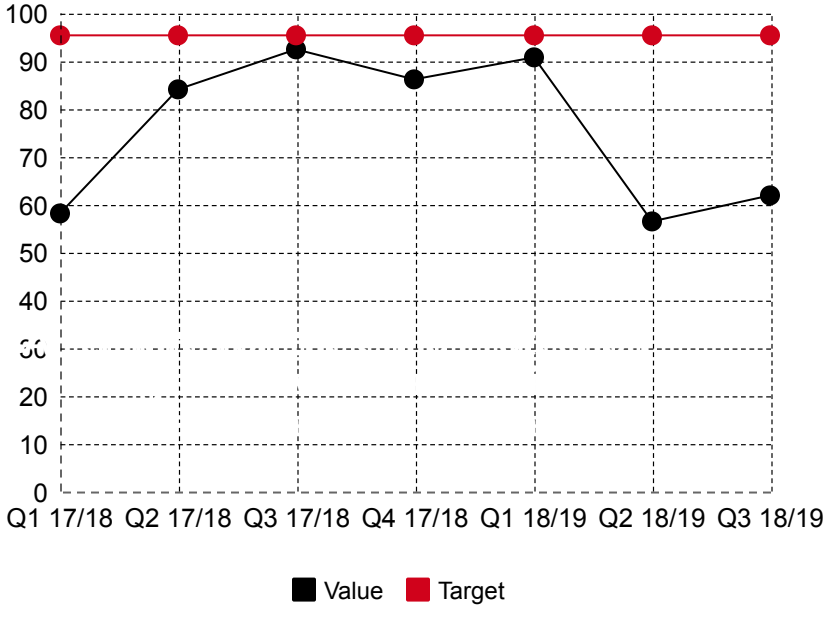


53 people (93%) started treatment within 18 weeks

All Adult Support and Protection clients have a current risk assessment and care plan

All children on the Child Protection Register have a current risk assessment and care plan

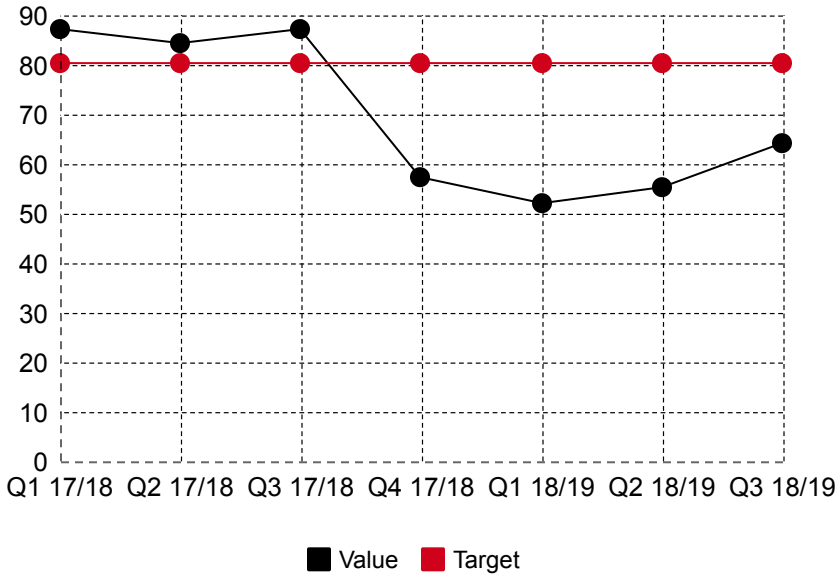
% of Child Protection investigations to case conference within 21 days



- 47 children on the Child Protection Register
- 88 referrals
- 21 of 34 case conferences within the timescale

51 referrals to the Scottish Children's Reporter on offence grounds

% of Community Payback Orders attending an induction session within 5 working days of sentence



Performance in relation to Community Payback Orders while still below target, is continuing to improve with 61 of the 95 orders (64.2%) inducted within timescale.

85% of Criminal Justice Social Work reports submitted to court by noon on the day prior to calling

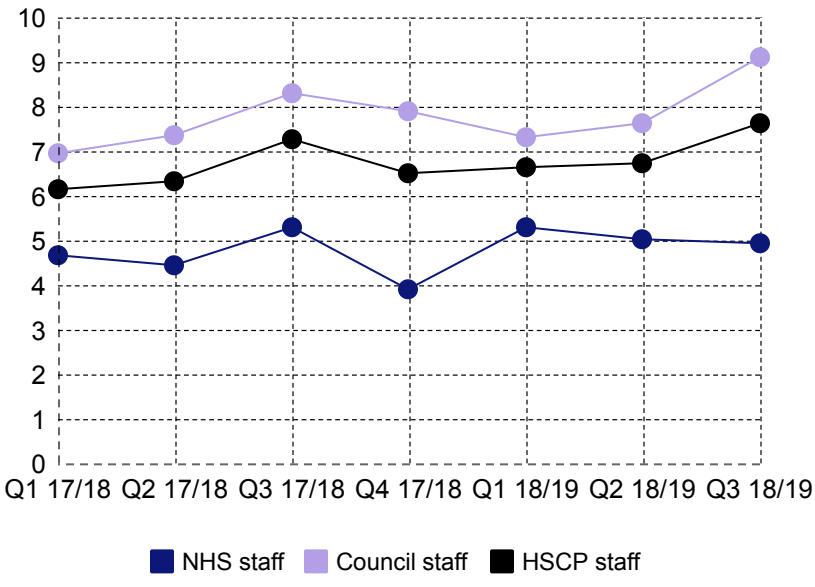
Target 98%

48% of Unpaid Work and other activity requirements commences within 7 working days of sentence

Target 80%

- **162 Criminal Justice Social Work reports requested**
- **95 Community Payback Orders**
- **79 Unpaid Work requirements**

Full time equivalent staff absence



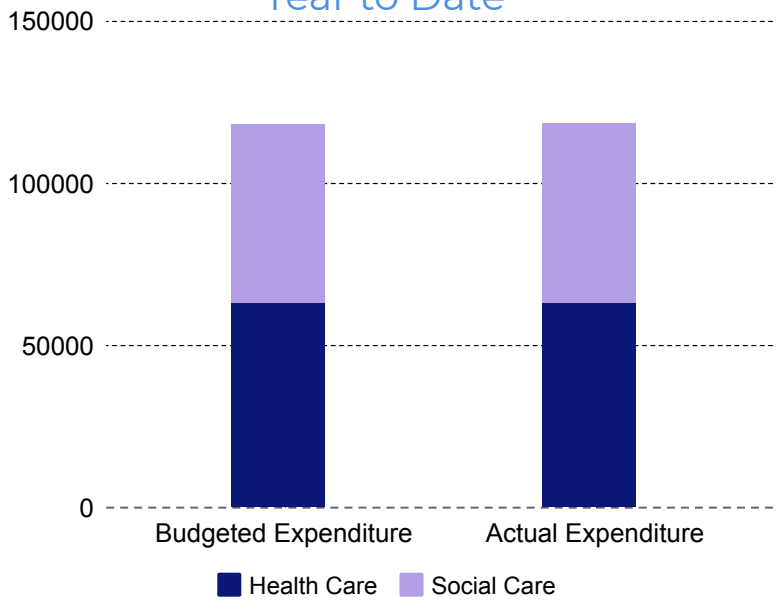
7.62% absence HSCP staff:

4.93% NHS staff

9.09% Council staff

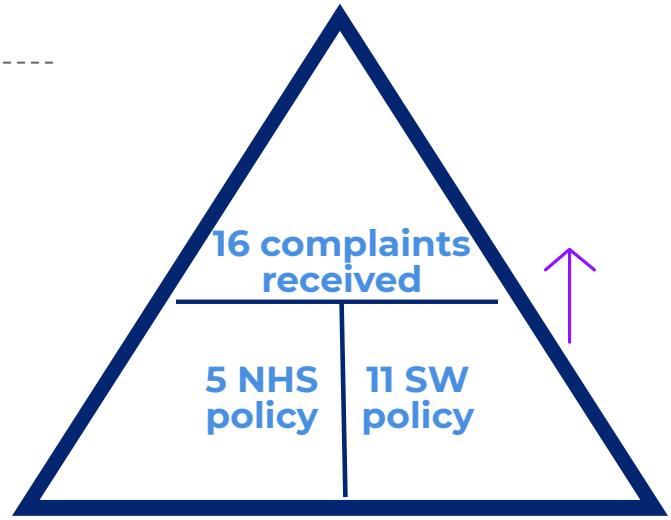
Compared to Quarter 3 2017/18

Health and Social Care Net Expenditure £000s - Year to Date



£305,000 overspend at December 2018

18% of complaints responded to within 20 working days



First sod cut at new Clydebank Care Home

The first sod has been cut to officially mark the start of the new multi-million pound Clydebank Care Home and Day Care Centre.

Councillor Marie McNair, Vice Chair of West Dunbartonshire's Health and Social Care Partnership (HSCP) broke the ground at the Queens Quay site where the £14.089 million state-of-the-art care facility is being built.

The home will have one 14 bedroom flat and seven 10 bedroom flats with each resident having their own en-suite room. Each flat will have living and dining areas and a kitchen to allow residents to maintain their independence.

The home will have many modern facilities including a multi-purpose space that can function as a cinema where residents can view films on the large screen. A number of activity rooms will allow residents to continue with their hobbies and there will also be an onsite café and hairdressing salon.

Along with the residential services, the home will offer day care for up to 50 elderly people who will access the facilities on site and relax in the themed garden courtyards and terraces.

Councillor McNair said: "I am delighted to cut the first sod to mark the start of work on this great new facility. The new home and day care underlines our commitment to give residents in Clydebank and beyond the opportunity to live as independently as possible, while still having access to support when they needed it. The facilities on offer will provide a real sense of community for all the residents living here and I look forward to seeing the progress of the home which is due to open in the summer of 2020."

Allan Macleod, Chair of WDHSCP, said: "I am pleased to see work starting at the new Clydebank Care Home. This new facility will play a crucial role in improving the care of the older people in our community whilst also promoting their independence. The communal courtyards will let residents enjoy outdoor activities in a safe and accessible environment with outstanding views over the Clyde."

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

8 May 2019

Subject: Preparation for Implementation of Carers' (Scotland) Act

1. Purpose

1.1 To present the Partnership Board with a re-drafted West Dunbartonshire Health and Social Care Partnership local Carers Strategy 2019 - 2022 following consultation process.

2. Recommendations

2.1 The Partnership Board is asked to:

- Approve the draft Carers Strategy 2019 – 2022 prepared with partners and carers across West Dunbartonshire and seek for officers to bring an Annual Report in April 2020 on progress against the actions and performance indicators.

3. Background

3.1 The Carers (Scotland) Act was passed on 4th February 2016. It gained Royal Assent on 9th March 2016. The implementation of the provisions in the Carers Act - which are designed to support carers' health and wellbeing - commenced on 1st April 2018; and builds on the aims and objectives set out in the National Carers and Young Carers Strategy 2010 – 2015.

3.2 The Act covers a range of areas relating to supporting carers including a number of new duties and requirements which impact on the Integration Joint Boards (IJBs) – i.e. the Act provides a joint duty for both health boards and local authorities to create local carer strategies.

3.3 The Carers (Scotland) Act 2016 (Commencement No. 1) Regulations 2017 brings into effect consequential amendments to update legal references in the Public Bodies (Joint Working) (Scotland) Act 2014. A consequence of this is that IJBs have now been identified as lead organisations for implementation with responsibility for duties previously highlighted as local authority; and so the Carers Act is now explicitly and expeditiously incorporated into our Integration Scheme.

4. Main Issues

4.1 HSCP Officers have then been working in partnership to prepare for the commencement of the Act since 2016, primarily through the local Carers' Development Group; and in particularly close conjunction with Carers of West Dunbartonshire, Y-Sort-It and West Dunbartonshire CVS (under the auspices of Partnership Agreements agreed with both those organisations by the Partnership Board).

4.2 The draft Carers Strategy 2019 – 2022 has been prepared with partners and carers across West Dunbartonshire and reflects key actions and activities prioritised by carers and their representatives.

4.3 The Strategy aligns to the priorities of the Strategic Plan of Early Intervention; Access; Resilience; Assets and Inequalities. The newly developed action plan links to the priorities which have been developed over the last year with carers, carer representatives and the wider community and partners. This three year plan sets an innovative tone to the support the HSCP and partners are offering to carers particularly in terms of partnership working across the sector.

4.4 As requested by the HSCP in February, there will be an annual reporting on the Strategy against the action plan and performance indicators which will ensure that members are informed and updated as to progress. The requirement for detailed timescales and actions was reflected within the formal consultation as a key activity; in addition those who responded

5. People Implications

5.1 No specific implications associated with this report.

6. Financial and Procurement Implications

6.1 It is acknowledged that the Act does place additional demands on HSCP budgets at a time of continuing fiscal austerity; and that much of these have as yet not been fully quantified nationally (e.g. the financial impact of waiving of charges for carers).

6.2 As previously reported to the Partnership Board there is an additional £66 million - for the whole of Scotland - to support additional investment in social care in recognition of a range of pressures local authorities are facing, including the Carers (Scotland) Act 2016. As the Chief Financial Officer already reported this reflects new monies for carers and to support implementation of the Act.

6.3 We are of course still mindful that as to whether West Dunbartonshire's share of the carers' funding is sufficient to cover the actual cost of local implementation and indeed the expectations of local carers; and there are ongoing discussions locally to ensure we are consistently funding support services for carers.

7. Risk Analysis

7.1 HSCP Officers have been and continue to take forward the work described in this report so that the Partnership Board will be best placed to appropriately meet its duties and responsibilities under the new Act.

8. Equality Impact Assessment (EIA)

8.1 Equality Impact Assessments has been completed as part of the development of the local Carers Strategy.

9. Consultation

9.1 Engagement was on-going and will continue to be an element of the Carers' implementation of the Action Plan. This will include focused HSCP Local Engagement Network (LEN) sessions jointly facilitated with Carers of West Dunbartonshire and Y-Sort-It.

10. Strategic Assessment

10.1 The Strategic Plan 2019 – 22 recognises the importance of working with and effectively supporting carers in order to delivery improved health and care outcomes within West Dunbartonshire.

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

Date: 16th April 2019

Person to Contact: Wendy Jack
West Dunbartonshire Health & Social Care Partnership, Aurora House, 3 Aurora Avenue, Clydebank, G81 1BF
E-mail: Wendy.Jack@west-dunbarton.gov.uk

Appendices: WD HSCP Draft Local Carers Strategy 2019-2022

Background Papers: Carers (Scotland) Act 2016:
http://www.legislation.gov.uk/asp/2016/9/contents/enacted

The Carers (Scotland) Act 2016 (Commencement No. 1) Regulations 2017:
http://www.legislation.gov.uk/ssi/2017/94/made

Carers Strategy 2019 – 2022

Wards Affected: All.

West Dunbartonshire Health and Social Care Partnership

Draft Local Carers Strategy 2019-2022

April 2019

Document Title:	Local Carers Strategy	Owner:	
Version No.	V3	Superseded Version:	V1
Date Effective:	April 2019	Review Date:	April 2020

Foreword

West Dunbartonshire Health and Social Care Partnership is pleased to present our Local Carer's Strategy. This strategy recognises the significant contribution that unpaid carers make to the health and wellbeing of the citizens of West Dunbartonshire and the value that we, as West Dunbartonshire Health and Social Care Partnership, place on the role that carers play across our communities.

The publication of this strategy is our response to the implementation of the Carers (Scotland) Act 2016 enacted on 1st April 2018. This Act requires each local authority and relevant health board to prepare a statutory local carers strategy as well as extending and enhancing the rights of unpaid carers, a position that the Health and Social Care Partnership welcomes.

Our strategy seeks to take into account those areas of a carer's life that may be impacted by their caring role and we seek to identify the provision of a variety of support in order that they can continue in that role should they wish to do so. Our aim is that they are enabled to have a life alongside caring.

This new duties in the Carers (Scotland) Act 2016 applies to local authorities and relevant health boards but is delegated to integration joint boards under the Public Bodies (Joint Working) Scotland Act.

It is our ambition that the role of unpaid carers is recognised, that their views are heard and used in designing and delivering services, not only for themselves but for those that they care for. We know that undertaking a caring role can often be a demanding and complex task and we hope that this strategy offers opportunities to lighten the load.

We acknowledge the demographic and financial challenges that we face and we recognise that unpaid carers are key to the sustainability of the health and social care system. Whilst funding is limited we will ensure we target what funding we have to the areas that need it most.

The implementation of this strategy will be taken forward in a partnership approach. The Health and Social Care Partnership, carers, the third sector and the independent sector, will ensure that the implementation plan is realistic, achievable and inextricably linked to the needs of carers in West Dunbartonshire.

We are committed to ensuring that young carers are seen as children and young people first and foremost and that any caring responsibilities that they undertake are appropriate and have regard to their age and maturity.

Beth Culshaw
Chief Officer
West Dunbartonshire Health and Social Care Partnership

Contents Page

1. Carers Strategy at a glance

How can this strategy help carers?

Area of Life	Issues	How this strategy might help
Health & Wellbeing	• Mental health (stress, worry, depression) • Sleep & energy levels • Physical health	• Respite/Short Break • Reassessment of need • Support groups and activities for carers • Information and advice
Relationships	• Strained relationships	• Counselling • Respite/Short Break • Additional services for the cared-for person
Finance	• Reduced income • Additional costs • Debt or money worries	• Support to maintain employment • Access to benefits such as Carers Allowance • Help with heating/travel costs
Life Balance	• Reduced ability to socialise • Feeling too tired/stressed	• Respite/Short Break • Additional services for the cared-for person
Future Planning	• Careers advice • Training opportunities • Socialisation	• Support groups and activities for carers • Information and advice
Employment and training	• Unable to work • Reduced hours • Restricted opportunity	• Additional help with care • Support from employers • Flexibility and understanding
Living Environment	• Adaptations • Location	• Information and advice • Link to relevant services to support
Education	• Access to education • Restrictions on positive destinations • Ability to engage with education	• Information on opportunities available • Young carers supported in schools, colleges and universities • Additional help with care to enable participation in education

What we want carers in West Dunbartonshire to be able to say as a result of this strategy.

"I am supported to identify as a carer and am able to access the information I need"
"I am supported as a carer to manage my caring role"
"I am respected, listened to and involved in planning the services and support which both I and the person I care for receive"
"I am supported to have a life alongside caring if I choose to do so"

2. The Carers (Scotland) Act 2016

The Carers (Scotland) Act 2016 seeks to give adult and young carers new rights, whilst bringing together all the rights carers currently have, within previous legislation.

West Dunbartonshire Health and Social Care Partnership is committed to delivering all aspects and requirements of the Act particularly in relation to:

- identifying both adult and young carers living within our communities
- understanding the care that they provide and their support needs
- providing comprehensive and easily accessible information and advice on the type of support available as well as how and where to get it

The Carers Act brings changes to how carers can access support through 'Adult Carer Support Plans' and 'Young Carers Statements'.

The Carers Act requires a focus on assessing the needs of the carer separately from the needs of the cared for individual.

New duties and powers	
Adult Carer Support Plans and Young Carers Statements	Adult Carer Support Plans will replace the old carers' assessments and consider a range of areas that impact on a carer. Young Carer Statements must be in place for children and young people.
Eligibility Criteria	Eligibility criteria for access to social care services for carers must be published. However, not all support offered to carers will be subject to the criteria.
Carer Involvement	Carers must be involved in both the development of carer services and in the hospital discharge processes for the people they care for.
Local Carers Strategies	Local Carers' strategies, such as this one, must be produced and reviewed within a set period.
Information and Advice	An information and advice service must be provided for relevant carers, with information and advice about rights, advocacy, health and wellbeing (amongst others).
Short Breaks Statements	To prepare and publish a statement on short breaks available in Scotland for carers and cared for persons.

3. Who are our carers?

A carer[1] can come from all walks of life; be any age, including young children; employed, in education or neither; and have other responsibilities in terms of family to look after. The lives of children and young people within a family environment who are not the direct care-giver can nonetheless be significantly impacted by the caring situation.

A carer can provide care for a few hours a week or 24/7. The care they provide can be light touch or intensive. Some carers have to care for more than one person, which presents unique challenges. They may have had a caring role their whole life or it may be for only a short time.

The Adult Carer Support Plan process can be accessed by

- carers who reside in the area of the local authority who provide or intend to provide care for cared-for persons in that area
- carers who do not reside in the authority's area but who provide or intend to provide care to cared-for persons in that area

The "cared-for person" can often be a family member, friend or neighbour. They can also be young or old and have a range of care needs including support within the home, help with getting out and about, and help with end of life care. Some cared for people may have multiple care needs.

Many people providing care do not see themselves as a 'carer'. They are first and foremost a husband, wife, son, daughter, or friend, who is undertaking acts of kindness, perhaps sometimes seen as a duty, for their loved one.

As the types of carer are varied, the approaches we take to support them must also be diverse and flexible.

[1] The term carer used throughout this strategy refers to those in an unpaid caring role.

4. Understanding the impact of the caring role

The National Carer Organisations has produced a Best Practice Framework for Local Eligibility Criteria for Unpaid Carers. In it they have identified seven areas of a carer's life which may be impacted by their caring role.

Each of the seven areas may not be impacted upon for all carers and not every carer will be impacted upon to the same degree, but the areas are relevant for consideration for all carers both young carers and adult carers and in all circumstances.

Health & Wellbeing

The impact could be on mental health, physical health or wellbeing and could range from feeling a bit worried about things to depression; from a general feeling of tiredness to serious joint and/or muscle damage; or from perhaps having to assist with lifting and moving the cared-for person.

Relationships

Caring for a loved one can often be upsetting particularly if the person is physically deteriorating or their personality is changing. This can affect the carer's emotions and in some cases their experience can be similar to grief or feeling bereaved. Relationships with family and friends can become strained.

Finance

The act of caring can incur additional expenses with the cost of transport and/or parking whilst attending medical appointments. Having to buy specialist equipment or products, replacing clothing, turning up the heating or doing more laundry all bring added expense. If the cared-for person was the main earner and their condition has meant that they have had to give up work this affects the overall household income. Some carers told us that they had taken out a loan or fallen behind with bill payments as a direct result of their caring responsibilities.

Life Balance

Dedicating time to caring can mean that the carer often cannot find time to socialise or even just have some "me time" to do things that they want to do for themselves. Often carers put the needs of the cared-for person first and don't have the time or the energy to fully consider their own needs leading to these being neglected.

Future Planning

In some situations it can be difficult for a carer to make any plans whether these are short, medium or long term plans. This can be in any area of their life from their career, their education and development, or even their social life. Even a simple invitation to a night out at the weekend may be impossible to accept. For some, future planning may include ensuring care will continue for the cared-for person should the time come when the carer is no longer around to do it themselves.

Employment and Training

Caring can affect the carer's ability to work and access to training opportunities. It can also impact on their choice as to what type of employment they do or training they undertake, where they work and how many hours they do. They may be forced to delay starting work or training at all, have to give up work or a course, take early retirement, or reduce their working hours as a result of their caring role. They may not be able to focus on career development, or apply for promoted posts and may be restricted to particular jobs in certain areas that allow them to continue to provide care. Carers told us that not all employers understand the caring role or are flexible enough to accommodate it.

Living Environment

In some cases a carer may have to adapt their home to accommodate the needs of the cared for person and this can fundamentally change a carers own living situation. Other carers do not live with the person that they care for but their living environment can still be impacted upon.

Impact on Young Carers

In addition to the principles noted above, the assessment of the impact of caring upon a young person is considered within the context of the eight well being indicators for children (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included). For example, caring responsibilities may impact negatively upon a young carer's participation in education and their educational attainment, especially if professionals in school are unaware of the situation within which they live.

Children and young people have reported that conflicting emotions were linked to the caring role. As well as the feelings of worry and loneliness that might be expected there were also feelings of happiness and pride at being able to support a loved one.

Children and Young people identified concerns about bullying and a lack of understanding from both their peers and their teachers as barriers to young carers seeking support. There were also concerns around knowing where and who to seek support from and concerns that they may be taken away from their parents or that they may be placed in residential care.

5. Strategic Priorities

Supporting carers is a key strategic priority for the Health and Social Care Partnership and their strategic partners.

The West Dunbartonshire Health and Social Care Partnership Strategic Plan 2019 – 2022 agreed five priorities across all areas of service; in addition each one can be linked to support for carers and recognises the commitment to person centred planning, self directed support and, where possible, living independently at home.

Early Intervention	• Identification of carers of all ages and offer of assessment
Access	• Clear pathways into support services and good up to date information
Resilience	• Peer support services, training and advice • Support services for carers
Assets	• Work in partnership with carers and carer organisations to identify carer needs
Inequalities	• Access to good health and well-being information • All carers feel included and listened to

There is a recognition that services across health, social care, education, third and independent sectors need to better support children, young people and adults in a caring role including, in some areas, improving practices and culture.

Our commitment to our carers will be monitored, measured and delivered through the commitment to the National Health and Wellbeing Outcomes; in particular "People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing."

The new national Health and Social Care Standards also aim to ensure that people across Scotland receive the same high standard of care and support, delivered in a way which reflects their own personal needs and circumstances. These new national Health and Social Care Standards sit beneath five overarching principles (dignity and respect; compassion; included; responsive care and support; and wellbeing). They set out what people should experience every time they use health and/or social care services.

Partners across all service areas recognise the significant role of unpaid carers and that their views are included, their health and wellbeing will be nurtured and the impact of their caring role on their everyday lives reduced as far as possible. This will be reported and monitored through the Strategic Planning Group and the Health and Social Care Partnership Board.

5.1 Early intervention and identifying carers

A key focus of the West Dunbartonshire Health and Social Care Partnership is the identification of carers and providing support linked to the type and level of care they provide. It is well documented that many carers do not recognise themselves as carers, therefore providing good information in a variety of settings is vital to ensuring that there are more opportunities for people in West Dunbartonshire to identify themselves as carers.

Identifying carers and asking carers to identify themselves is dependent on carers recognising:

- caring activities can often be seen as just a part of the relationship and the term 'carer' can seem alien to people
- caring often starts at a low intensity so can go unnoticed
- accepting the identity of carer means acknowledging the other person needs care, which can be difficult
- there may be a general lack of awareness of the role of a carer

As a Health and Social Care Partnership, alongside partners, it is our responsibility to ensure practitioners and staff are able to identify adult and young carers; as well as informing carers of their right to identify themselves as a carer if they so wish and what this would mean for them.

West Dunbartonshire's Social and Economic Profile 2017 shows that there is a relatively large increases in our share of the 20% most deprived data zones in Scotland, showing the biggest increase in relative deprivation from 2012.

West Dunbartonshire's Health and Social Care Partnership Strategic Needs Assessment reports high levels of people with long term and complex conditions. This can be linked to the history of heavy industry in the area, with related diseases affecting people at a relatively young age. The findings of the demographics and carers service information have been considered and reflect the actions in the carers strategy.
For more information on the Strategic Needs Assessment please see
http://www.wdhscp.org.uk/useful-information/adults-and-older-people/

Strategic Priorities
1. West Dunbartonshire Health and Social Care Partnership and partner agencies, will deliver awareness raising events throughout the area both at specific carer events and with participation in other events.
2. West Dunbartonshire Health and Social Care Partnership and partner agencies, will seek to improve the identification of young carers by working collaboratively and in partnership.
3. West Dunbartonshire Health and Social Care Partnership and partner agencies will brief and train our staff across the partnership to better enable them to identify and support carers.

5.2 Access and clear pathways into support services

The Health and Social Care Partnership is committed to working with carers in West Dunbartonshire and ensuring that carers have access to advice, information and support. As such the Health and Social Care Partnership works with patients and clients to provide a high quality of care and recognises the need to support carers to continue in their caring role.

Carers have consistently highlighted that they can derive considerable benefits from their caring role and that services delivered to patients and carers can help them enjoy a quality of life out-with their caring responsibilities, thus enabling them to sustain the caring roles they provide. It is noted by all partners that individuals may not choose to be carers and assumptions about caring roles should not be made by practitioners.

The Health and Social Care Partnership seeks to build on and improve access to support for carers. It recognises that it is necessary to be consistent about what we expect carers to reasonably and safely provide when supporting loved ones at home.

We also need greater flexibility in responding to the needs of individuals. For young carers in particular, we seek to reduce the numbers of young carers undertaking inappropriate caring roles by raising awareness of young carers and by improving their ability to access help and support.

West Dunbartonshire Adult Carer Support Plan	• Informal assessment and planning may be enough for some carers whilst others may need additional information to contribute to the formal assessment of an Adult Carer Support Plan • Assessment and information gathering is a shared responsibility and should involve carers, practitioners and carers representatives as appropriate • The processes and systems of assessment and information gathering need to be simple, accessible and user friendly
West Dunbartonshire Young Carers Statement	• Informal assessment and planning may be enough for some carers whilst others may need additional information to contribute to the formal assessment of a Young Carer Statement • Assessment and information gathering is a shared responsibility and should involve carers, practitioners and carers representatives as appropriate • The processes and systems of assessment and information gathering need to be simple, accessible and user friendly

The Health and Social Care Partnership works to support carers of all ages with their caring roles through assessing their needs for health and social care services.

Step 1 Tier One	Carer Conversation is recorded within the cared for persons Self Directed Support assessment tool	Carer conversation is between the worker and the carer; this conversation and subsequent record will contain relevant questions around the caring role that the carer is undertaking detailing the type of support being provided by the carer and type of support the carer is seeking.
Step 2 Tier Two	Adult Carer Support Plan or Young Carer Statement	Tier 2 Adult Carer Support Plans or Young carer Statements is completed after a Tier 1 Carer Conversation has taken place and it has been identified that the carer needs or has requested a full Adult Carer Support Plan.
Step 3 Outcomes	Adult Carer Support Plan or Young Carer Statement	All carer outcomes are captured by the Tier 2 Adult Carer Support Plan or Young Carer Statement as above.
Step 4 Service	Self-Directed Support	All partners are able to ensure carers are informed about how carers can have their support arranged i.e. the 4 self-directed support options and will assist the carer to choose from the 4 Self Directed Support options available.
Step 5 Service Review	Adult Carer Support Plan or Young Carer Statement	The Tier 2 Adult Carer Support Plan or Young Carer Statement will remain in place until a review is undertaken. Review of support will normally take place annually **or** when there has been a significant change to the carers or to the cared for persons circumstances. The review of the Adult Carer Support Plan or Young Carer Statement can be done by statutory services or third sector partners.

It has been well documented that carers need good information and access to timeously assistance as well as knowing how to access support and how to make the best use of it. This is true both for carers of people receiving social care or health care services and for carers unknown to social care or health care services.

All carers, including young carers, have the right to an assessment to identify the help that they may need to continue in their caring role. The Health and Social Care Partnership works in partnership with all agencies in a family centred way when assessing and meeting the needs of carers of any age and also promotes inclusion whenever possible.

Those carers who choose not to have their needs formally assessed will, as far as possible, be provided with information and advice and signposted towards available community supports. It is necessary to maintain a focus on the provision of timely, accurate and good quality assessment, information and advice, not only when someone is new to caring but also whenever information and advice is needed.

The Carers (Scotland) Act does not prescribe specific timescales for assessments to be completed except for cases which involve those carers caring for those with a terminal illness. In West Dunbartonshire the timescales for completion of an Adult Carer Support Plan or Young Carer Statement vary due to the urgency, complexity and risk of each individual case.

The preparation of the Adult Carer Support Plan or Young Carer Statement will always be prepared as quickly as it appropriate with a focus on achieving the right outcomes for the carer based on their individual situation rather than adherence to a particular timescale. Young carers and their families need an assessment which will take account of both their individual needs and the needs of the family as a whole.

West Dunbartonshire Health and Social Care Partnership is committed to ensuring carers can access support to ensure they are able to continue in their caring role and consequently believe that the best option for carers and their cared for people is to have an eligibility criteria which reflects this position.

Strategic Priorities
4. All staff within the Health and Social Care Partnership and partner agencies will ensure carers are listened to with the overall purpose of establishing their outcomes and then needs.
5. The Health and Social care Partnership will review the assessment tools and the processes to ensure emergency arrangements and future planning so that carers can successfully plan for periods of transition or crisis.

5.3 Resilience of carers

Why resilience matters - Resilience refers to the ability to 'bounce back' and cope in the face of adversity, so for carers this is really important.

We know from carers that:

- Resilience is the ability to see opportunities for personal growth in the midst of hardship may distinguish spouses who thrive as compared to others overwhelmed by caregiving demands'
- Three resilience domains—personal mastery, self efficacy and positive coping styles— have been found to mitigate the impact of stress on carer health
- Some factors may help reduce the effects of chronic stress in caregivers such as social support, engagement in pleasant activities, self-esteem, positive attitudes towards the caregiving role, hope and optimism
- Carers have a 20% increased chance of mental health problems

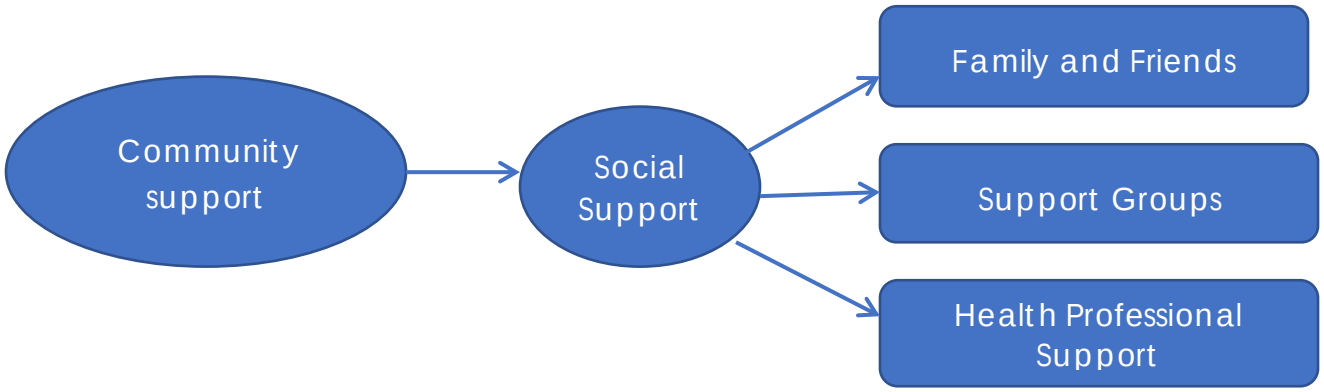
Resilience can be defined as

- the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma.
- behavioural process' built on strengthening personal attributes and external assets such as supportive relationships and community resources
- to increase the person's 'hardiness' to remain psychologically and physically healthy

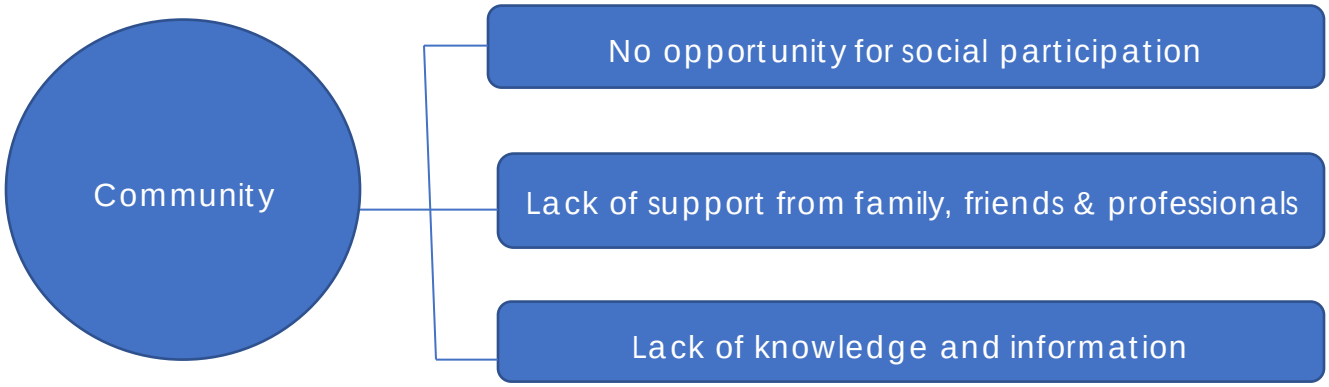
Factors that hinder resilience at individual level

- Relationship pressures
- High Stress

Factors that facilitate resilience at community level



Factors that hinder resilience at a community level



Conclusions
At individual level, learning from life experiences and a sense of gratitude seem to be important resources for resilience.

Foundations for building capacity for resilience at

- Community level social supports from family, friends, groups and health professionals and social participation and relationships matter, so need to work to strengthen these.
- Individual level- staying positive, having a sense of humour, and a fighting spirit
- Society – remove stigma and negative attitudes

Most people have the capacity to be resilient and building resilience matters but everyone struggles at some stage and support brings people through. West Dunbartonshire Health and Social Care Partnership is committed to building the resilience of carers and supporting them in the way that suits each individual carers needs.

Strategic Priorities
6. All staff within the Health and Social Care Partnership and partner agencies will ensure that after identification of needs all carers have access to information, advice and support including peer support.
7. All staff within the Health and Social Care Partnership and partner agencies will ensure that young carers have access to advice and information. By developing a tiered approach to service delivery from the pro-active and comprehensive availability of information and advice for young carers with low level needs; through to support for those with moderate needs and support from a specialist and individualised service to promote the young person's resilience for those with high level needs.
8. All staff within the Health and Social Care Partnership and partner agencies will recognise carer's strengths and limitations and the resources and assets that exist in their immediate network and wider.

5.4 Assets and planning for carers

The Health and Social Care Partnership and partners are mindful that for some carers much of the time their caring role can be a positive and rewarding experience, giving them a sense of purpose, building confidence and self esteem. However from time to time carers may feel angry, guilty or frustrated when caring gets in the way of the life they would like to lead. For young carers specifically, they are also often very reluctant to talk to anyone about their problems as they think it will reflect badly on their ability to cope.

As such, the identification of person centred support for carers from a variety of places can often help carers to continue in their caring role. One important source of support is ensuring that carers have access to Short Breaks.

The purpose of a Short Break is to support the caring relationship and promote the health and well-being of the carer, the supported person, and other family members affected by the caring situation.

Carer Short Breaks can take any number of forms in order to achieve the carer's desired outcomes. The purpose is for carers to have a life outside or alongside their caring role, supporting their health and wellbeing. This can also benefit the cared-for person and others (e.g. family members) and may sustain the caring relationship.

West Dunbartonshire Health and Social Care Partnership promotes an individual, creative, personalised, person centred approach to short breaks that will meet the individual nature of the needs of each carer (and the cared for person). It should be noted that there are important distinctions to be drawn between young carers, young adult carers and adult carers whilst recognising that there are similarities in the caring experiences.

For carers planned respite is not always an option and as such the Health and Social Care Partnership and partners can provide access to emergency support for carers; providing carers with a jointly agreed contingency plan and peace of mind should an emergency situation arise. An emergency plan sets out the practical arrangements for these unexpected situations. By writing it down and involving others, creating an emergency plan can give the carer and the person they you care for peace of mind and help avoid a crisis.

A key stage for young carers is the point at which they transition from being a young carer to an adult carer. This age group is often characterised by life transitions such as the transition to college, university and work; living away from home; wanting to reduce the caring role; or not wanting to be a carer at all. These may impact upon and change the caring role and the need for support, the Health and Social care Partnership is committed to ensuring that this is reflected in the Young Carer Statement. When a young carer transitions,

the Young Carer Statement is considered relevant until an Adult Carer Support Plan has been carried out.

For all carers who are seeking to create their own package of care based on their assessment of need; carers are able to access Self Directed Support as a means to assist people who may need support to have maximum choice and control over how this support is planned and provided. The Social Care (Self-directed Support) (Scotland) Act 2013 provides a framework for transparency and clarity in how partnership and collaborative practice can be effective in supporting practice to work creatively and resourcefully. This approach is embedded in the Carers (Scotland) Act to support carers to make informed choices on how their individual budget is used to meet the outcomes they have agreed.

The Health and Social Care Partnership works with service users to offer more flexibility, more choice and more control over their support so that they can live at home more independently. It is important that our local services create arrangements which will facilitate more choice and control over service provision and promote the opportunities for patients and clients. This includes the use of technology for the cared for person and for carers to support the caring role.

Strategic Priorities
9. All staff within the Health and Social Care Partnership and partner agencies will ensure carers have information and advice on access to short breaks and respite.
10. All staff within the Health and Social Care Partnership and partner agencies will ensure carers have information and advice on accessing the four options of self directed support.
11. All staff within the Health and Social Care Partnership and partner agencies will ensure that the use of **Telecare** options is explored to further assist with the caring role.
12. The Health and Social care Partnership and partners will ensure that dedicated Information and advice is available to all carers and that this will continue to be developed and managed thus ensuring that it is continuously updated and improved.
13. We will give consideration to those caring for the terminally ill ensuring that they plan for their life after caring, including young carers who may be left without a parent or other significant adult in their lives.

5.5 Equalities and carers as partners

Recognising that carers, young and old, come from all areas of our wider population, the Health and Social Care Partnership seeks to engage with them in a variety of ways that is appropriate to a carers' needs, capacity and in a format which is familiar.

The Health and Social Care Partnership is a particularly keen to increase the identification of young carers in West Dunbartonshire. It is not only our responsibility to educate practitioners and staff to assist in this but also to inform young carers and people who support them of their right to identify themselves if they so wish and what the benefits of identification may mean.

The Health and Social Care Partnership, with partners, has undertaken a series of awareness raising events to help the wider population understand the needs of adult and young carers and the challenges that they face. Moving forward, we will continue to maximise every opportunity at other events to raise the profile of carers and enable people across West Dunbartonshire to identify as a carer.

Young carers in West Dunbartonshire have identified through consultation and engagement events the key supports that would be most helpful for them to maintain their caring role; these relate to time and space within school environment; having someone to talk to and having planned time away from their caring role.

All partners recognise that engaging with carers of all ages is vital in ensuring that services and support which are delivered are high quality and appropriate.

Equal Partners in Care is a joint project between National Health Service Education Scotland and the Scottish Social Services Council aimed at achieving better outcomes for all involved in the caring relationship.

This project has a set of core principles which were developed in consultation with a wide range of stakeholders and are based on key outcomes. These are very relevant to this strategy and as such we have adopted these as the best practice we will work to.

The 'Equal Partners in Care' Principles are:

- carers are identified
- carers are supported and empowered to manage their caring role
- carers are enabled to have a life outside of caring
- carers are fully engaged in the planning and shaping of services
- carers are free from disadvantage or discrimination relating to their role
- carers are recognised and valued as equal partners in care

The principles of equality, diversity and human rights are the basic rights for all carers. Carers reflect the diversity of Scotland's population. We will work to ensure that carers are aware of their rights under this legislation and that no carer is disadvantaged due to age;

disability; gender reassignment; marriage and civil partnership; pregnancy and maternity, race; religion or belief; or sex or sexual orientation, in line with the Equality Act 2010.

All children and young people have an established set of rights and principles based on the United Nations Convention on the Rights of the Child. These say that nobody should treat a child or young person unfairly and that when adults make a decision about a child or young person it is what's best for the child or young person that should be the most important thing to consider. The child or young person must have their say too.

As an adult or young carer, being aware of their rights and those of the person they care for can help both get fair access to things that most people take for granted.

Strategic Priorities
14. The Health and Social Care Partnership and partners will seek to ensure that we sensitively identify young carers within schools via awareness raising, training and continuous professional development building on the principles of Getting it Right for Every Child.
15. The Health and Social Care Partnership and partners will continue to maximise every opportunity at other events to raise the profile of carers and enable people across West Dunbartonshire to identify as a carer.
16. The Health and Social Care Partnership and partners will ensure that carers are involved in planning services and support for both carers and cared-for people.
17. The Health and Social Care Partnership and partners aim to involve young carers in every step of the implementation of the new Strategy as was done with the development of the new Young Carer Statement.
18. The Health and Social Care Partnership and partners will continue to be committed to the core principles of Equal Partners in Care.

6. Financial Information

The Health and Social Care Partnership's strategic priorities for carers ensure that carers are supported to have a life alongside caring if they choose to do so.

This strategy will be monitored through the Strategic Planning Group and Health and Social Care Partnership Board with regular reporting.

The Scottish Government has allocated funding for the implementation of the Carers Act through its annual financial settlements to both local authorities and health boards, with the recommendation that this funding was transferred to Health and Social Care Partnerships.

In 2017/18 the Scottish Government allocated a total of £107 million to support health and social care integration. Of this total £2 million was identified to support the implementation of the Carers Act. The Health and Social Care Partnership's share of this amounted to £39,000 and was directed towards Carers Engagement Events.

In 2018/19 the Scottish Government's increased its investment in Integration by £66m, and of this total, £19m was to be directed to the enactment of the Carers (Scotland) Act from 1st April 2018. The Health and Social Care Partnership's share for 2018/19 is £340,000 and the detail of how this will be spent is reported to the Health and Social Care Partnership Board through the Financial Performance Reports. Any funds remaining by the end of the 2018/19 financial year will be considered as part of the Annual Accounts in line with the approved Reserves Policy.

Further funding from the Scottish Government is anticipated in the 2019/20 budget settlement to local authorities.

Strategic Priorities
19. The Health and Social Care Partnership and partners will ensure the use of Best Value of spend linked to carers services and commissioning approach.

7. Action Plan

The Health and Social Care Partnership has developed this Local Carers Strategy which lays out our aspirations for supporting carers in their caring role.

We have identified some statements we would wish carers in West Dunbartonshire to be able to meet.
We have the feedback from our consultation and engagement with carers, with staff and other relevant stakeholders.
We have a profile of the carers in West Dunbartonshire and a sense of the scale of the number of carers we have yet to identify.
We have an understanding of the impact that the caring role can have and we know the support that is currently available to carers.

The priorities identified and specified within this strategy and within other work-streams for the Health and Social Care Partnership affect carers in our communities and impact on a range of community health and social care services.

In developing effective strategies to support carers, a wider range of partners, beyond health and social care, need to respond to the needs of carers with the aim of enabling carers to continue to live fulfilled lives, notwithstanding their caring responsibilities. Making a reality of the aspirations of the Health and Social Care Partnership for carers is only likely if local partners develop robust joint commissioning strategies across care groups which are developed and monitored in conjunction with carers and their representative organisations.

The Health and Social Care Partnership will continue to work to identify carers in need of support whilst acknowledging there is risk that the expectations of carers cannot be supported by available resources and / or allocated funding.

The Health and Social Care Partnership Strategic Priorities	Actions	Timescales
1. West Dunbartonshire Health and Social Care Partnership and partners agencies will deliver awareness raising events throughout the area both at specific carer events and with participation in other events.	Partners continue the programme of awareness with staff, stakeholders and partners as to what it means to be a carer. Recoding and evaluating training as it is delivered Working in partnership with Carers of West Dunbartonshire, Y Sort it and CVS to deliver.	Throughout 2019 – 2020
	Continue our programme to raise awareness with staff, stakeholders and partners to the needs of carers as adults and young people. Working in partnership with Carers of West Dunbartonshire, Y Sort it and CVS to deliver.	Throughout 2019 – 2020
2. West Dunbartonshire Health and Social Care Partnership and partners agencies will seek to improve the identification of young carers by working collaboratively and in partnership.	Implement Young Carer Statements across partner agencies working with young people. Learning from and working with Y Sort it to deliver.	June 2019
3. West Dunbartonshire Health and Social Care Partnership and partners agencies will brief and train our staff across the partnership to better enable them to identify and support carers.	All partners will work across our communities and with our communities to support them to understand the support available to carers, particularly vulnerable carers. Recoding and evaluating training as it is delivered Working in partnership with Carers of West Dunbartonshire, Y Sort it and CVS to deliver.	Throughout 2019 – 2020

The Health and Social Care Partnership Strategic Priorities	Actions	Timescales
4. All staff within the Health and Social Care Partnership and partner agencies will ensure carers are listened to with the overall purpose of establishing their outcomes and their needs.	Continue to work with carers and their representatives within the review, planning and delivery of local services. Review carers' census information and ongoing feedback from carers groups and representatives	Throughout 2019 – 2020
	Continue to seek opportunities to work with carers and their representatives on specific and targeted programmes of work e.g. hospital discharge and addictions issues.	3 sessions to be delivered in 2019 – 2020
5. The Health and Social Care Partnership will review the assessment tools and the processes to ensure emergency arrangements and future planning so that carers can successfully plan for periods of transition or crisis.	The Health and Social Care Partnership will implement the principles of the Self Directed Support asset based assessment tool into Tier 2 carers assessment.	Linked to SDS Action Plan; focus groups and joint work throughout 2019 – 2020
6. All staff within the Health and Social Care Partnership and partner agencies will ensure that after identification of need all carers have access to information, advice and support.	Refresh current mapping of carers support available across communities and identify gaps. Link with work already underway with NHS Inform	September 2019
	Continue to review the information, advice and signposting available to carers.	September 2019
7. All staff within the Health and Social Care Partnership	Continue to review the information, advice and	April 2020

The Health and Social Care Partnership Strategic Priorities	Actions	Timescales
and partner agencies will ensure that young carers have access to advice and information; by developing a tiered approach to service delivery from the pro-active and comprehensive availability of information and advice for young carers with low level needs; through to support for those with moderate needs and support from a specialist and individualised service to promote the young person's resilience for those with high level needs.	signposting available to young carers. Focus groups with young carers to be held in 2019 – 2020 to seek their views and feedback, in partnership with Y Sort it	
	Continue to develop with key partners the transition process for young carers becoming adult carers. Focus groups with young carers to be held in 2019 – 2020 to seek their views and feedback, in partnership with Y Sort it	October 2019
8. All staff within the Health and Social Care Partnership and partner agencies will recognise carer's strengths and limitations and the resources and assets that exist in their immediate network and wider.	The Health and Social Care Partnership will implement the principles of the Self Directed Support asset based assessment tool into Tier 1 and Tier 2 carers' assessments.	Linked to SDS Action Plan; focus groups and joint work throughout 2019 – 2020
9. All staff within the Health and Social Care Partnership and partner agencies will ensure carers have information and advice on access to short breaks and	The Health and Social Care Partnership Short Break Services Statement will be reviewed in 2020 following a year of implementation.	April 2020

The Health and Social Care Partnership Strategic Priorities	Actions	Timescales
respite.	Alignment to review of charging policy will be required	
10. All staff within the Health and Social Care Partnership and partner agencies will ensure carers have information and advice on accessing the four options of self directed support.	The Health and Social Care Partnership will continue to work with partners on raising awareness of Self Directed Support for carers e.g. Shop-Mobility, Y Sort it and Carers of West Dunbartonshire.	Linked to SDS Action Plan; focus groups and joint work throughout 2019 – 2020
	Monitor the numbers of carers taking up Option 1 under Self-Directed Support. In line with carers' census and SDS reporting and promotion of SDS across all service areas	Linked to SDS Action Plan; focus groups and joint work throughout 2019 – 2020
11. All staff within the Health and Social Care Partnership and partner agencies will ensure that the use of Telecare options is explored to further assist with the caring role.	The Health and Social Care Partnership will monitor the increased use of Telecare options to support carers. Working in partnership with Carers of West Dunbartonshire, Y Sort it and CVS to deliver.	Throughout 2019 – 2020
12. The Health and Social Care Partnership and partners will ensure that dedicated information and advice is available to carers and will continue to develop and managed this thus ensuring that it is continuously updated and improved.	Health and Social Care Partnership will continue to review public information available on line, in print and on social media.	Throughout 2019 – 2020
	The Health and Social Care Partnership will continue to fund care representative organisations to provide up to date information	Throughout 2019 – 2020

The Health and Social Care Partnership Strategic Priorities	Actions	Timescales
	on variety of carer issues. Working in partnership with Carers of West Dunbartonshire, Y Sort it and CVS to deliver.	
13. We will give consideration to those caring for the terminally ill ensuring that they plan for their life after caring, including young carers who may be left without a parent or other significant adult in their lives.	The Health and Social Care Partnership and partners will develop a Palliative Care Statement for carers caring for those with end of life and palliative care needs. Working in partnership with Carers of West Dunbartonshire, Y Sort it and CVS to deliver, as well as a specialist palliative care services within statutory and voluntary services.	April 2020
14. The Health and Social Care Partnership and partners will seek to ensure that they sensitively identify young carers within schools via awareness raising, training and continuous professional development building on the principles of getting it Right for Every Child.	Develop a pathway and protocol for transition planning from Young to Adult Carer, including response to and provision for 16 and 17 year old young carers. Working in partnership with Carers of West Dunbartonshire and Y Sort it as well as Integrated Operations Managers.	April 2020
15. The Health and Social Care Partnership and partners will continue to maximise every opportunity at other events to raise the profile of carers and enable people across West Dunbartonshire to identify as a carer.	Maximise opportunities for carers to access support groups and activities; ensuring recordable and reportable information Working in partnership with Carers of West Dunbartonshire, Y Sort it and CVS to deliver.	April 2020
16. The Health and Social Care Partnership and partners will ensure that carers are	Continue to monitor carers' experiences through a variety of methods including focus groups,	3 sessions to be delivered in 2019 –

The Health and Social Care Partnership Strategic Priorities	Actions	Timescales
involved in planning services and support for both carers and cared-for people.	surveys and feedback. Focus groups with carers to be held in 2019 – 2020 to seek their views and feedback, in partnership third sector and through the Local Engagement Network	2020
	Monitor numbers of carers involved in service planning through participation and engagement	April 2020
17. The Health and Social Care Partnership and partners will aim to involve young carers in every step of the implementation of the new strategy as was carried out when developing the new Young Carer Statement.	All partners ensure engagement of young carers in commissioning and planning of services aimed at young carers. Monitor numbers of young carers involved in service commissioning through participation and engagement	3 sessions to be delivered in 2019 – 2020
18. The Health and Social Care Partnership and partners will continue the commitment to the core principles of Equal Partners in Care.	The Health and Social Care Partnership and partners will continue to promote and deliver Equal Partners in care training across communities and professional groups within West Dunbartonshire. Monitor numbers of staff participating	Throughout 2019 – 2020
19. The Health and Social Care Partnership and partners will ensure the use of Best Value of spend linked to carers services and commissioning approach.	Review the data being gathered as part of the Carers Census as well as existing performance measures.	Throughout 2019 – 2020
	Develop a robust financial	September

The Health and Social Care Partnership Strategic Priorities	Actions	Timescales
	framework linked to additional and existing funding available for carers.	2019
	The Health and Social Care Partnership will ensure commissioned services are adapted to account for new legislation. In partnership with WDC Procurement Team and in line with SDS Action Plan	September 2019
	Carers to be involved in future commissioning of carer support services. In partnership with WDC Procurement Team and in line with SDS Action Plan	December 2019

Health and Social Care Partnership Strategic Priorities	Performance Measures	Outcome
Early Intervention of Carers	Number of Young Carers Statements completed Number of Adult Carer Support Plans completed Number of adult carers who have had a carer conversation as part of the cared for person's assessment - Tier 1	We will be able to show that we are intervening earlier for carers and that we are identifying carers earlier.
Access to support/services for carers	Number of carers being provided with support Number of Carers accessing short breaks /respite % of adult carers requesting an Adult Carer Support Plan who have received one % of Young Carers who have received a Young Carer Statement	We can show that more carers are accessing support and that they can do this easily through all services. We can improve carer services/support based on identifying any issue as a result of monitoring and reporting info to the Scottish Government.
Resilience of Carers	% of adult carers who feel they are able to care when asked as part of their Adult Carer Support Plan or carer conversation % of young carers who feel they are able to care when asked as part of their Young Carers Statement	We can show that we are working to enhance/improve the resilience of carers.
Assets	Number of carers opting for Option 1 Self Directed Support Number of carers opting for Option 2 Self Directed Support Number of carers opting for Option 3 Self Directed Support	We can show that we are working to support our carers and also that we see them as valuable assets in our overall planning model and to shape improvements t o carers services
Inequalities	Report on numbers of carers from identifiable equality groups.	We can evidence that we are improving services for all groups and that we have strong partnership working at the heart of our approach to supporting carers.

8. Acknowledgements

West Dunbartonshire Health and Social Care Partnership expresses its thanks and appreciation to all participants who have worked hard to ensure that the West Dunbartonshire Local Carers Strategy is as comprehensive as it can be and covers carers of all ages.

Most importantly, carers from across West Dunbartonshire area were involved to assist with this work. It was important that the local Carers Strategy was written taking into account the views and voices of a range of carers in West Dunbartonshire as this would lead to a better informed document.

West Dunbartonshire's Carers Strategy will be jointly reviewed in 2020 by both the Health and Social Care Partnership and partners as required by the Carers Act (Scotland) 2016. An annual report on progress will be produced for the Health and Social Care Partnership Board to ensure robust monitoring and review of the Strategy.

Further information on this Local Carers Strategy can be obtained by contacting West Dunbartonshire Health and Social Care Partnership as detailed below.

West Dunbartonshire Health and Social Care Partnership
Church Street
Dumbarton
G82 1QL

Email: wdHealth and Social care Partnership @west-dunbarton.gov.uk

Website: http://www.wdHealth and Social care Partnership .org.uk/carers/

This Strategy was produced by a short life working group of the overarching West Dunbartonshire Carers Development Group. Membership of the short life working group was taken from the Carers Development Group and supplemented by others chosen by the Carers Development Group who had an interest in being involved in this work.

- West Dunbartonshire Health and Social Care Partnership
- Carers of West Dunbartonshire
- Y Sort-it Young Carers service
- West Dunbartonshire Community Volunteering Service
- Greater Glasgow and Clyde Health Board
- Adult carers living in West Dunbartonshire
- Young carers living in West Dunbartonshire

9. Support available for carers in West Dunbartonshire

Short Breaks - Access to personalised, flexible short breaks provision is crucial. Short breaks (also known as respite services) are a key support for carers. The Health and Social Care Partnership is committed to ensuring flexible initiatives based on individuals' assessed needs and circumstances that support carers to have time away from their caring responsibilities.	All carers
Information and Advice - The Health and Social Care Partnership is committed to providing the right type of information at the right time to carers, depending on their particular circumstances. All Health and Social Care Partnership services and partners play an important role in providing information that can help carers to understand and deal with difficult or challenging circumstances.	All carers
Health and Wellbeing - In recognition of the key role carers' play, they have access to opportunities for building their confidence and capacity in their caring role. This can address the emotional impact and practical demands of caring. Specific training e.g. moving and handling awareness and managing medication can be tailored to assist the carer to manage the cared for persons needs as well as supporting them to manage their own health and well-being.	All carers
Partnership Working - The Health and Social Care Partnership and other third sector partners have been providing key carer support services within West Dunbartonshire for several years. Through partnership with the third sector, opportunities continue to be offered to carers to develop their skills and knowledge and these include condition specific training as well as more general issues.	All carers
Outcome focused - The Health and Social Care Partnership is committed to identifying, assessing and supporting carers in a person centred and outcome-focused way which is consistently applied to all carers (including the provision of short breaks or respite).	All carers
Early identification - The emphasis for the Health and Social Care Partnership is on early intervention and preventative support By working in partnership across services, our approach supports early identification of the most vulnerable within our communities and their carers, thus supporting access and availability to the necessary supports that enable continued quality-of-life and in turn prevents crisis.	All carers
Self Directed Support - By aligning the development of self-directed support and carer's support, we aim to bring together our investment from a range of key policy developments to facilitate and expand opportunities for models of co-production and community capacity building.	All carers

10. For further information on carers services in West Dunbartonshire contact:

Carers of West Dunbartonshire
84 Dumbarton Road,
Clydebank,
G81 1UG
Tel – 0141 941 1550
Fax – 0141 941 1546
Email – **clydebankcc@carerswd.org**
Website – **www.carerswd.org**
Twitter – **www.twitter.com/CarersofWestDun**

Young Carers - Y Sort It
5 West Thomson Street
Clydebank
G81 3EA
Tel 0141 941 3308
Email - info@ysortit.com
Website - **https://ysortit.wordpress.com/**

WDCVS - West Dunbartonshire Community Volunteering Service
Arcadia Business Centre, Miller Lane,
Clydebank,
West Dunbartonshire,
G81 1UJ
Tel 0141 941 0886
Website - **info@wdcvs.com**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

8 May 2019

Subject: Update on the local eligibility criteria for carers

1. Purpose

1.1 To present the Partnership Board with an update on the local Eligibility Criteria for carers which was published on 31st March 2018 in line with the Carers (Scotland) Act 2016.

2. Recommendations

2.1 The Partnership Board is asked to:

- note the contents of this report referring to overview of the implementation of Carers Eligibility Criteria and;
- to agree to further reviewing of the local eligibility criteria for carers with a report being presented to the Partnership Board at a future meeting in early 2021in line with the Carers' Act requirements.

3. Background

3.1 The Carers (Scotland) Act 2016 commenced on 1st April 2018 and included a range of new duties and responsibilities for local authorities. One of these new responsibilities was the development of local eligibility criteria for carers. The Act required that this local eligibility criteria for carers was published by 31st March 2018.

3.2 The Carers (Scotland) Act 2016 also specified that the local authority must review its local eligibility criteria for carers before the expiry of 3 years from publication (prior to March 2021) but could carry out an earlier review if it wished.

4. Main Issues

4.1 It was agreed to provide an update to the Board following the first year of implementation of the local eligibility criteria for carers as the local response ensures carers are able to access support, advice and information timeously and appropriately. As such ensuring carers are able to continue in their caring role.

4.2 West Dunbartonshire HSCP undertook a process of consultation and engagement with carers to determine carers' needs and views thus ensuring that any local eligibility criteria met the expectations of local carers.

4.3 The local eligibility criteria for carers adopted within West Dunbartonshire ensures that no carer would be excluded from receiving support from a range of opportunities, wider agencies and support organisations following assessment; thus supporting a preventative and early intervention approach to supporting carers.

4.4 In the first year of operation no issues have been raised by carers or partner agencies or HSCP practitioners and managers in relation to the delivery of the eligibility criteria.

4.5 At the time of this update there has been no issues highlighted in relation to the local eligibility criteria for carers which would warrant it being changed.

4.6 A full review of the local eligibility criteria for carers will be carried out in accordance with the timescales set in the Carers (Scotland) Act 2016. This will mean a full and comprehensive review will be undertaken towards the end of 2020 and a report presented to the Partnership Board May 2020.

5. People Implications

5.1 No specific implications associated with this report.

6. Financial and Procurement Implications

6.1 It is acknowledged that the Carers (Scotland) Act 2016 does place additional demands on HSCP budgets at a time of continuing fiscal austerity.

7. Risk Analysis

7.1 HSCP officers continue to take forward work in relation to supporting carers to continue in their caring role and ensure carers are able to access support, advice and information.

8. Equalities Impact Assessment (EIA)

8.1 Equality Impact Assessments have been completed as part of the development of the Local Carers Strategy 2019 – 2022 including the local eligibility criteria.

9. Consultation

9.1 Engagement has been an ongoing element of the Carers Development Group Implementation Action Plan.

10. Strategic Assessment

10.1 The HSCP Strategic Plan 2019-22 recognises the importance of working with and effectively supporting carers in order to deliver improved health and well being outcomes for carers. The implementation of the Carers Strategy 2019-

22 also highlights the strategic importance of supporting carers to have a life alongside their caring role.

Name: Karen Marshall
Designation: Improvement Officer
Date: 14th April 2019

Person to Contact: Wendy Jack – Interim Head of Strategy Planning and Health Improvement,
West Dunbartonshire Health and Social care Partnership,
Aurora House,
3 Aurora Ave,
Clydebank,
G81 1BF
Email: Wendy.Jack@west-dunbartonshire.gov.uk

Appendices: None

Background Papers: Local Eligibility Criteria for Carers
http://www.wdhscp.org.uk/media/1971/eligibility-criteria-draft-april-2018.pdf

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Wednesday, 8th May 2019

Subject: West Dunbartonshire Local Primary Care Improvement Plan

1. Purpose

1.1 To provide the HSCP Board with an update on the performance of the Primary Care Improvement Plan (PCIP) for 2018/19 (Year 1).

1.2 To provide information on the workforce and funding profiles as required by the Scottish Government.

2. Recommendations

2.1 Members are asked to:

- Note the contents of the report
- Agree for an update to be provided to the IJB in six months' time

3. Background

3.1 The Scottish Government and the BMA developed and agreed the General Medical Services (GMS) Contract 2018. This requires the development and delivery of new community based services as highlighted in the national Memorandum of Understanding (MOU). An outline of the GMS contract/MOU was provided to the HSCP Board on 2nd May 2018.

3.2 Local delivery over the initial 3 year period (2018/19 to 2020/21) of the contract is being phased in via West Dunbartonshire's local Primary Care Improvement Plan. The plan for 2018/19 was approved by the HSCP Board on 8th August 2018.

4. Main Issues

4.1 Utilising the funding available for full delivery in Year 1 locally agreed priorities were set namely:

- Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment and Care Services
- Additional Professional Roles – Advance Practice Physiotherapists
- Community Link Workers

A brief summary of progress is given below:

Vaccination Transformation Programme

- Being progressed on a GGC wide basis
- Roll out of Pre-5 immunisation service completed Mar 19

Pharmacotherapy

- Successful recruitment of an additional 2.8 WTE pharmacists and 2.2 WTE technicians
- However retention has been an issue with 2.4 WTE pharmacists moving to other areas
- Previous pharmacotherapy services have been maintained (Pain Clinics, DOAC reviews)
- The increased use of Medicines Care & Review (serial prescriptions) has been supported.
- Piloting of Level 1 services (IDLs and repeats) in a limited number of GP Practices commenced Mar 19.

Community Care & Treatment Service

Treatment Rooms

- Appointment/record keeping/administration systems being developed
- GGC wide review of I.T. support ongoing
- Successful recruitment of 1.0 WTE nurse

Phlebotomy

- Successful recruitment of all 8.0 WTE healthcare support workers to act as phlebotomists
- Partial practice-based service provision has commenced
- Space for delivery remains an issue

Additional Professional Roles

- Advanced Practice Physiotherapist (1.0 WTE) now in post covering 2 practices (Clydebank and Dumbarton)

Community Link Workers

- A procurement exercise for the provision of a pilot service by CVS for 3.0 WTE workers is being undertaken.
- Anticipated that the contract will be awarded by end of May 19 subject to Tendering Committee approval.

These posts have been evaluated in accordance with the NHS Agenda for Change Scheme.

4.2 Signposting training has been provided for Practice Staff to assist with the correct utilisation of both the existing and recently created Primary Care Services

4.3 Mental Health staff recruited as a result of the Action 15 monies will also provide a range of complementary community based services in relation to

physical healthcare, Wellbeing, Distress and common mental health problems.

4.4 Lack of suitable space within the GP Practices and the Health Centres is an issue. A HSCP Premises Group is being established to ensure maximum utilisation of current estate and to explore any other suitable options going forward.

4.5 The plan for Year 2 (2019/20) is currently under development, in conjunction with the PCIP Steering Group, with a continued focus on fully implementing and expanding on the delivery of Year 1 priorities.

5. People Implications

5.1 The PCIP focuses on the development of multi-disciplinary teams around GP practices.

5.2 There are a number of new roles being established to assist with the delivery of the services set out in the MOU.

5.3 The current workforce profile is detailed in the PCIP – Local Implementation Tracker (Appendix 1)

6. Financial and Procurement Implications

6.1 The Scottish Government has provided previously confirmed (May 18) the funding allocation to HSCPs for the provision of the new GMS contract.

6.2 The current funding profile is detailed in the PCIP – Local Implementation Tracker (Appendix 1).

6.3 Ongoing funding for the PCIP is expected to rise substantially over the next 2 years.

6.4 Award of Pilot Community Link Worker Service Contract
This procurement exercise was conducted in accordance with the agreed contract strategy produced by the Corporate Procurement Unit in close consultation with Health & Community Care officers and the provisions of Contract Standing Orders, the Financial Codes and relevant procurement legislation.

This Link Worker Service will contribute to the delivery of the PCIPs strategic priorities through the direct availability of social prescribing for patients attending their GP Practice. This aims to reduce pressure on GP appointments for health issues and advice primarily related to social circumstances. The contract provisions will provide an additional benefit of creating new jobs.

7. Risk Analysis

7.1 The lack of delivery of the PCIP could lead to a lack of sustainability for local General Practice.

8. Equalities Impact Assessment (EIA)

8.1 An EIA was undertaken prior to the approval of the Plan.

9. Environmental Sustainability

9.1 Not applicable

10. Consultation

10.1 The HSCP has undertaken discussions with patients, public and professionals as detailed in the Year 1 PCIP.

11. Strategic Assessment

11.1 At its meeting on 25 October 2017, the Council agreed that its five main strategic priorities for 2017 - 2022 are as follows:

- A Strong local economy and improved employment opportunities.
- Supported individuals, families and carers living independently and with dignity.
- Meaningful community engagement with active empowered and informed citizens who feel safe and engaged.
- Open, accountable and accessible local government.
- Efficient and effective frontline services that improve the everyday lives of residents.

11.2 The PCIP contributes to a strong local economy and improved employment opportunities through the development of new roles.

11.3 The development and availability of these new local multi-disciplinary services should improve the everyday lives of residents.

Person to Contact: Jo Gibson
Head of Health & Community Care
16 Church Street, Dumbarton G82 1QL
Jo.gibson@ggc.scot.nhs.uk

Appendices: PCIP – Local Implementation Tracker (Appendix 1).
Improvement Plan (Appendix 2)

Background Papers: GMS Contract 2018
Memorandum of Understanding 2018

Wards Affected: All Wards

Funding profile 2018 - 2022

Financial Year	Total Budget (All figures in £000s)	Service 1: Vaccinations Transfer Programme	Service 2: Pharmacotherapy	Service 3: Community Treatment and Care Services	Service 4: Urgent care	Service 5: Additional Professional roles	Service 6: Community link workers	Other / comment	Total Planned Expenditure			
2018-19*	790	92	169	31	0	18	0	0	310	**(Note - £310k is actual 18/19 Spend.)**	**Balance of £480k will be carried fwd in Earmarked Reserve.**	**Balance of Tranche 2 18/19 funding (£47k remains unclaimed at 31 March with Scottish Gov't)**
2019-20	1006	119	598	268	0	115	121	48	1269			
2020-21	2012	294	926	863	58	175			2316			
2021-22	2835	318	1129	889	180	231			2747			
Total Expenditure	6643	823	2822	1162	238	539	121	48	6642			

* For 2018-19, please include how much you spent in-year and how much unutilised funds you carried over.

Workforce profile 2018 - 2022 (WTE)

WTE Table

	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)		Service 5: Additional professional roles			Service 6: Community link workers	Other / comment
Financial Year	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other	ANPs	Advanced Paramedics	Mental Health workers	MSK Physios	Other [1]		
2018-19***	2.8	2.2	1	8*0.7	0	0	0	0	1	0	0	
2019-20	6.6	2.2	2	8*0.7	1.5	0	0	1	2	1	3	
2020-21	12	2.2	2.4	25	1.5	1	0	2	3	1	3	
2021-22	15	2.2	2.4	25	1,5	3	0	3	4	0	6	

Appendix

West Dunbartonshire
Health & Social Care Partnership

Transforming Primary Care in West Dunbartonshire

West Dunbartonshire Primary Care Improvement Plan
Year 2

West Dunbartonshire Health & Social Care Partnership
Local Primary Care Improvement Plan

1. Background

The General Medical Services Contract in Scotland was agreed by General Practitioners in January 2018. The implementation of the contract was supported by the Memorandum of Understanding (MOU) and requires Health & Social Care Partnerships (HSCPs) to develop annual Primary Care Improvement Plan which aims to set out a 3 to 4 year implementation plan to expand the Primary Care Team by April 2021. This change will support the development of the GP workforce and support the retention of GPs in General Practice.

West Dunbartonshire HSCP works collaboratively with GPs to provide, enhance and develop services to improve the health of our local population. West Dunbartonshire is an area which offers a positive career for GPs.

The Primary Care Improvement Plan will be kept under review and updated annually.

1.2 Aims and Priorities

HSCP Primary Care Improvement Plans will enable the development of the expert medical generalist role through a reduction in current GP and practice workload. By the end of the 3 to 4 year plans, practices in West Dunbartonshire should be supported by expanded teams of NHS Greater Glasgow and Clyde Board employed health professionals providing care and support to patients.

This will help to improve practice sustainability, and reduce risk, thus enabling GPs to focus on undifferentiated presentations, complex care and whole system quality improvement and leadership.

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

1.3 Delivery of Memorandum of Understanding Commitments

The Primary Care Improvement Plans is being developed to support and communicate the HSCPs approach to the delivering the 6 key requirements set out in the Memorandum of Understanding, April 2018.

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

- Vaccination Transformation Programme,
- Pharmacotherapy Services,
- Community Treatment and Care Services

- Urgent Care (by Advance Nurse Practitioners or Advance Practice Paramedics)
- Additional Professional Roles (Advance Practice Physiotherapists and Community Mental Health Practitioners)
- Community Link Workers.

The Primary Care Improvement Plan will be approved by the GP Sub Committee and implementation will be monitored by the Local Medical Committee. The plan will be shared across NHS Greater Glasgow and Clyde and with the HSCP Integrated Joint Board.

2. Local Needs

The population of West Dunbartonshire is much more socio-economically deprived than that of Scotland and of many other NHS GG&C partnership areas. The population will begin to age over the period to 2025, and there will be a fall in the proportion of working age people, children and young people in the area. This will lead to a significant rise in the dependency ratio in West Dunbartonshire, and will also raise the uncertainty around population and demand projections.

2.1 Deprivation

SIMD data at October 2017 indicated that within West Dunbartonshire 34% of patients registered with Clydebank practices live in areas in the 15% most deprived in Scotland, in Alexandria this is 32% (in 2012 between 19% -22% of patients registered within Alexandria practices lived in areas in the 15% most deprived in Scotland) and Dumbarton is 16.5%."However, socio-economic disadvantage is not always experienced in neat concentrations of people in recognisable communities. Indeed two out of three people who are income deprived do not live in deprived areas. So while it may be appropriate in many cases to take an approach focussed on areas of multiple deprivation, there will also be a need to look at deprivation as it affects particular communities or place or communities of interest".[8]

2.2 Disease Prevalence

The population experiences lower life expectancy and lower healthy life expectancy for men and women, and higher deaths rates from cardiovascular disease, deaths in young adults and cancer deaths than the Scottish average. Residents were also more likely to be diagnosed with cancer, heart disease or respiratory disease.

Table 1: Disease Prevalence per 1,000 populations December 2018

Disease	West Dunbartonshire	Scotland
Cancer	27.9	26.6
Heart Failure	12.1	8.5
COPD	30.8	24.6
Asthma	63.5	64.1

The population also had lower mental wellbeing and life satisfaction scores than their Scottish counterparts. Younger residents are more likely to access emergency unscheduled care and older residents are more likely to use primary care services.

2.3 Life Expectancy

In West Dunbartonshire, female life expectancy at birth is lower than at Scotland level and male life expectancy at birth is lower than at Scotland level. Life expectancy at birth was higher for females (79.1 years) than for males (75.0 years) in 2015-17. Male life expectancy at birth has increased more rapidly than female life expectancy at birth between 2001-03 and 2015-17.

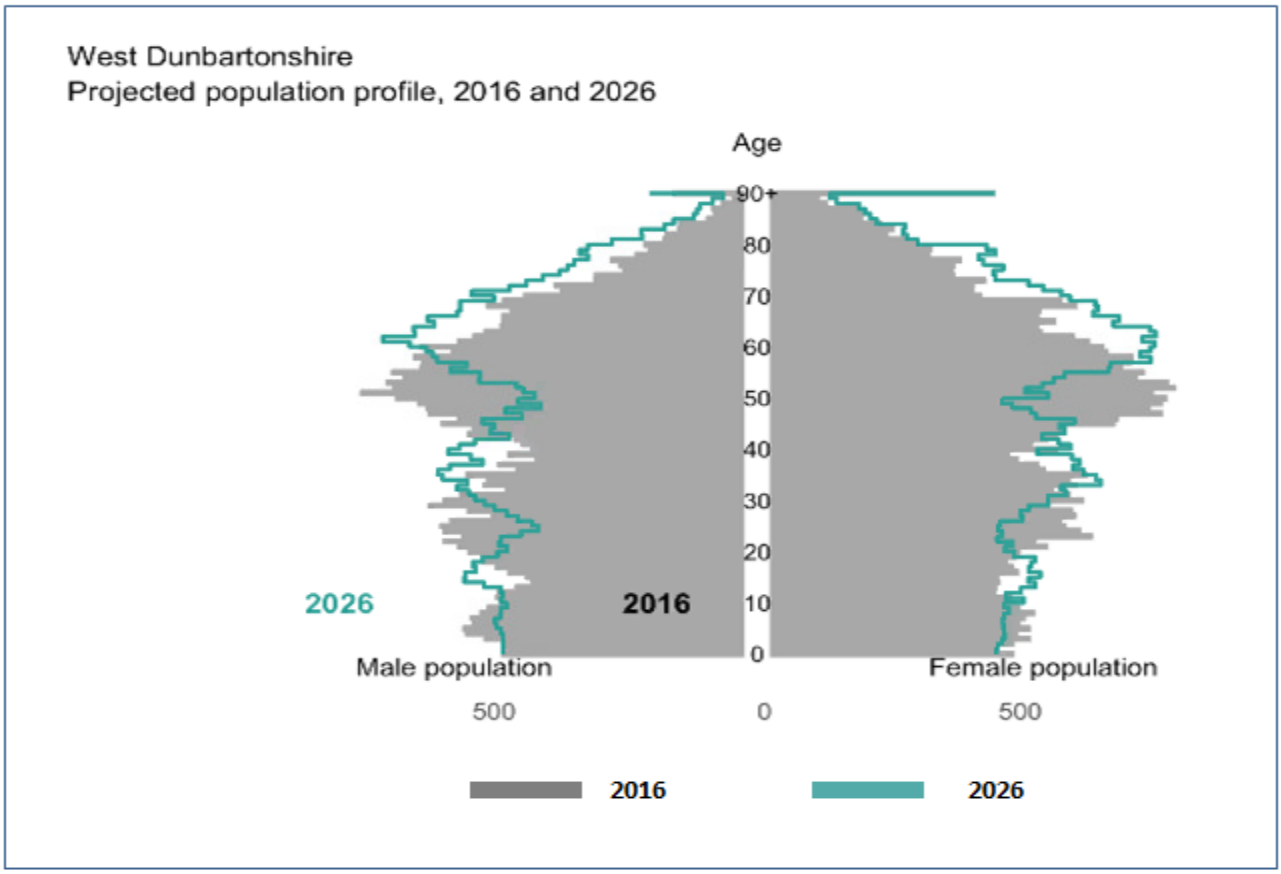
The leading cause of death for females was dementia and alzheimer Disease 14.4%, malignant neoplasm of trachea, bronchus and lung 8.7%, ischaemic heart diseases 8.5%, cerebrovascular disease 7.0% and chronic lower respiratory diseases 5.7% and the leading cause of death for males was ischaemic heart diseases 17.5%,dementia and alzheimer disease 7.1%, chronic lower respiratory diseases 6.3%, malignant neoplasm of trachea, bronchus and lung 6.1% and cerebrovascular disease 4.3%.[11]

2.3 Mental Health

Mental health prevalence in West Dunbartonshire for the conditions recorded is broadly similar to the Scottish rates the mental health register held within primary care, specifically records patients with schizophrenia, bipolar disorder and other psychoses. In West Dunbartonshire the prevalence of the above register is 9.3 per 1,000 compared to 9.4 per 1,000 in Scotland.

2.4 Older People

The population pyramid below shows the current population (2017) and projected population in 2026, for West Dunbartonshire residents. The change projected results show a continued increasing older population with increases in those over 65, over 75 and over 85, and a fall in the number of working age adults, which will further increase the dependency ratio. The population of children and young people will also continue to start to fall during this period.



National Records of Scotland (2017)

Between 2016 and 2026, the 45 to 64 age group is projected to see the largest percentage decrease -11.1% and the 75 and over age group is projected to see the largest percentage increase +18.8%. In terms of size, however, 45 to 64 is projected to remain the largest age group within West Dunbartonshire. [11]

West Dunbartonshire Practice over 65 population January 2019			
Age	**Population**	**West Dunbartonshire %**	**Scotland %**
65-74	**9895**	**10.28**	**10.6**
75-84	**5398**	**5.61**	**6.2**
85+	**1927**	**2.00**	**2.3**

3. GP Services

West Dunbartonshire has sixteen GP practices, 14 of our practices are located within Health Centres (Vale Centre for Health & Care (3), Dumbarton Health Centre (5) and Clydebank Health Centre (6)). 2 practices are situated within GP owned premises. Practices provide a service to a population of 96,214 registered patients.

There are 67 GP partners with 94 GPs working in West Dunbartonshire[7,x2]. 6 (37.5%) practices expect to have one or more GPs retiring in the next 3 years, this

compares to 52%[1] across GG&C. This is 9.5% (7) of our GP workforce. 8 practices are training practices.

GP practices continually review and undertake improvement to enhance the quality of life of their patients. At the beginning of April 2018 (prior to implementation of the Primary Care Improvement Plan) a number of our GP practices provide extended consultations with GPs, the aim of the plan is to free up GP time to enable a greater focus on the management of complex patients.

3.1 Clusters

In West Dunbartonshire there are 3 clusters which are naturally aligned to our health centres, locality arrangements and our acute care provision. The Alexandria cluster consists of 4 practices with a population of 25,758. Dumbarton Cluster has 5 practices with a population of 24,191, both these clusters align to the Alexandria / Dumbarton Locality. Clydebank cluster / locality has 7 practices with a population of 46,265.

Our Clusters were established in 2016 and are supported by a Cluster Quality Lead with 2 sessions per month. During 2018 the Cluster Quality Lead role became vacant, the HSCP has been unable to fill this role. The Practice Quality Leads within the cluster are considering the options available to move forward.

All practices have an identified Practice Quality Lead who actively engages in local quality improvement activity to help identify and improve the quality of services in their locality. Clusters work collaboratively with each other and also local services to identify and implement areas for improvement. Where improvements identified within one cluster /locality would benefit patients this is developed across the HSCP.

Public Health involvement in cluster discussions are ongoing with engagement during 2019 envisaged around the Primary Care Intelligence Report, this will support improvements aligned to some of the local population needs.

During 2018/19 clusters have benefited from the support of the Information Services Division LIST Analyst in accessing local data relating to local areas of improvement.

3.2 Localities

West Dunbartonshire has 2 locality areas which reflect our natural communities. These are Clydebank and Alexandria & Dumbarton. GPs and the practice team provide a central role in delivering and co-ordinating care to local communities; and, by working more closely with their colleagues within wider community teams, NHS acute care, and the third and independent sector help to improve outcomes for local people.

West Dunbartonshire has established effective multidisciplinary team working with GP practices through our District Nursing and Health Visiting Teams and we are building on this locally through our integrated services for older people, adults, children and hospital discharge teams. As services are re-designed the parts of the wider system of care will also be considered ensuring patients' needs are being met.

During 2018/19 we introduced the Advance Practice Physiotherapist to 2 practices, we will build on the multidisciplinary team within practices during 2019/20, this will include an increase in practices accessing Advance Practice Physiotherapist and look to introduce Wellbeing nurses, Practice based Pharmacy support and Community Link workers.

3.3 Facilities

In 2012, the Vale Centre for Health & Care was open and work continues in order to reach financial close for the development of our Integrated Health and Care Centre in Clydebank. This will provide a modern space to provide our future health and care services for the communities within Alexandria and Clydebank.

The HSCP has set up a premises group which will meet quarterly to assess and manage the current space within premises, considering how new services and roles can be accommodated within the HSCPs and practice facilities.

4. Primary Care Improvement Plan

4.1 Primary Care Improvement Plan Steering Group

In March 2018 the West Dunbartonshire Primary Care Improvement Plan Steering Group was established to oversee the development of local plans and to ensure the involvement of a wide range of stakeholders' views. The group reviewed all the available information/evidence informing the initial priorities presented for year 1 and the subsequent year 2 plan.

The group is chaired by the Head of Health and Community Care and includes GP representatives (including GP subcommittee representative), Practice Manager, integrated operations managers, professional leads and our third sector interface.

The Steering Group is instrumental in agreeing the approach to the prioritisation and deployment of resource across the HSCP and through methodology agreed with the Practices to ensure the equitable allocation of resource in year 1 and beyond. The LMC will monitor implementation through the GP subcommittee member.

4.2. Key Stakeholder Engagement

4.2.1 NHS Boards

West Dunbartonshire is engaged in the NHS Greater Glasgow and Clyde Primary Care Programme Board which has a board wide role in the development of Local HSCP Primary Care Improvement Plans. In addition, there is ongoing engagement with NHS Greater Glasgow and Clyde Board wide professional groups and leads around the specific requirements.

4.2.2 HSCP Engagement

There has been an ongoing conversation with key groups within the HSCP attended by GPs and a wider range of professionals. The HSCP has formally engaged in discussions at HSCP Locality Meetings, Practice Nurse Locality Meetings, Cluster Meetings, Practice Manager Meetings, Joint Staff Forum and with our GP Sub Committee. In addition, Cluster Quality Leads are members of the Primary Care Improvement Plan Steering Group and have an essential role in representing and being accountable to the cluster PQLs and Practices.

Further engagement has also taken place with professional and operational teams through existing and established clinical and professional groups across health and social care.

4.2.3 Public Engagement

In year 1 in collaboration with Greater Glasgow and Clyde Health Board the HSCP hosted two events in June in Clydebank and Alexandria /Dumbarton to commence initial engagement with members of the public.

In year 2 we will work alongside our Public Involvement Officer to ensure engagement, and raise awareness of the changes being progressed within Primary Care.

4.2.4 GP Engagement Event

GP engagement has been managed through the Cluster and Locality meetings. A schedule of meeting has been set up for 2019/20 to ensure ongoing engagement in developments of services and to ensure that practices are supported to develop practice based approaches to accommodate new ways of working.

To support the allocation of the additional year 2 resource, HSCP leads meet with practices to identify the practice preference for additional resource in year 2. This information has informed the priorities and the approach for year 2.

4.3 Key Requirements

The Memorandum of Understanding and associated guidance identifies a number of areas as immediate key priorities, these include; Vaccination Transformation Programme, Pharmacotherapy Service and Community Treatment and Care Services. The redesigned services should be delivered and transferred to HSCPs by the end of the transition period (year 3), April 2021.

Recognising this and the constraints in the local workforce, the HSCP is working with our local stakeholders to develop a plan that will deliver the ambitions of the contract and meet the needs of our local GPs, patients, service users and carers.

4.4 The Vaccination Transformation Programme (VTP)

NHS Greater Glasgow and Clyde Programme Board co-ordinates, directs and oversees related projects and activities to deliver the objectives of the VTP. Including:

- Pre 5 Vaccinations

- Adult Immunisation Programme
- Travel Immunisation & Advice

In West Dunbartonshire immunisation rates were slightly higher than for NHS Greater Glasgow and Clyde across all at risk groups in 2018.

Table 2: West Dunbartonshire Influenza Immunisations 2018

	Over 65s	Under 65s at risk group	Pregnant (not in clinical risk group)	Pregnant (in clinical at risk group)
West Dunbartonshire	77.2%	49.4%	53.5%	76.1%
NHS GG&C	73.9%	45.6%	54.2%	64.1%
NHS Scotland	73.6%	44.8%	48.1%	61.8%

It will be important to maintain immunisation rates and improve them across the population and subgroups of it, such as the more deprived, through the period of the vaccine transformation programme.

Immunisation is the most cost-effective activity in healthcare, contributing significantly to reductions in infant mortality, and increased life expectancy at all ages. Controlling vaccine-preventable disease depends upon very high levels of uptake across the population in order to create herd immunity. Herd immunity is a form of indirect protection from infectious disease that occurs when a large percentage of a population has become immune to an infection, thereby providing a measure of protection for individuals who are not immune. Herd immunity can protect the most vulnerable members of a community who cannot develop immunity on their own, and therefore rely on the immunity of others around them for protection.

Scotland has a robust childhood immunisation schedule which has been delivered by both health visiting teams and GPs for many years. The recently announced Vaccine Transformation Programme will see changes to the delivery of this programme, with the HSCP becoming accountable for the delivery of childhood, and then adult immunisation over the next few years.

It will be critical to ensure that during this time of transition, uptake levels of immunisation do not drop at the population level, within localities and across socio-economic deprivation quintiles.

4.4.1 Childhood Immunisation

West Dunbartonshire had good levels of immunisation uptake across children for primary immunisation for diphtheria, tetanus, polio, haemophilus influenza type b, pneumococcus, meningitis group b, rotavirus, measles, mumps and rubella. In order to maximise herd immunity, it is important to keep uptake above 95%.

Preschool booster uptake for young children is lower than we would wish. Measles is a highly contagious illness with significant health risks. It is critical that we proactively maintain and improve the uptake of the MMR vaccine across the transition programme.

In year 1 the HSCPs ambition was to deliver Pre 5 Immunisation Vaccination Programme across all practice. This was delivered to all practices in January 2019. With the HSCP and NHS Board monitoring uptake to ensure patient safety isn't compromised.

Funding for Pre 5 Immunisation has been identified as £192,350 per annum, with £100,200 being funded through the HSCP budget. This commitment will continue until year 3 or 4 when the full service will be funded through the Primary Care Improvement Fund.

4.4.2 Adult Vaccinations

Adult vaccination uptake is similar across West Dunbartonshire and NHS Greater Glasgow and Clyde, and is lower than for childhood vaccinations. These programmes immunise against 'influenza and shingles in "at-risk groups", which includes individuals on the basis of specific clinical need or identified risk factors (for example, people who are immune compromised) rather than immunisation for the entire population. It is hoped that the vaccine transformation programme will improve the uptake of immunisation in this population, leading to lower levels of illness and premature death.

West Dunbartonshire GPs and District Nursing Teams work collaboratively to administer the influenza vaccine to housebound patients on the District Nursing caseloads, and also their informal carers. They also accept referrals via GP practices for those who are not on their caseload but are housebound. District Nursing Teams work collaboratively with West Dunbartonshire residential care homes to vaccinate all residents, and deliver peer immunisation clinics for HSCP frontline staff. This is a significant addition to the District Nursing workload between the months of September and December. The pneumovac and shingles vaccines are also administered as prescribed to those who are housebound by the District Nursing service.

Initial timescales for the Transformational Vaccination Programme are provided below. The HSCP will work with the programme to develop local plans to support roll out.

Pre-5s/Childhood Flu Immunisation	• Anticipated roll out 2019/20
65 and Over Flu	• VTP potentially running 'test of change' in year 2 for '65 and Over' and Under 65s 'At Risk' within HSCPs. Mixed delivery models, could be one or more
Under 65s 'At Risk' Flu	

Influenza/Pneumococcal (other)	HSCPs involved for each 'test of change' model. Indicative costs have been estimated.
Pertussis & Flu Pregnant Women	• Proposal that Midwifery service deliver service. Detailed modelling to be approved. • Rollout anticipated 2019/20
Shingles (70 – 79 years old)	• Projected Rollout year 4 (2021/22)
Travel Vaccines	• Projected rollout year 4 (2021/22) Travel Health Advice may be national, coordinated model – business case to be submitted to Scot Gov.

4.5 Pharmacotherapy Services

Locally within West Dunbartonshire all GP practices have access to traditional prescribing support delivered by a combination of Prescribing Support Pharmacists (PSPs) and Prescribing Support Technicians (PSTs). This is supported by a NHS Greater Glasgow and Clyde Board team who collate and provide data, analysis, support materials and co-ordinate with other parts of the NHS Greater Glasgow and Clyde Board.

The Prescribing Support Team has developed over many years and our current pharmacists and technicians have excellent multi-disciplinary links across the HSCP; with the aim of promoting good quality cost-effective prescribing which includes the delivery of prescribing savings. The GMS Contract aims to build on even greater collaboration of pharmacists and pharmacy technicians with GP practice staff and their patients through the development of pharmacotherapy services over the next 3 years. However this is reliant on having the right workforce in place to deliver the three levels of service set out within the GMS Contract 2018 which includes core and additional services. Ultimately the overall level of service that can be provided will be driven by workforce availability.

Building on the work prior to the MOU the HSCP has implemented elements of all aspects of the pharmacotherapy service as envisaged in the MOU including; medicine reconciliation of Immediate Discharge Letters (IDL), targeted polypharmacy reviews of frail, elderly, and care home patients, plus the limited provision of pain and respiratory clinics. It is planned to continue/expand the current support plus increase acute/repeat authorisation during 2019/20 with the aim of every practice having access by 2020/21.

The pharmacotherapy service is being led nationally by the Directors of Pharmacy for the three year trajectory period to allow workforce planning to be supported, appropriate governance arrangements embedded and the successful initial momentum to be maintained[4]. Within NHS Greater Glasgow and Clyde Board there is a board-wide group to take this forward and West Dunbartonshire is actively involved.

In year 1 the HSCP's ambition was to increase our pharmacy resource by 2 WTE Prescribing Support Pharmacists. The overall resource in year 1 increase by 0.4

WTE by March 2019, with additional 1 WTE recruited and starting in May 2019.

During year 1 a total of 2.8 WTE Pharmacy Resource was recruited to West Dunbartonshire however there was a number of staff that moved to other roles due to the competitive workforce market for Pharmacists at present.

Following agreement with the Steering Group the HSCP recruited 2.2 WTE Prescribing Support Technicians. This is in recognition of the workforce availability and the need to develop a Pharmacotherapy Services with the appropriate skill mix to deliver the Pharmacotherapy Service going forward.

In addition The Pharmacy team has supported the increase in the number of patients on serial prescriptions which has been growing steadily, in the long term this will reduce the workload for repeat prescribing.

It is the HSCP's ambition to increase the pharmacy workforce during 2019/20, with funding up to £457,000 (6.6 WTE band 7 and 2.2 wte band 5), in year 2 with a further increase in year 3 and 4. The skill mix of the recruitment in year 2 will be driven by the workforce availability and the HSCP is flexible in its approach to ensure the pharmacotherapy workforce is being built to meet the requirements of the MOU.

The HSCP is working closely with the NHS Board Pharmacy Team to understand the skill mix and models of practice. The HSCP is working with Clydebank Locality to deliver a practice based model in year 2. A practice based approach will also be explored with the Alexandria / Dumbarton localities as the workforce is increased.

Due to the workforce availability and the experience in year 1 the PCIP Steering group have supported a flexible approach to recruitment, ensuring where staff of varying skill mix are available the HSCP are flexible in the staff recruited.

At present the NHS Greater Glasgow and Clyde Pharmacy Team is considering different service models to inform the workforce requirements for pharmacotherapy service within HSCPs. This resource required varied based on the modelling reported at the Primary Care Programme Board, West Dunbartonshire HSCP would be required to recruit from 11.5 WTE Prescribing Support Pharmacist to over 30 WTE. Based on the workforce availability and the funding available this would not be a viable service. Further work is being undertaken and will inform the West Dunbartonshire Pharmacotherapy Service.

4.5.1 Pharmacy First – emailed Pamela 25/03/19

Community pharmacy has an important contribution to make to the pharmacotherapy service. Pharmacy First[1] and serial dispensing were given as examples of existing services that can reduce GP workload.

Funding for Pharmacy First in West Dunbartonshire is £23,100 in year 1, it has been indicated there may be a specific Pharmacy First funding stream to support the progress of this activity. If it is decided that the funding for Pharmacy First is to

[1] PharmacyFirst allows patients to access free advice and / or treatment without having to attend the GP Practice for a limited range of conditions.

remain in the PCIP, we would aim to seek the views of GPs to see if this type of service would reflect their priorities and would result in a reduction in their workload.

4.6 Community Treatment and Care Services

The Community Treatment & Care Service includes (but is not limited to) the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring and related data collection. This service is identified as a key immediate priority within the GMS contract with responsibility for all aspects of this service passing to the HSCP by the end of year 3. Phlebotomy is identified as a specific requirement within the first stages of the Primary Care Improvement Plan.

Our Clydebank and Dumbarton GP Practices currently receive a treatment room service which includes many of the components of the Community Care and Treatment Service. The service (excluding phlebotomy) is currently available to approximately two thirds of the West Dunbartonshire practice population.

In Year 1 the HSCP's ambition was to scope out the requirements for the Community Treatment and Care Service across the HSCP including understanding the requirements of a phlebotomy service.

In year 1 the HSCP has recruited the 5 WTE band 3 Health Care Support Workers, with staff commencing the role between February and May 2019, the timescales are to accommodate recruitment procedures and induction programme as the staff are coming with a range of experience.

The Treatment Room Nurse commenced part time induction in January 2019 within the existing treatment rooms, this was to support staff competencies. The Service is scheduled to open to practices in the mornings from end of April 2019, with an increase in full capacity by end of 2019/20. In addition a service will operate from Old Kilpatrick.

The additional Admin support set out in year 1 has been carried forward.

In year 2 the HSCP will recruit an additional Treatment Room Nurses (1 WTE) this will provide additional Nursing resource and provide additional managerial and leadership capacity for the current band 6 within the Treatment Room Service in Dumbarton Health Centre who will be responsible for the management of the extended treatment room service in Alexandria and also the Healthcare Support Workers employed to deliver the phlebotomy service.

During 2019/20 the practice based model of phlebotomy will be evaluated to review the most appropriate model of delivery (practice / cluster based). In 2020/21 the number of healthcare support works will be increased to deliver a full service. It is anticipated that this will require an additional 20 WTE Band 3 staff. With a total funding of £696,613 required.

The existing funding for the Treatment Room Services in Clydebank and Dumbarton is £249,000.

HSCP premises within Clydebank and Dumbarton provided limited opportunity to host additional services. This may restrict the expansion of the current treatment rooms to include phlebotomy and additional treatment room services. Innovative solutions to this are being sought.

4.7 Urgent Care (Advanced Practitioners)

The redesigned GP Service will have a focus on urgent (home visits) and unscheduled care which will be supported by the provision of advanced practitioners as a first response for this activity. This has not been considered as a priority for Year 2 by the local stakeholders. It is expected that the development of the Focused Intervention Team (FIT) will provide additional practitioners working to address unnecessary unscheduled care demands.

4.7.1 Advanced Nurse Practitioners

The Advance Nurse Practitioner is a generalist nurse qualified at PgD level. The competencies of this role enables the nurse to comprehensively assess and diagnose a range of conditions, make autonomous decisions, to request and interpret relevant tests; to formulate a plan of action; and to discharge or refer as appropriate. The Advance Nurse Practitioner role incorporates clinical leadership and evaluation of care delivery.

Within West Dunbartonshire GP Practices there are 6 trainee ANPs, with an additional 3 practices considering an ANP.

During 2019/20 the HSCP aim to initiate the recruitment process for 1 WTE ANP to commence in year 3, increasing to 3 WTE by end of Year 4 (2021/22), the development of the HSCP ANP role will be informed by the activity within other areas across NHS Greater Glasgow and Clyde.

To train Advance Nurse Practitioners an identified Designated Medical Professional is essential for each ANP student for the prescribing, clinical assessment and clinical practice portfolio modules this will be part of the local consideration when developing the role locally.

4.8 Additional Professionals

4.8.1 Advance Practice Physiotherapist

A model has been developed and tested to use an Advanced Practice Physiotherapist (APP) within the GP practice as first point of contact for patients presenting with MSK conditions. The model provides a condensed physiotherapy assessment to reach a working diagnosis and discuss management options with the patient including onward referral or investigations if appropriate. The APP role has

been shown to offer a safe, cost effective alternative to the GP and brings additional patient and organisational benefits.

In Year 1 the HSCPs ambition was to recruit 1 WTE Advance Practice Physiotherapist. In November 2018, 2 practices (Clydebank and Dumbarton) were allocated an Advance Practice Physiotherapist who has been delivering a practice based model of Advance Physiotherapy.

The HSCP indicated that it would accommodate up to 3 WTE Advance Practice Physiotherapist however additional workforce was unavailable.

In Year 2 the HSCP will increase the Advance Physiotherapist Practitioner to 2 WTE requiring funding of £115,374 (+ 6% pension costs), this is in line with the MSKs Service work force plan for APPs. The HSCP has advised the MSK service that funding would be available for additional Advance Practice Physiotherapists if the workforce was available.

Within the MSK Workforce Plan for Advance Practice Physiotherapist West Dunbartonshire workforce will increase by 1 each year to 4 WTE in 2021/22. Costing £230,748 (+ 6% pension costs) by year 4.

By year 4 it is our ambition to provide the resource across all practices within the HSCP however the workforce challenges in this area and the overall funding may restrict the HSCP in spreading the service across the HSCP within these timescales.

4.8.2 Community Clinical Mental Health Professionals

The Scottish Government Mental Health Strategy 2017-2027 shares the ambition of having "multidisciplinary teams in Primary Care to ensure every GP Practice has staff who can support and treat patients with mental health issues".[1]

In year 1 the HSCP's ambition was to develop ideas on how we support services locally including what is required to support GP practices thus minimising pressure on primary care, Primary Care Mental Health Team and Community Mental Health Teams.

The Mental Health service worked collaboratively with GPs from Clydebank to develop a practice based well being nurse service. The service specification has been developed with 2 practice identified in Clydebank to pilot the service.

In Year 2 the HSCP will pilot 2 well being nurses (1 WTE band 6) within 2 practices. An evaluation will be undertaken with the aim to expand the service by the end of year 2.

Action 15 "Developing the Workforce" is part of the work being progressed within the NHS Greater Glasgow and Clyde Mental Health Programme Board, which is looking

at ways of improved working in line with the Boards Mental Health 5 year plan. This The HSCP will also consider how we support other service areas such as justice and children's services to include adverse childhood events and older people services.

The HSCP is working with NHS inform to develop an online platform to include some self-help and social prescribing pages that will provide additional self-management support to patients.

4.9 Community Link Worker/Practitioner (CLW)

"Community Links Worker (CLW) is a generalist practitioner based in or aligned to a GP practice or cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community"[2].

Building on the work within West Dunbartonshire; the HSCP supported by local GPs, is committed to recruiting Community Link Works.

In year 1 the HSCPs ambition was to recruit 3 WTE Community Link Practitioners.

During year 1 the HSCP explored all options available for delivery of this service. As a result a service specification for delivery of a pilot service by the third sector was developed which went to procurement October 18. The 3rd sector approach is supported by the NHS Scotland Part 3: Improving Workforce Planning for Primary Care In Scotland.

The Community Link Worker Contract tender was finalised in March 2019 which has recommended a direct award to West Dunbartonshire Community Volunteering Service. The commencement of contract is expected by the end of April 2019 with recruitment to take place as soon as possible thereafter.

In year 2 the HSCP will work with West Dunbartonshire Community Volunteering Service to roll out the Community Link Practitioner Service to practices identified within the year 1 resource allocation. Funding for year 2 is £100,980 plus the addition of VAT (£20,196).

The service will include an evaluation which will inform the future model and wider rollout of the service within West Dunbartonshire.

The HSCP is required as part of the Scottish Governments Community Link Worker commitment to expand the Community Link Worker workforce to 4.5 WTE by the end of year 4. However, if the service demonstrates benefit to patients and GP workload this could be extended up to 6 WTE by year 4 if funding allowed, thus ensuring all practices had equitable access and support for their patients.

4.10 Focus on Frailty

In addition to the developments in the Memorandum of Understanding, West Dunbartonshire HSCP has identified the management of those at risk of admission to hospital.

The HSCP has identified circa £700,000 from the HSCP budget to establishment an inter disciplinary Focussed Intervention Team. The Focussed Intervention Team will build on current good practice in regards to frailty and anticipatory care planning and will enhance service provision to people with frailty and complex care needs. The team's remit will encompass multi-morbidity and long term conditions across adulthood.

This team aim to support adults / older people to remain at home during an episode of ill health that could otherwise require admission to hospital or a care home. There is approximately 18 staff in the Focussed Intervention Team that operates over 7 days including public holidays.

5. Leadership, Coordination and Evaluation

To ensure effective management and capturing the learning from the service redesign to inform future up scaling, West Dunbartonshire HSCP will for the first 3 years invest funding in the leadership, coordination and evaluation of the implementation of the Primary Care Improvement Plan.

In year 1 the HSCPs ambition was to invest in the leadership, coordination and evaluation of the Primary Care Improvement Plan.

During year 1 the PCIP invested in a range of activities including GP participation in the steering group and sub groups, which informed the development and implementation of the Primary Care Improvement Plan.

Sessional support was provided to Cluster Quality Leads within our 3 clusters. Through the cluster test of change monies the PCIP fund has invested in Optimising Workflow for 9 practices, with 7 practices considering this through local discussions.

In year 2 we will employ the Evaluation support and provide a contribution to the NHS Greater Glasgow and Clyde Public Health Service to evaluate The Primary Care Improvement Plans. There are 6 questions agreed by the Primary Care Programme board for evaluation:

1. Have we shifted non-complex work to the wider MDT, and concentrated complexity on the GP resource?
2. Are the new ways of working improving professional satisfaction and sustainability in primary care?
3. Are patients confident and satisfied in their use of the new primary care system?
4. Are patient outcomes and safety sustained and improved under the new system?
5. Have we improved equity across primary care? and

6. What are the impacts of the Scottish GP contract on the wider health and care system?

The HSCP will invest up to £80,000 in 2019/20. This will include investment to support implementation of the plan plus the existing Cluster Quality Lead sessions. Investment in this area plus the key success indicators over the life of the plan will be monitored by the Primary Care Improvement Plan Steering Group.

5.1 Information Sharing

The GMS Contract 2018 identified GP Practices and their contracting NHS Board as joint controller of the GP patient record, by limiting GP contractors responsibility the risk to practice is reduced and practice sustainability is increased.

National data sharing agreement is still in development and NHS Greater Glasgow and Clyde Board will implement a local approach in line with national guidance when available.

Information sharing will be a key consideration during the re-design of services to support delivery of the key requirements of the Memorandum of Understanding with information technology being developed locally or nationally to support this.

5.2 Signposting

To support patients to navigate through the GP expanded service signposting training will enable the GP receptionist to direct a patient to the most appropriate source of advice or guidance. This will save time for the patient and will also free up GP appointment time. Signposting within GP practices is imperative to the success of the changes proposed within the GMS Contract 2018.

In year 1 the HSCPs ambition was to provide signposting training for practice staff.

In 2018/19, Signposting training was provided to over 130 staff.

Within Alexandria / Dumbarton a number of local services, Optometry, Pharmacy and Minor Injuries provided information sessions to support admin staff to sign post patient safely and effectively. This will be delivered within Clydebank during 2019/20.

In year 2 the HSCP will work with practices to agree appropriate support to GP practice to enable them to achieve delivery of the new GP contact, this may include further embedding Signposting, Workflow optimisation, practice website and promoting self management.

5.3 Inequalities

An Equality Impact Assessment of the Primary Care Improvement Plan has been undertaken to ensure that the plan is fair, Best Value and meets the legal requirements and that we have considered relevant ethical issues. "Clear international evidence that strong primary care systems are positively associated with better health and better equity"[10]. The Equality Impact Assessment process supported the HSCP to ensure that due regard has been taken where appropriate within the plan to eliminate discrimination, advance equality of opportunities and foster good relations for protected groups.

The EQIA identified a positive impact on age, disability and socio economic characteristics A key aim of the Primary Care Improvement Plan is to increase capacity within General Practice to enable the GP to provide an enhanced service to patients with complex care needs which would include multi morbidity. As long term conditions are more common with age, an enhanced GP service would positively benefit older people who may also have disabilities.

In addition, the Community Link Worker and Mental Health Worker are designed to support socio-economically deprived communities where the social impacts of poor health can impact more on individuals.

The Equality Impact Assessment was updated for the year 2 Primary Care Improvement Plan, with the service re-design activity being subject to an Equality Impact Assessment. The HSCP will improve data collection and monitoring processes in relation to equalities for HSCP commissioned/ managed services described within the Primary Care Improvement Plan.

The implementation of the priorities within the Plan will be shared across the Localities as equitably as possible – with the agreement of the PCIP Steering Group and Practices - ensuring the allocation of resource will address locally identified need.

5.4 Supporting People through Self-care

Self-management is about people living with long term health conditions being 'in the driving seat'. Self-management supports people to live their lives better, on their terms, to take control and think positively about the future. The health status of our population is characterised by premature illness, associated with adverse life circumstances. This is underpinned by health and socio economic factors.

We will work collectively across the partnerships and with acute services and other planning partners such as the third sector and professional education to deliver strong, person-centred self-care approaches which will explicitly take account of inequalities and differences in health literacy. This approach will support new models of care, and ensure that these tackle inequalities and over-reliance on reactive care.

Across all current and developing services we are developing our approached to direct and support more people to access and use alternative self-management tools, community resources and other services, where required we will support

people to do this through improved access to information, support, social prescribing and community link workers.

6. Funding

In Year 1 the HSCP was allocated £837,000, this was released in 2 tranches of 70% and 30%. The 70% (£487,257) was released to HSCPs in June 2018.

HSCPs were required to complete the Scottish Governments PCIP Template C in September 2018, based on the projections submitted, the HSCP was allocated £162,056 from the 30% (2nd Tranche). The remaining £46,768 will be held in reserves at the Scottish Government.

Table 1: Funding Allocation – Year 1

Year 1 Funding - West Dunbartonshire						
Year 1 Allocation	**Baseline Allocation Deducted**	**HSCP allocation**	**1st Tranche 70% allocated & received**	**2nd Tranche 30% allocate**	**2nd Tranche received**	**2018/19 Funding reserves in Scottish Government**
£837,000	£141,000	£696,081	£487,257	£208,824	£162,056	£46,768

In year 1 the HSCP has spent £514,880 a breakdown is included below

MOU Requirements	2018/19 Spend
Vaccination Transformation Programme	£91,950
Pharmacotherapy Service	£141,000 £179,154
Community Care & Treatment Service	£5,000
Additional Professionals Advance Physiotherapist	£36,330
Cluster Quality Lead	£27,600
Cluster Test of Change	£15,000
Training • Signposting • Admin Back pay	£10,500
Meetings • PCIP Steering Group • CLW Steering Group	£3,210 £990
GP Event	£546

Pre 5 Immunisations Equipment	£3,500
Total	£514,880

6.1 The Primary Care Improvement Fund

The resource identified for the Primary Care Improvement Fund is recurring and not to be used for any general savings requirements or wider funding pressures. The Primary Care Improvement Fund will be monitored as part of the funding arrangements with HSCPs.

Strictly as a planning assumption, and subject to amendments by ministers without notice below is a guideline for funding over the next 3-4 years. Confirmation of Year 2 funding is awaited.

	2018/19	2019/20	2020/21	2021/22
Scotland	**£45m**	**£55m**	**£110m**	**£155m**
West Dunbartonshire	**£837k**	**£1.037m**	**£2.1m**	**£2.9m**

6.2 Agreed Investment Priorities for Year 2

Following the engagement the areas detailed below were agreed by the Primary Care Improvement Plan Steering Group as priorities for additional investment in Year 2:

- Preschool Flu and Pregnant Women Immunisations
- 1 WTE Advance Practice Physiotherapist
- Increase Pharmacotherapy Service to 6.6 WTE (utilising appropriate skill mix of staff
- Implement Community Link Workers Service Provided by West Dunbartonshire Community Volunteering Service
- Increase Treatment Room nurse by 1 WTE
- Leadership, Coordination and Evaluation

A headline investment plan is attached as appendix 1 which outlines spending plans for Year 1 and 2. With projections included for Years 3 and 4. Likely ongoing commitments, plus the cost of the Community Treatment and Care Service and increasing investment in Advance Practice Physiotherapists is captured in year 3 and 4 columns. This will be supplemented with plans to invest across the remaining priority areas to ensure full delivery of the priorities by end of years 3 / 4, and is subject to workforce availability.

Not included within the investment plan is a breakdown of the additional costs associated with NHS staff, this would include travel expenses, uniform, equipment etc. NHS practice is to allocate £1,500 per staff member, as this expenditure is identified it will be costed to the relevant area of the plan.

6.3 Reserves

West Dunbartonshire HSCP received funding during 2017/18 to develop local test of change in anticipation of the GMS Contract 2018. In addition the underspand from 2018/19 are also detailed.

The HSCP reserves for the Primary Care Improvement Plan implementation are detailed in table 2. It should be noted it is anticipated these reserves will be utilised to support the implementation of the Primary Care Improvement Plan in Year 2 and beyond.

Table 2: Primary Care Improvement Fund Reserves

Fund	Reserve	
PCTF transferred from hosted Primary Care Support (Renfrewshire SCP) – 2017/18	£101,967	This funding will sit within Primary Care Support (hosted in Renfrewshire HSCP)
Redesign (Phlebotomy / Treatment Rooms, Frailty ANPs) – 2017/18	£74,521	2017/18 balance
PCTF - CQL cluster support (current 3x2sessions) – 2017/18	£35,880	2016/17 and balance of 2017/18
Cluster Test of Change – 2017/18	£15,000	2017/18 balance
PCIF reserves – 2018/19	£322,120	(Year end spend to be finalised)

7. Additional Content

7.1 Community Pharmacy

There are a number of areas where arrangements with community pharmacy could be developed, some areas are explored below.

There are in the region of 60-70% of Community Pharmacies currently offering a private flu service out with the NHS provision – although it is unclear as to the level of uptake. Although under current legislation they would be unable to provide an NHS service they could under a private Patient Group Direction to deliver a flu service in line with National Guidelines. This skill set could and would be easily transferable to being able to deliver travel vaccinations that currently go through the GP practices.

Community Pharmacy is well placed to deliver a range of addition services that can help and benefit the healthcare needs of patients in the community e.g. An extension of Pharmacy First to treat a range of minor conditions e.g. Urinary Tract Infections, Impetigo, Shingles etc. under Patient Group Direction as well as maximising the use of the minor ailments service to ensure patients are managing their own conditions.

Polypharmacy reviews and serial dispensing of prescriptions over a year can easily be managed by Community Pharmacy without the need of the patient to attend their GP practice ensuring that only complex patients are being seen by the GP.

A range of tests and checks can be completed within the Community Pharmacy network that are in relation to specific conditions e.g. Blood pressure checks to

manage blood pressure issues and management of contraception, Inhaler techniques to manage asthma and COPD conditions.

7.2 Optometry

In November 2017 the Lead Optometrists Group developed a report Community Optometry and Health & Social Care Partnerships, developing Community Optometry in response to the Community Eyecare Service Review and local developments. Nationally work is underway and to revisit the General Ophthalmic Services Regulations which will support the HSCP and the NHS Greater Glasgow and Clyde Board to further develop Community Optometry and Hospital Eyecare Services.

Community Optometry have a key role in responding to urgent eyecare requests. West Dunbartonshire has local systems in place to support this and patients are signposted from GP practices to their local Community Optometrist. Further work will be undertaken to support staff and educate patients about their first port of call for treatment relating to the eye.

8. Challenges

While the GMS Contract 2018 offers potential and opportunity it also potentially brings challenges associated to other current service delivery e.g. community pharmacy, physiotherapy and district nursing.

It is clear that full roll out will be dependent on funding, availability of suitable staff and must be delivered in a safe, sustainable approach that focuses on patient safety and supports prescribing improvement activity. Ultimately this should lead to greater professional satisfaction as well as releasing GP time.

As it can take several years to fully train for these new/additional roles with the required skills, the availability of a suitable workforce will be a consistent challenge over the 3 year transition period.

In addition a number of the roles within the Memorandum of Understanding, need to work with a Designated Medical Practitioner to support their professional development to deliver the competencies required within the advanced roles.

9. References

[1]Scottish Government, Mental Health Strategy 2017-2027
[2]Memorandum of Understanding, November 2017
[3]NHS Greater Glasgow & Clyde, West Dunbartonshire HSCP Primary Care Improvement Plan Intelligence Chapter, May 2018
[4] National Health & Social Care Workforce Plan – Part 3, May 2018
[5] The 2018 General Medical Services Contract in Scotland, November 2017
[6]West Dunbartonshire Strategic Needs Assessment Adults and Older People 2018
[7]The NHS Greater Glasgow &Clyde Performers list reports
[8]The Fairer Scotland Duty, March 2018
[9]The Scottish Government Information Sharing Short Life Working Group – May 2018
[10] Andrew Scott, Gregor Smith, Richard Foggo Scottish Government, 2017
[11] National Records of Scotland website

Appendix 1 – West Dunbartonshire HSCP Investment Plan

Please note at the point of writing this paper, the allocation for Year 2 has not been formally notified to HSCPs by Scottish Government

	Year 1 2018/19 Full Year Effect	Year 2 2019/20 Notional NRAC	Year 3 2020/21 Notional NRAC	Year 4 2021/22 Notional NRAC
Primary Care Improvement Fund	836000	1,037,000	2,100,000	2,900,000
(Boards Baseline Funding) DEDUCTED	140,687	TBC	TBC	TBC
Tranche 1 (70%)	487,257	TBC	TBC	TBC
Tranche 2 (30%)	208,824	TBC	TBC	TBC
Years Allocation	696,081	TBC	TBC	TBC

West Dunbartonshire HSCP Investment Plan (cont.)

	Delivery Plan Summary		Year 1 2018/19 Actual	Year 2 2019/20 Notional	Year 3 2020/21 Notional	Year 4 2021/22 Notional
The Vaccination Transformation Programme (VTP)						
Phase 1 - Pre 5 Vaccinations	Fully implement Childhood immunisations across HSCP		91,950	91,950	91,950	91,950
	Pre School Flu Pregnant Women		0	24,303	24,303	24,303
Phase 2 - Adult Vaccinations	Anticipated year 3 / 4		0	0		
Phase 3 - Travel Vaccinations	Anticipated year 4		0	0	0	
Pharmacotherapy Services						
Pharmacists			141,000 179,154	141,000 456,993	141,000 784,622	141,000 987,792
Community Care & Treatment Services						
Treatment Room Service (new - Alexandria) HSCP Phlebotomy & Biometrics	2 wte Band 5 nurses 25 wte Band 3 Healthcare Support Workers 1.5 WTE Band 2 Admin support		5,636	267,877	862,774	888,657
Urgent Care (Advance Practitioners)						
Advance Nurse Practitioner / Other			0	0	58,133	179,631
Additional Professional Roles						
Advance Practice Physiotherapist	1 WTE band 7 allocation from year 1, increasing by 1wte each year.		36,330	115,374	174,700	230,748

	Delivery Plan Summary		Year 1 2018/19 Actual	Year 2 2019/20 Notional	Year 3 2020/21 Notional	Year 4 2021/22 Notional
Others i.e. Mental Health Practitioner	1 WTE Band 6		Action 15 Funding			
Community Link Workers						
Community Link Workers	3 WTE CLW at band 5		0	121,176	121,176	242,352
Leadership, Coordination & Evaluation						
Evaluation Analyst			0	47,847	49,282	0
Public Health Evaluation			0	6,059	0	0
6% pension increase			0	76,130	135,029	156,547

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

8 May 2019

Subject: West Dunbartonshire Winter Plan Update

1. Purpose

1.1 This report provides an overview of the implementation of plans across West Dunbartonshire in order to ensure readiness for the additional pressures in unscheduled care often experienced over winter. There has been detailed joint working across the Greater Glasgow & Clyde HSCPs and with acute colleagues over recent months to ensure optimum management of the health and social care system.

1.2 West Dunbartonshire's Winter Plan and the wider Winter Plan for NHS Greater Glasgow and Clyde (NHSGGC) were considered by this Integration Joint Board at its meeting in November 2018, and an update on progress was considered in February 2019.

1.3 This paper describes in more detail, the progress of implementation of these plans, the pressure being placed on the system, and our process for ensuring ongoing monitoring and timely response to changes in demand.

2. Recommendations

2.1 The Board is asked to note the contents of the Winter Plan Progress Report.

3. Background

3.1 Unscheduled care activity is commonly understood to refer to A&E attendances and hospital admissions, although an impact is often felt in terms of demand on primary and community care also. Over recent years, levels of demand have been seen to rise over the winter months.

3.2 West Dunbartonshire's role in managing unscheduled care can be described as two-fold, to ensure local services and plans are implemented and working to maximum capacity to consume as much demand as possible locally, and to play our full part as a component of the NHSGGC system, to ensure that together, we are managing the system to its best possible performance.

3.3 As we enter spring, we are reviewing our winter plans and ensuring lessons are learned across the system.

4. Main Issues

There has undoubtedly been increased pressure across acute sites over the winter period, in terms of both hospital attendances and emergency

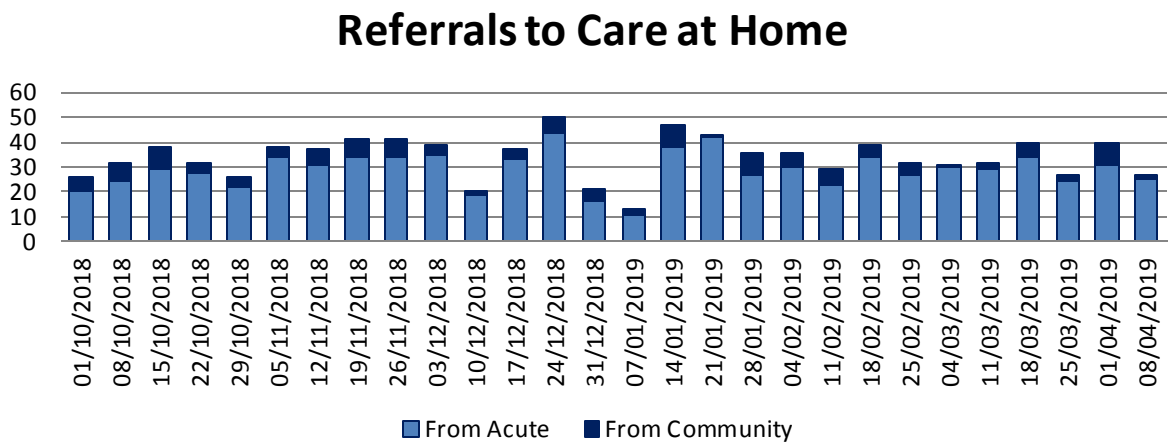
admissions. While, in West Dunbartonshire services, demand and performance has remained reasonable stable, there are challenges in the increasing rate of A&E attendances and emergency admissions by people from West Dunbartonshire.

An overview of performance and demand on local services is provided below.

4.1 Demand on local community services.

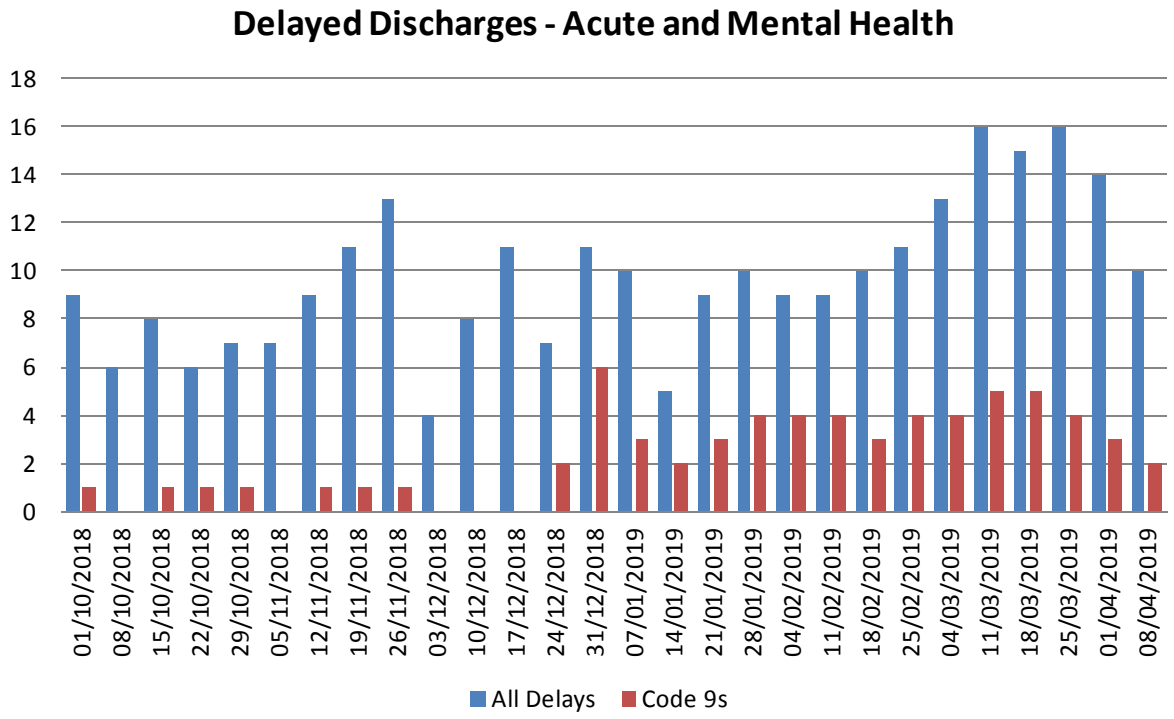
Demand on services has remained relatively constant, with a slight decrease in demand seen in the first week of the new year.

Week Ending	02/12/2018	09/12/2018	16/12/2018	23/12/2018	30/12/2018	06/01/2019	13/01/2019	20/01/2019	27/01/2019	03/02/2019	10/02/2019	17/02/2019	24/02/2019	04/03/2019	11/03/2019	18/03/2019	25/03/2019	01/04/2019	08/04/2019
Older People's Team	80	60	68	56	75	41	85	86	78	88	83	78	90	91	78	79	72	101	77
Adult Care Team	41	26	36	31	35	31	43	26	27	28	41	31	39	27	30	33	34	38	37
Hospital Discharge Team	47	43	46	45	47	12	61	70	50	72	53	58	59	64	61	56	47	49	56
Total	168	129	150	132	157	84	189	182	155	188	177	167	188	182	169	168	153	188	170



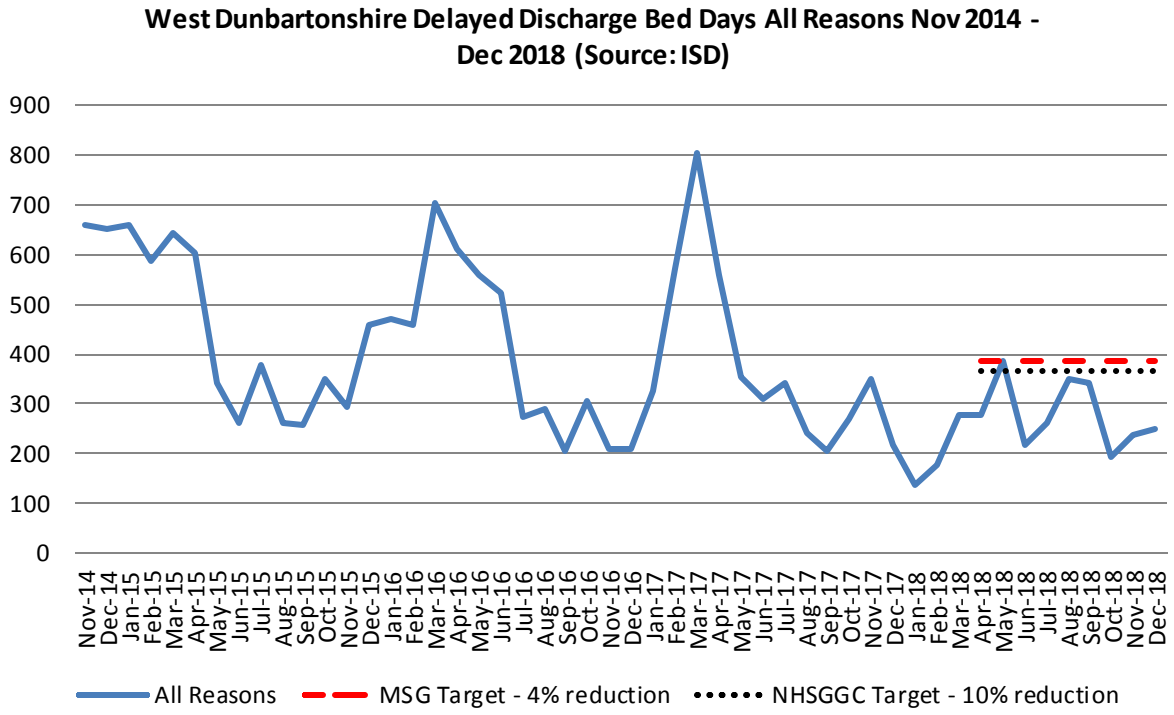
4.2 Delayed Discharges

Delayed Discharges are an important indicator of potentially significant pressure on the system. Over the early winter months, West Dunbartonshire has continued to see a downward trend on this measure, however numbers of people delayed did increase over February and March as a result of key social work staff needing to respond to a significant situation. This work has now been completed and performance has returned to average levels. The teams work very actively to monitor residents who have been admitted to hospital and to engage early with them and the acute ward teams, to discuss and facilitate discharge as soon as is possible.



- Note Code 9s relate to adults who are deemed to lack capacity, and statutory legislation applies.

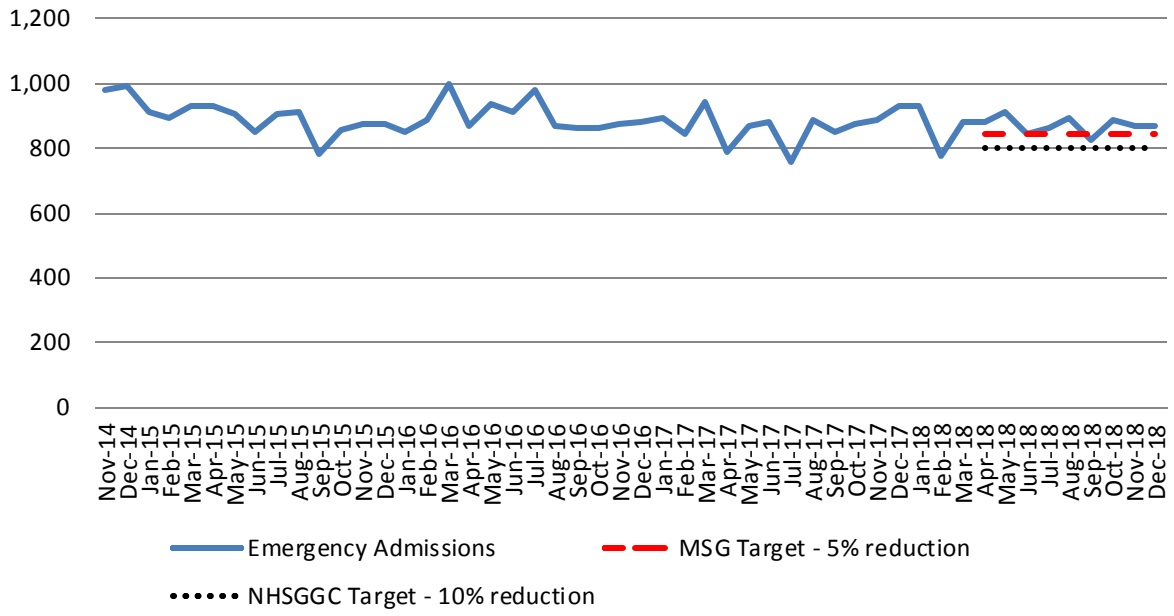
The total number of bed days lost to delayed discharge has improved significantly over the last few years.



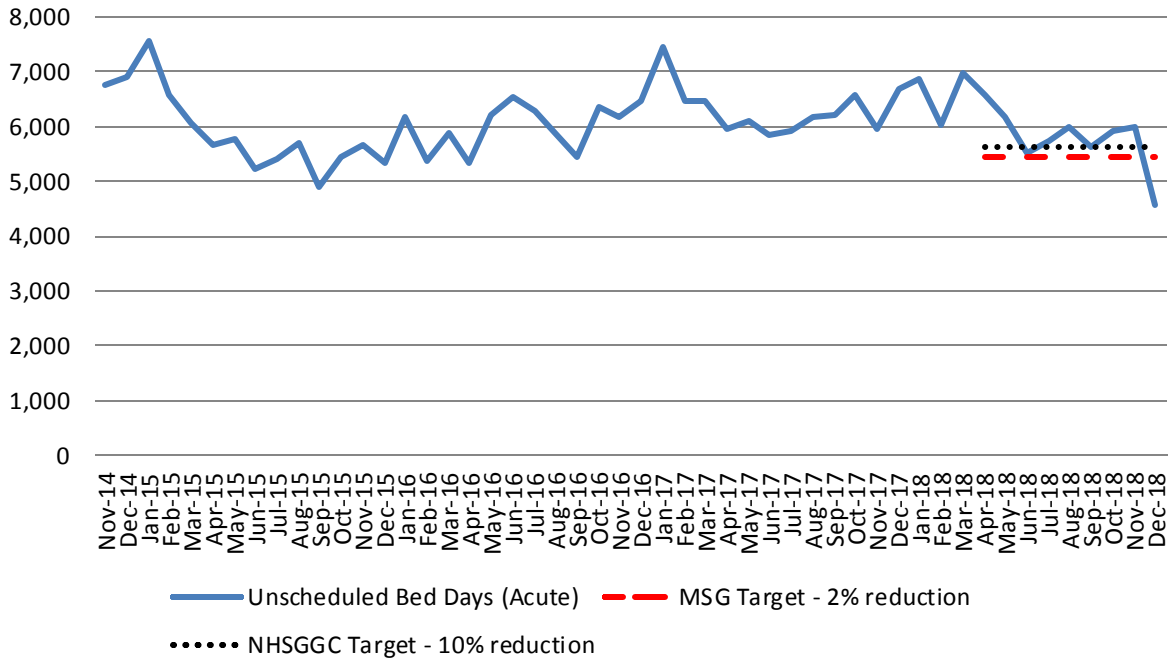
Delayed discharges are monitored on a daily basis with each person's needs identified and key steps tracked. The most common reason for a person's discharge to be delayed is either due to requirements relating to the legislation that protects Adults with Incapacity, or due to families needing time to make the right choice for their loved one.

Emergency admissions to hospital have remained relatively static over the past year but do remain higher than target and will be an important area of focus for this financial year.

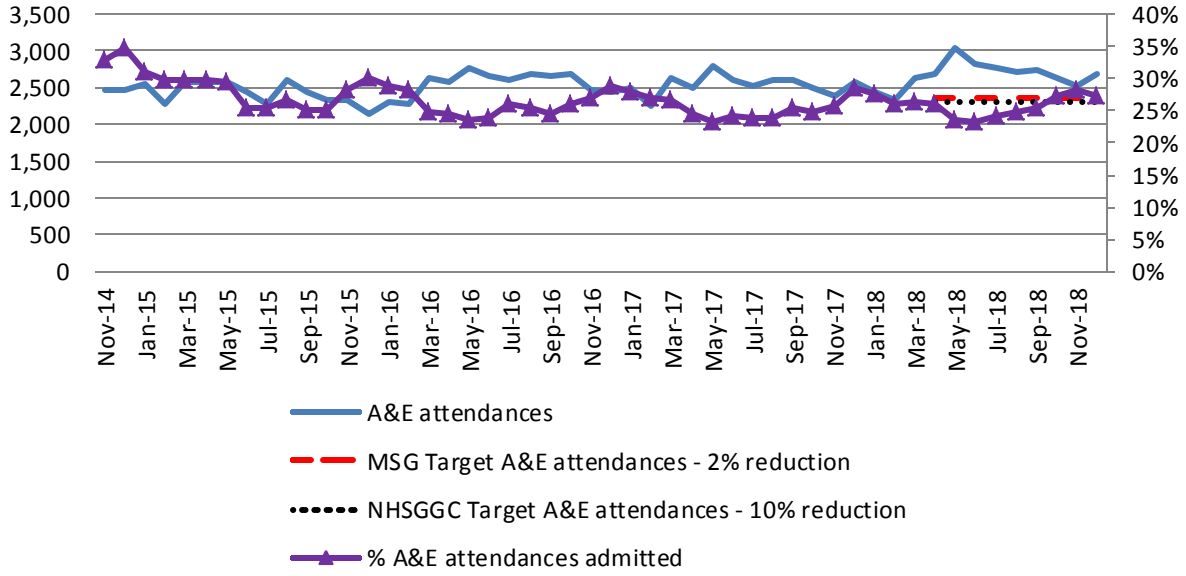
West Dunbartonshire Emergency Admissions Nov 2014 - Dec 2018 (Source: ISD)



West Dunbartonshire Unscheduled Bed Days (Acute) Nov 2014 – Dec 2018 (Source: ISD)



A&E attendances and % of attendances admitted West Dunbartonshire Nov 2014 - Dec 2018 (Source: ISD)



Like the rest of GGC, a significant challenge for West Dunbartonshire is the level of A&E attendance. While a reduction can be seen since the peak in May 2018, we remain above target levels.

4.3 Additional Capacity Available

To ensure West Dunbartonshire had the capacity to cope with an increase in demand, some surge capacity was created in the community teams, meaning that we could at short notice, increase the levels of staffing in the teams, or increase their operating hours into evenings and weekends In addition, an additional 7 beds of inhouse care home capacity have been made ready. This additional capacity has to date, not been required.

4.4 Flu Vaccination Rates

HSCP staff and GP practices have had comprehensive plans in place throughout the autumn to roll out flu vaccinations. 601 staff across the partnership have been vaccinated against flu.

4.5 Development of Focussed Intervention Team (Frailty and Complex Needs)

As reported to the Board in November, West Dunbartonshire HSCP is creating a Focused Intervention Team (Frailty and Complex Needs) who will work across 3 areas:

- Community Supports - to enable community led initiatives to provide alternatives to health and social care services that will promote health and well-being
- Anticipatory care - to enable a person-centred proactive approach for individuals requiring services and to support conversations, set personal goals to ensure timely access to the right service
- Rapid response (responding within 2 hours to a GP or community team referral) to assess and put plans in place, if medically appropriate, to maintain a person in their own home, following exacerbation of symptoms or change in frailty scores

The team will be made up of a range of professionals including:

- Registered Nursing
- Dietetics
- Physiotherapy
- Care at Home
- Pharmacy
- Occupational Therapy
- Specialist nursing, e.g. COPD nurses

Recruitment is almost complete for the new team and training and induction has now commenced.

4.6 Reviewing the support needs of people who frequently attend hospital

In preparation for winter, the HSCP carried out a review of all clients/ patients who have attended A&E regularly or who have had a number of hospital admissions over the past year. The purpose of this work is to better understand and anticipate the needs of these patients and to put more effective supports in place for them. One of these activities involved reviewing patients who have a diagnosis of COPD (Chronic Obstructive Pulmonary Disease). West Dunbartonshire is demonstrating a reduction in people being admitted to hospital with COPD, and a reduction in the length of stay in hospital for those who are admitted.

4.7 Supporting Care Homes

Significant work is being carried out to support both our in-house and our independent care homes in preparing for winter. One aspect of this work has been the development of the red bag scheme, which ensures that every client who is admitted to hospital from a care home, will have their key belongings and care plan packed safely in a customised red bag. This initiative has the dual purpose of ensuring that personal belongings such as clothing, glasses and medication are much less likely to get lost, whilst also giving acute hospital staff quick access to the care plan for each particular client; ensuring their needs and personal wishes can be better met. In addition to this initiative a monitoring framework, which ensures that each client who is admitted to hospital from a care home is reviewed, has been established. This allows us to quickly understand the reasons for hospital admission and to take any action appropriate to support the client back safely to the care home. There has been a reduction of approximately 30% in admissions to hospital from West Dunbartonshire Care Homes over the last year.

5. Ongoing Monitoring

5.1 It is vital that we remain prepared to respond should the impact of unscheduled care demand change. Members of the Senior Management Team meet every Tuesday, with representatives across NHSGGC, to share information and update on capacity and pressures. Every Wednesday, members of the SMT meet with operational managers locally to track demand, understand service capacity and pressures and oversee plans to improve people's care and their use of the system.

5.2 National information sources and local dashboards are used to track current and predicted demand, and to respond accordingly.

6. People Implications

6.1 The report makes reference to a number of developments which have implications for staff.

7. Financial and Procurement Implications

7.1 None

8. Equalities Impact Assessment (EIA)

8.1 There is no equalities impact from these developments. These plans seek to ensure that people who are vulnerable, due to disability, ill-health or age, are supported to receive the most effective care for them.

9. Risk Analysis

9.1 Due to the volatile nature of attendances during the winter months, data will be closely monitored.

10. Environmental Sustainability

10.1 No impact.

11 Consultation

11.1 All components of West Dunbartonshire's winter plan have been subject to consultation with staff, GPs, third and independent sectors, and staff side representatives.

12 Strategic Assessment

12.1 At its meeting in March 2019, the IJB agreed its Strategic Plan for 2019 – 2022, including its strategic priorities/

12.2 The work laid out in this report is in support of the vision and priorities of the Strategic Plan.

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Designation: Head of Health and Community Care
Date: 8th May 2019

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Appendices: None

Wards affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

8 May 2019

Subject: Update on the Ministerial Steering Group targets for West Dunbartonshire HSCP

1. Purpose

The purpose of this report is to present HSCP Board Members with the proposed 2019/20 Ministerial Strategic Group targets for West Dunbartonshire HSCP, and outline actions intended to facilitate delivery of these target.

2. Recommendations

2.1 HSCP Board members are asked to approve the 2019/20 Ministerial Strategic Group (MSG) targets.

HSCP Board members are asked to note the planned work underway to support delivery of these targets in West Dunbartonshire HSCP.

3. Background

3.1 In early 2017, the Ministerial Strategic Group for Health and Community Care (MSG) agreed six main indicators to be used as a high level assessment of the progress of Health and Social Care Integration. It was recognised that these indicators should not be looked at in isolation and would require local context and narrative as well as other relevant data in order to look at the overall picture.

It is widely recognised that supporting people at home or as near to home as possible gets the best outcomes and is the preferred option of most people. The MSG targets are part of a suite of policy drivers to support this aiming, helping ensure people are admitted to acute care only when necessary and even then, are supported home as soon as it is safe to do so.

The recent review of integration also challenges the system to increase the pace of integration to ensure the balance of care is shifted and we improve outcomes for individuals.

The development of these targets has been undertaken in collaboration with HSCP and acute colleagues across NHS GGC.

4. Main Issues

4.1 The table outlines the target improvements being proposed by West Dunbartonshire HSCP in line with our priorities and operational plans. It is important to note that despite fluctuations in performance over the intervening

years, the baseline year against which these targets will be tracked is 2015/16.

Target	Baseline 2015/16	Actual 2016/17	Actual 2017/18	Projected 2018/19	Target % Change	2019/20 Target
Emergency Admissions	9,275	10,718	10,316	10,464	-7%	8,626
Unplanned Bed Days - Acute	64,696	75,131	75,355	69,528	-2%	63,402
Unplanned Bed Days - Geriatric Long Stay	1,549	N/A	N/A	N/A	-100%	0
Unplanned Bed Days - Mental Health	25,428	N/A	N/A	N/A	-12.5%	22,241
A&E Attendances	22,348	30,875	30,463	32,800	0%	22,348
Delayed Discharge Bed Days	4,832	4,882	3,439	3,322	-28.8%	3,440
% Last 6 Months of Life Spent in the Community	86.70%	87.9%	88.9%	90%	+2.3%	89%
% of 65+ Population Living at Home (Supported and Unsupported)	95.50%	95.7%	95.8%	N/A	+1%	96.50%

A number of actions are underway or are planned to support delivery of these targets. These include:

- Development of FIT (Focussed Intervention Team) providing rapid, multi-disciplinary and intensive care at home or in a care home, where conditions escalate and where hospital attendance may become likely. In terms of reductions in emergency admissions, in 2019/20 we are predicting a reduction of 7%, or 326 admissions. This is based on the projected impact of the roll out of the Focussed Intervention Team. In 20/21, with a full year effect and the new teams working at full potential, we expect this to increase to a reduction of 480 admissions, or 10.3% on 2015/16 levels.
- The roll out of the Primary Care Improvement Plan, detailed in the accompanying paper, creating wider teams in primary care, including

physiotherapy; community treatment rooms; immunisation; pharmacy and community link workers.

- The roll out of the Red Bags initiative across all care homes, ensuring anyone admitted to hospital has all of their personal belongings and key documents with them, in a distinctive red bag.
- A programme of training for care home and care at home staff to better identify the signs and respond appropriately in relation to infection.
- Detailed regular analysis of those frequently attending A&E and proactive contact with these individuals to develop more appropriate supports.
- Work with the Vale of Leven Hospital to ensure best use of day hospital and clinic capacity for people who are suffering from frailty and who would benefit from hospital services.

5. People Implications

5.1 There are direct improvements for individuals through the achievement of these targets. By supporting people to be cared for closer to home, with a range of professionals, we aim to improve the experience of care and the outcomes for individuals.

6. Financial and Procurement Implications

6.1 There are no additional financial implications for the HSCP aside from those already agreed through the indicative budget set in March 2019. The delivery of these targets across NHS GGC will create a more cost effective unscheduled care resource and will have implications for the set aside.

7. Risk Analysis

7.1 None

8. Equalities Impact Assessment (EIA)

8.1 The implementation to these targets will improve care for people with frailty or complex co-morbidities, improving their opportunities to retain their independence and to have more choice in their care plan.

9. Consultation

9.1 The implications of these targets have been the subject of consultation with the public and with stakeholders as part of the development of our new Strategic Plan.

10. Strategic Assessment

10.1 These recommendations are in line with our vision and priorities as set out in our Strategic Plan; in particular, in improving access, early intervention, building resilience and using assets to their full potential.

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Appendices: None

Wards Affected: All

West Dunbartonshire Health and Social Care Partnership Local Engagement Network

West Dunbartonshire Health and Social Care Partnership Strategic Plan

NHS Greater Glasgow and Clyde Moving Forward Together Programme

Alexandria Community Centre 13th March 2019

At Alexandria Community Centre the Chair of Dumbarton/Alexandria Local Engagement Network (LEN) Chair Barbara Barnes welcomed everyone to the session. A total of 26 members of the community attended including the local MSP.

The session started with a presentation on the West Dunbartonshire Health and Social Care Partnership Strategic Plan from Beth Culshaw (WD HSCP Chief Officer)). This was followed by a presentation to bring people up to date with NHS Greater Glasgow and Clyde Moving Forward Together Programme from Jonathon Best (NHSGGC Chief Operating Officer).

General questions and comments following the presentation:

- Evening meetings for the public to attend was requested – both speakers agreed to this request.
- Life expectancy in West Dunbartonshire – is it still increasing as per national average?
- When services are getting homes ready for when people leaving hospital this takes too long – e.g. when wet floor showers to be put in – this issue for time delay affects people this related to Helensburgh area. There is always a delay in delivery of work being undertaken.
- What will be at Vale Hospital in future? There was a 2017 Plan for the Vale but there has been no feedback as to the progress of the Plan if NHS GGC continues to centralise area services then we need to know what will be available in GP surgeries.
- There continues to be an issue of accessing breast screening locally.
- What is happening about community assets e.g. Alexandria Community Centre which is being proposed by the Council to be closed as part of the funding cuts, the Health Board should ask WDC to keep centres as its important for local communities to build local services.
- Optimising services is important there should be a 30 years programme of work to support local services which must be kept and developed to maintain local health and well-being. This needs to be reflected in the capital investment action plan.
- Save the Vale Group reported that there were issues outstanding which need to be addressed which have s far not been answered by the Health Board.
- Both budget setting processes need to look at what local people are saying and hear what people want to see in future in their local areas.

- The Health Improvement Scotland consultation on digital readiness; Scotland must be more digitally ready and digital input to be developed; people need to get support to get to Hospital or to use local facilities with the use of digital support.
- Need to ensure that all facilitators are informed about each local area, they need to be well-informed about local area e.g. if services based in Paisley they don't know the local areas and what travelling means when you don't have a car to get from Helensburgh to Paisley.
- I was admitted to Hospital with dementia; where are champions for dementia in hospital in 10 days no-one came to see me; I tried to find them for the 10 days I was in hospital.
- Are you keeping dementia unit in the Vale Hospital or is it to be closed if everything is being moved into the community?
- My wife has dementia in October 18 an assessment was completed; people doing estimates for work for adaptations only now; at Christmas my wife was in hospital but they did not take account of dementia. Alzheimer Scotland got in touch with Dementia Champion then everything changed. She is now out of hospital and I have to pay for services but there is free personal care for under 65 years – will she gets services for free? There also has been a long delay for shower to be put in, could this have been done more quickly?
- Local Dementia Strategy – why has it not been published in West Dunbartonshire?

Each individual issue raised was addressed out-with the formal consultation part of the meeting with individuals and managers in the room.

Table top discussion:
What matters most to people?

- Long conversation about support for local carers; proposal for new model of care and hospital services there is a need for good GP / Acute care. GPs must be used more appropriately used in the community and there is a concern that we go back to third sector as key provider as this was in Victorian times
- Scottish Alliance for Long Term Conditions should be involved in the delivery of local services
- Behavioural change in people using services needs to happen to ensure they can access the right type of services
- Balance between volunteers and clinical provision, we do not want volunteers doing triage in GP surgeries
- How do we ensure that ANP get clinical expertise; lead in time for multi-disciplinary teams is long and people must be qualified to do this work
- Patients need to have confidence in those they are being referred to issues with NHS24 people are unwell or have long term or have a Learning Disability /Mental Health we need to make better use of NHS inform

West Dunbartonshire Health and Social Care Partnership Local Engagement Network

West Dunbartonshire Health and Social Care Partnership Strategic Plan

NHS Greater Glasgow and Clyde Moving Forward Together Programme

Clydebank Town Hall 19th March 2019

At Clydebank Town Hall a total of 35 members of the community attended. The session started with a presentation on the West Dunbartonshire Health and Social Care Partnership Strategic Plan from Beth Culshaw (WD HSCP Chief Officer)) and Wendy Jack Interim Head of Strategy, Planning and Health Improvement. This was followed by a presentation to bring people up to date with NHS Greater Glasgow and Clyde Moving Forward Together Programme from Dr David Stewart (NHSGGC Depute Medical Director for Acute) and John Barber (NHSGGC Public Engagement Manager) .

General questions and comments following the presentation

- It would be helpful to link appointments for the same day so older people do not have to travel between venues/hospitals.
- Appointments should be co-ordinated between services better.
- There needs to be more focus on preventative activities such as – active bike trails this also addresses ongoing environmental issues.
- It feels like much of the activity has been focused and based across the river of NHGGGC. Prevention needs to be based on community approaches to diet/smoking.
- Access to hospital services should be based around communities as using taxis to travel patients between hospital sites is expensive and seems wasteful.
- There are public transport difficulties from West Dunbartonshire into the sites and between the sites for hospitals across Greater Glasgow and Clyde.
- Transport issues have yet to be agreed at Queens Quay, despite there being questions asked and promises given at the start of the process - this needs to be confirmed to ensure patients have easy access to the new health and care centre.
- Transport issues from West Dunbartonshire into Glasgow but also into the new centre if people are to access primary health care there needs to be transport.
- Joined up services are a good idea but placing it at river side of Clydebank away from the centre of Clydebank where it is currently means patients in the Faifley corridor cannot access services easily as it requires two buses for those in Faifley/ Hardgate/Duntocher.
- Great expectations of having transport links into riverside being available from across the local area however following building of college and leisure centre this has not happened, too difficult for people to access.

- Can people access primary care services in Bearsden and Milngavie rather than using services for away at Clydebank Quay?
- Keen to hear about the new Post Director of Access which is to be appointed.
- There is nothing in the Strategic Plan relating to loneliness and isolation; could you use home carers to identify people with issues linked to loneliness and use the information to help to address them as part of local approach.
- Delighted to see issues being discussed in the round rather than as specifics of each individual service; I have a diagnosis of dementia/following a diagnosis of prostate cancer. There is much more to do in terms of linking up the health service but people also need to work for themselves and look after their own health.
- There is a huge opportunity for Quayside and new health centre to deliver future; and plan for the future; there are tremendous changes in how people live and this needs to be reflected in local services.
- We need to talk about carers and need to support carers to keep being carers and there is potential for doing a great deal in our communities.
- Having a health condition is an emotional journey but also a learning curve for patients who can learn from each other people with conditions and like better.
- How do we let people know about these consultation meetings.

Table top discussion:
What matters most to people?

- Feedback from Health Board of my results was really good, I chose Gartnavel to get blood taken and then phoned later for results and I got the results over the phone, opportunity to ask questions over ½ hour phone appointment. Although there are still challenges for Health Board, this worked very well for me. Blood tests could they be taken at local health centre or pharmacy rather than at hospital.
- New health centre do not have an x-ray machine and there is a need for it.
- Why are health centres not open during public holidays, this would alleviate pressure on acute services, particularly access to GPs and out of hours provision.
- Access to GP services: difficult due to access, need to ensure that people with additional needs can access services; health board needs to be patient centred and people are diagnosed.
- HSCP 70% looked after at kinship carers, issues with child care social work, all of youth. West Dunbartonshire Council are saying no cuts to social work budget, but the group do not believe it.
- X-ray facilities at Clydebank Health Centre are an issue for Clydebank Seniors Forum, they feel it is a disgrace that there will be no x-ray facilities in new health centre as this is supposed to be a state of the art health centre and there was talk this would be accessed at Golden Jubilee but nothing more has been heard.
- Proposal for community bus service with WDC from transport officer, this could be an answer to local transport link.
- Leisure Trust closing small community centres – this is not about community and making services, need to keep community centres open – can the health board talk to the council about their savings and stop centres being closed?

West Dunbartonshire HSCP Health & Safety Committee

Draft Minute

The Boardroom, Hartfield Clinic, Latta Street, Dumbarton, G82 2DS

Tuesday 29 January 2019, 2.00 – 4.00pm

Item	Subject	Lead	Paper
1	**Welcome & Apologies** Serena Barnatt, Chair Joanna McKale, GMB Rep Thomas McWilliams, Unison H&S Rep Stephen Gallagher, WDC H&S Officer Annie Ritchie, HSCP Childcare Manager Berny Smith, Integrated Operations Manager Kirsteen MacLennan, Integrated Operations Manager, ACT and HDT Fraser Downie, Integrated Operations Manager – Mental Health Lynne McKnight, Integrated Operations Manager, Care at Home Val Jennings, Unison H&S Rep Brian Keogh, Senior L & E Advisor Jacqui McGinn, Health Improvement Manager Nazarin Wardrop, Unite H&S Rep Kate McLachlan, Minute **Apologies:** Shirley Furie, GMB rep David Scott David Sawers No Health and safety advisors available to attend this meeting from NHS.	Serena Barnatt	
2	**Minutes of Previous Meetings** i. HSCP H&S Committee Minute accepted as an accurate record of the meeting. ii. NHS GGC Board H&S Forum Minutes noted. <u>Alcohol and Substance Testing.</u> TMcW confirmed that this was still being discussed at the NHSGGC Board health and safety forum. This item is to be kept on this agenda. <u>Driving at Work</u> It was noted there was a draft policy for driving at work being		

	discussed. It was agreed that this will be added to agenda once policy is agreed. **Action:** Driving Policy to be shared once agreed. **Action:** Alcohol and substance to be kept on agenda. iii. Joint (Corporate) H&S Committee WDC Minutes noted. SG advised that Health and Safety are currently reviewing all safety management standards (new title) to be completed by end of April. One policy to cover the whole organisation. New Safety Management Standards will be corporate documents and service specific policies will be superseded by these. Where required, specific guidance documents will be developed for HSCP. SG and EW will look at protocols again when review of Safety Management Standards is complete. Joint Health and Safety Committee meeting - SG advised there is a proposal for meetings to take place only twice a year, this is subject to ongoing discussions. **Action:** SG to provide an update on Safety Management Standards.	CMcL CMcL EW/SG SG	
3.	Matters Arising • CM2000 compliance LMcK updated that a meeting with Unions will be held to discuss compliance of Homcarers using CM2000. This is a concern not just from a Service perspective but also in relation to lone working. • Health & Safety Operational Plan A Meeting was held today with WDC H&S. It was agreed that they will not develop a stand-alone health and safety plan as there will be now one for the whole organisation. (SG will provide an update for next meeting) as this needs to		

	be implemented by April this year. **Action: SG to provide update at next meeting.** • Reliance to be taken off agenda. Reports to be provided by exception.	SG	
4.	**HSE Implementation Plan (NHS)** SB asked all managers to confirm the progress updates and if there were any missed. - Brian Keogh attended meeting on test of change for Sharps. Around 44 people require training. BK to share list and service managers are asked to prioritise this. **Action:** Managers to be identified for each service. Each service needs to agree what target they have for their own services. Managers are to report back to next meeting. Targets will be recorded and will be set. Annie to advise Sheila and Mags NHS. Managers and responsible people and targets to be confirmed for next meeting and process agreed to ensure we maintain compliance. Monthly Reports - If there are any errors shown on monthly reports please email BK directly to let him know so that this can be amended. It needs to be confirmed that the report shows that it is the job that is out of scope and not the person. Skills register – BK advised that Fiona Rodgers has a local register up and running which is a good tool to capture training not just for health and safety. It was agreed that managers can contact BK or FR for them to share the skills register for use in their services **Action:** Contact BK/FR about skills register Managers to ensure outstanding sharps training is completed. To be kept on agenda.	BK All (in required areas) Service Managers CMcL	

6.	**Standing Items – Health & Safety Reports (Datix)** i) H&S Proforma's Community Care. Paper noted – one issue. Admin – Paper noted. Member of staff locked in building. Left via fire exit. There is now notices with contact number if anyone is locked in. Residential Care – Elderly Paper noted. BS advised that they are seeing a reduction in violent incidents recently. 12 staff from care homes and independent section are to attend training – Essential in Psychological Care for people with Dementia. Starts on 20 February 2019. Staff need to have already completed a Skilled level dementia. Mental Health and Addictions Services Paper noted. Significant Event ??? gone to Procurator Fiscal – actions in terms of process of duty service in Helensburgh. Action Plan to look at what went wrong in the process of admission. Looking at that process and to ensure this doesn't happen again. This will go to the Clinical and Care Governance Group. MSK Physio Paper noted. No resuscitation officer for MSK – Serena to email Elaine White and will copy Janice in Children's Services.	All Leads SB SB	

	Paper noted. Children's Services NHS Proforma was omitted in error by when papers were sent out, this will be sent to group by Kate. Violent Incidents in children's units has been highlighted, with concerns raised in relation to the amount of incidental reports for children's houses. Annie discussed a client who is accessing social workers Facebook accounts. There is a warning system on Carefirst which only manager's can access, this will show red, and staff need to approach manager to be informed of warnings. Annie will link with relevant manager to discuss client. **Action -** Annie to look into trauma based training for children's services and report back to next meeting. Two reports produced for Looked After Children. **Action -** Stevie will pick up with services in relation to reporting recording of incidents. Homecare Paper noted. One Riddor – fire doors in West Bridge End. Worker injured opening heavy fire door. ii) H&S Reports (Figtree) iii) Quarterly Health & Safety Committee Report SG spoke to report. In terms of getting incidents approved weekly reminders are being sent out to authorising managers. If not complete, then strategic lead will be informed. iii. Learnpro Needlestick Deferred until next meeting as Elaine White was not in attendance.	CMcL AR SG	

	iv) Datix Group • Datix Bulletin Paper noted. v) Fire Training (standing item) Manual Handling module – basic awareness training required to be completed before doing moving and assisting course can commence. **Health & Safety Reports FIGTREE:** Joint report submitted from NHS / WDC. Discussion around the elements of the report from Care First and TUs requested that more detail is provided around incidents related to Residential Care Homes that do not go through the FIGTREE system. SG stated that he will add further detail in future reports. SG confirmed that residential care home will have face to face training. **Action** - Stevie will feedback to next meeting. **Update on all training:** SG stated that iLearn modules have been developed for a variety of subjects, including Fire, Slips trips and falls. Driver Safety Awareness and these modules will be available in near future via the WDC iLearn platform. vi) Update Figtree Risk Assessment hopefully going live by end of February.	SG	
7.	Statutory and Mandatory Training Fire safety has gone down by nearly 2%, which is concerning. Compliance needs to be increased. **Action:** Managers to remind team that this needs to be completed and 95% required for all modules.	All	
8.	Violence and Reduction Group (NHS) Group is concerned about the lack of reporting of violent incidents in district nursing, health visiting. Group asked if each HSCP have a training needs analysis completed/in place. Violence and Reduction Group (NHS) notes a lack of reporting of violent incidents in district nursing, health visiting across NHS GG&C. A concern was raised at this group that this was being under reported within these services. Following discussion within the meeting it was suggested that the reporting is a fair	FD	

	reflection on the number of incidents. Fraser will report this back to the Violence and Reduction Group. There are no issues in district nursing. Fraser to link in with Mags Simpson in relation to Health Visiting.	FD/MS	

9.	***Dates for the year:***	***Time:***	***Venue:***
	29 January 2019	2pm - 4 pm	The Boardroom, Hartfield Clinic
	30 April 2019	10am – 12pm	The Burgh Meeting Room, 16 Church Street, Dumbarton
	30 July 2019	10am – 12pm	Ballantines Meeting Room, 16 Church Street, Dumbarton
	22 October 2019	10am – 12pm	Ballantines Meeting Room, 16 Church Street, Dumbarton
	Invites have been sent to group – advise group of new venue for meetings.		